The London Bridge Hospital

Quality Report

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

Ratings

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

Mental Health Act responsibilities and Mental Capacity Act and Deprivation of Liberty Safeguards

We include our assessment of the provider's compliance with the Mental Capacity Act and, where relevant, Mental Health Act in our overall inspection of the service.

We do not give a rating for Mental Capacity Act or Mental Health Act, however we do use our findings to determine the overall rating for the service.

Further information about findings in relation to the Mental Capacity Act and Mental Health Act can be found later in this report.

Summary of findings

Letter from the Chief Inspector of Hospitals

The London Bridge Hospital, opened in 1986, is operated by HCA Healthcare UK who took over the running of the hospital in 2000. The group provides care at several other hospitals in the UK including locations in London and Manchester.

The hospital has 124 inpatient beds, four renal dialysis chairs and 15 day case trollies. Facilities include six operating theatres, a catheter laboratory for interventional procedures, an 18 bedded level two and three critical care unit and several outpatient and diagnostic imaging facilities.

London Bridge Hospital provides a range of surgical procedures, medical care including oncology and care in the last days of life, a level two and three critical care unit and outpatients and diagnostic imaging. We inspected all the services provided except outpatient chemotherapy.

We inspected this service using the new comprehensive independent hospitals methodology. We carried out an announced inspection on 21 and 22 September 2016, along with two unannounced visits to the hospital on 29 September and 6 October 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.

Overall we have rated The London Bridge Hospital as Outstanding. For the hospital overall we rated the key questions as follows:

Are services safe?

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

We rated safe as Good because:

- There was an established hospital incident reporting system. Incidents were reviewed and monitored and examples of learning were demonstrated. Patient morbidity and mortality meetings were held regularly as part of patient safety measures.
- Areas we visited were visibly clean and tidy and staff adhered to Infection prevention and control (IPC) protocols. Dedicated IPC link nurses and medical staff worked to improve IPC practices in the hospital.
- Equipment was accessible to staff as required and was safety tested and well maintained.
- There were issues with the storage of large items in theatre that were rectified during inspection, and staff told us there was a long term solution for storage of these items.
- Medicines were stored securely and in ward areas were accessed by use of an electronic key system. Pharmacy staff were available to assist in all areas with any concerns, medicines reconciliation or patient discharge.
- Records were stored securely and paper notes were scanned onto the computer so all notes were accessible online.
- Staff were trained to undertake child and adult safeguarding to a level appropriate to their job to ensure patients were protected against abuse.
- Information about patients was recorded including past medical history and risk assessment and was available to staff via an online system.
- There was adequate nursing and allied health professional staffing throughout the hospital to ensure patients were cared for safely. Staff had completed mandatory training and bank staff completed competency checklists before undertaking shifts.

Summary of findings

- The hospital employed its own Resident Medical Officers (RMOs). They were highly trained in their speciality and worked rotas on-call 24 hours a day seven days a week. Consultants were available for each speciality within 30 minutes of the hospital and some Consultants such as anaesthetists and intensivists stayed on site during their on call period.

However:

- The five steps to safer surgery checklist were not always completed. Poor completion of the debrief has previously been addressed via an action plan but audits showed that it was still not completed in some cases.

Are services effective?

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

We rated effective as Good because:

- Patient care and treatment was planned and delivered in line with current best practice, evidence based guidance and current legislation. National guidance such as National Institute for Health and Care Excellence and the Royal Colleges was evident.
- There was a local audit system in place. Where concerns were noted, action plans with clear times for completion of change were in place.
- The hospital participated in national audits including the National Institute for Cardiovascular Outcomes Research (NICOR) and Intensive Care National Audit and Research Centre (ICNARC) to benchmark practice against other units in the UK. For those it could not participate in it continued to collected data to internally assess practice for example the National Diabetes Audit framework.
- There were two pain management consultants who attended the hospital, pain clinical nurse specialisits and pain link nurses available on each ward to assist staff in controlling patient's pain.
- There were a range of clinical nurse specialists within the hospital in areas such as nutrition, diabetes, gastrointestinal and cardiac conditions and symptom control for oncology patients . These nurses assisted in improving care and implementing positive change.
- Consultants practised at the hospital under practising privileges which were reviewed yearly. Any concerns about a consultants practice could be discussed at a decision making forum through the Medical Advisory Committee (MAC).
- There were significant learning opportunities for all staff in both clinical and non - clinical subjects including masters degrees and specialist training in renal dialysis, intensive care nursing and oncology.
- There was a strong multidisciplinary team working ethos within the hospital which was well supported by the senior management and involved both external and internal bodies.
- Staff had a good understanding of the Mental Capacity Act (2005) and Deprivation of Liberty Safeguards (DOLs) throughout the areas we inspected.

Are services caring?

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

We rated caring as Good because:

- Patients received care from highly motivated individuals who aimed to provide the highest quality care.
- There were good patient feedback channels and staff acted on any concerns patients highlighted throughout their stay.
- Staff were prepared to go the extra mile for patients by accommodating as many requests as possible even if this meant staying behind after shift or it was difficult to organise.
- People were cared for holistically with staff taking into account social, spiritual and cultural needs.

Summary of findings

- There was appropriate information available to patients to help them make informed choices about their care. Patients felt they had time to ask questions about their treatment and discuss options.

Are services responsive?

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

We rated responsive as Outstanding because:

- Services were planned in a holistic manner to meet both the local and the international population the hospital served. Some clinics offered a one stop service to make it easier for patients to attend.
- Staff were expected to undertake specialist customer and cultural training. They were supported in learning by the practise development team and local practice development nurses.
- There was a large team of allied health professionals and house keeping including physiotherapists, occupation therapists, dieticians, chefs, receptionists and radiographers. Team work was exemplary and provided a range of therapies and comfort measures to all patients.
- There were no waiting lists for patients in any speciality. Patients could be admitted on the same day or select a day suitable for them and staff told us there was never an issue in admitting at the requested time. Dedicated discharge nurses aimed to ensure a smooth discharge process for staff and patients alike.
- There was an dedicated onsite translation service and hospital signage for those patients who spoke Arabic. All other languages could be accessed via language line which staff used regularly.
- Staff understood that patients living with dementia may require adjustments when using hospital services and told us ways in which they would provide these.
- Staff made arrangements for families to stay with patients where possible and we saw examples of birthday cakes and wedding celebrations catered for within the hospital.
- Complaints were dealt with promptly by the patient experience manager and we saw that where complaints had been raised changes to practice had been made to rectify these quickly.

Are services well-led?

We rated well-led as Outstanding because:

- There was a clear and visible vision and set of values within the London Bridge Hospital. Staff understood and were highly motivated to achieve the corporate and local values in all aspects their work.
- There was strong and visible local leadership and senior management teams. Consistently across the hospital staff spoke highly of the local leadership and senior management team, they said they were very approachable, open and listened to staff when they had concerns. We saw that the Chief Executive Officer knew staff in clinical areas by name and the Chief Nursing Officer did a daily morning walk round of the clinical areas. There was strong clinical leadership and medical staff across all grades were actively involved in developing and improving patient care and services.
- Managers had an inspiring shared sense of purpose and worked towards shared goals of providing the highest quality patient care possible. They motivated staff to work as a team and encouraged a positive working culture of openness and learning.
- There was an effective governance structure. All meetings within the governance framework were well attended across the hospital. Feedback from the governance meetings was presented at the weekly senior management team meeting and to the board and also fedback to staff in clinical areas.
- The hospital was continually looking to improve and sought feedback from both patients and staff. Where concerns were raised management would aim to make changes to improve care and working conditions across the hospital. Feedback from both patients and staff was overwhelmingly positive.
- Staff were given many opportunities to achieve recognition through an employee of the month scheme, research and further learning. Some staff we spoke to told us about when they had received this award and been mentioned in the "Tooley Times" staff newsletter.

Summary of findings

- We saw innovative practice throughout the hospital including new research taking place in theatre, new infection prevention and control practises and safer medicines management through use of an electronic key system.

We saw several areas of outstanding practice including:

- An electronic key for use when obtaining and dispensing medication had been introduced to make medicines management safer. It allowed staff to see which member of staff had accessed medicines cupboards and reduced delays in patients receiving their medications.
- The hospital employed its own RMOs who were highly trained in the speciality in which they worked. Consultants were available for both their own patients and on an on-call basis for example on call intensivists and anaesthetists. Consultants on call would stay on site in the hospital if required.
- We found excellent multidisciplinary team (MDT) working with close collaboration between all staff including live donor liver transplants in conjunction with a local liver specialist team.
- A clinical perfusionist within theatre was being supported to undertake innovative research which would have results published nationally once it was complete.
- HOT boards were available in each clinical area which provided a standard set of information including risk registers, new policies and procedures, incidents and learning from these and new complaints. It allowed staff to learn about risk management and quality improvement and encouraged them to learn about other services within the hospital.
- The hybrid catheterisation laboratory allowed consultants to perform complex medical procedures by both imaging and intervention supported by surgical teams in one session.
- Staff were encouraged and motivated to take part in learning opportunities provided by the hospital. Learning included masters degrees, specialist training in renal, intensive care and cardiac conditions.
- There were no waiting times for patients to be seen in a clinic or admitted to hospital if a procedure was required.
- Leadership at both a local and senior level was visible and motivational and staff were overwhelmingly positive about the support they received from their managers. The felt that they could raise issues in a timely manner and their concerns would be listened to and acted upon.

There were also areas where the provider needs to make improvements.

The hospital should:

- Continue to work to ensure the five steps to safer surgery including the debrief after surgery are fully embedded
- Ensure that staff are aware of who to contact and how to care for a patient living with a learning disability being admitted to the hospital.
- Equipment in theatres should be stored in a safe manner to ensure that patient safety is not compromised within the theatre department.

Professor Sir Mike Richards
Chief Inspector of Hospitals

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Medical care	Good	The hospital had systems to minimise risks to patients. Staff had an awareness of safeguarding and steps to take to report any safeguarding concerns to protect patients from abuse. An innovative electronic key system for medicines was introduced to prevent medicines errors and promote good practice. Patients who deteriorated were managed safely and effectively and there was good communication within the multidisciplinary team. Treatment was provided in line with national guidance and staff were aware of the National Institute for Health and Care Excellence (NICE) guidance related to all areas of medical care. All of the patient feedback we received was positive including involvement in care and privacy and dignity. Staff were seen to be kind and caring and their focus was on delivering individual patient care. Services were planned to meet patient's needs from both national to international patients and their families. Complaints were responded to and acted upon in a timely manner and lessons learnt and fed back to staff where required. There was a strong, motivated and inspiring leadership at ward and departmental level which staff told us pushed them to be the best and provide the highest quality care. All staff told us that senior managers were very visible and approachable and we saw that the CEO of the hospital knew all staff by name during out inspection. Staff were aware and passionate in delivering of the hospital's vision and values. The culture within all the areas was one of openness and honesty and staff were overwhelmingly proud and positive about their contribution to patient care.
Surgery	Good	We found good processes for reporting and escalating incidents and good sharing of learning from incidents.

Summary of findings

There were some issues with storage of large equipment in theatre corridors, particularly on day one of the inspection, however this was rectified during our visit and a long term solution for storage was in place.
There was a good understanding of the duty of candour regulation and major incident policies amongst clinical staff.
There were good patient outcomes across surgical specialties and care was delivered in line with relevant national guidelines. The service performed well in national clinical audits.
Staffing needs were based on acuity of patients.
Patients had effective and timely pain relief.
Staff felt supported with good supervision and training opportunities, including funding for additional courses. There was good multidisciplinary team (MDT) working between all staff.
Staff across the surgery service were friendly, caring and professional, and patients were treated with dignity. Staff often went 'the extra mile' to ensure that patient needs were met and patients were comfortable and informed about their treatment and care. We observed numerous positive, caring interactions between staff and patients.
Patient flow from admissions, through theatres and onto to surgery wards was satisfactory and bed availability was managed effectively.
We found a cohesive and supportive leadership team, with well-established members of staff. Senior staff, ward managers and matrons were highly visible on the wards. The consultant body within the service provided clear clinical direction. There were comprehensive and effective governance and risk management processes in place.
Staff at all levels in surgery were supported to carry out additional training.
However, the five steps to safer surgery checklist indicated that end of list debriefings to complete the five steps were not consistently carried out.

Critical care

Outstanding ☆

Incidents were reported and staff received feedback and learning from incidents. The CCU was clean and staff adhered to infection control policies and protocols. Record keeping was comprehensive and audited regularly.

Summary of findings

Decision making about the care and treatment of a patient was clearly documented using a multi-disciplinary approach. Patients were assessed and responded to in a timely manner if they were at risk of becoming unwell. There was good medicines management.
Patients received treatment and care according to national guidelines such as the National Institute of Health and Care Excellence. Patients experienced good outcomes as evidenced by a range of national audits. The Intensive Care National Audit Research Centre (ICNARC) was used as a basis to quality assure its critical care services.
Multidisciplinary working was robust. All staff had access to further development and clinical training. All staff had received annual appraisals and the opportunity to complete mandatory training. The services were flexible, provided choice and ensured continuity of care at a time that suited the patients. Staff went the extra mile to make sure patients' care was of the highest quality, timely and compassionate. Leadership at a local level was excellent and staff told us about being supported and empowered and enjoyed being part of a team. The service had reviewed its governance arrangement in order to ensure it continually met best practice and ensured its systems were robust and fit for purpose. There was an open, transparent no blame culture.
Staff were empowered to lead the way in making improvements to the service with the support of senior staff.

Outpatients and diagnostic imaging

Outstanding ☆

There were effective systems in place to protect patients from harm and a good incident reporting culture. Patient records were comprehensive, with appropriate risk assessments completed. Medicines were generally stored safely and securely.
Staff used evidence based care and treatment in line with national guidelines and local policies. Staff were competent in their roles and a number of staff had completed further training and development.
Patient feedback for the services visited were consistently positive, patient satisfaction survey results were positive and patients felt supported. Confidentiality, dignity and privacy was respected by staff.

Summary of findings

Clinics and services were developed to meet the needs of patients, including where clinics were located. Staff were aware of people's individual needs and considered these when providing care. The department dealt with complaints and concerns promptly.

We saw excellent local leadership within the department and staff reflected this in their conversation with us. There was a positive, open and non-blame culture in the OPD and members of staff said they could raise concerns with the leadership team.

Staff said they were motivated to go the extra mile to make sure patients receive the best care and are safe. There were effective and robust governance processes and risks were proactively reviewed. There was evidence of staff and patient engagement and changes being made as a result of concerns.

The outpatients department had implemented a number of innovative services and developed these to meet patient's needs. Staff had been encouraged to contribute to developing and improving services.

Summary of findings

Contents

Outstanding ☆

The London Bridge Hospital

Services we looked at:

Medical care; Surgery; Critical care; Outpatients and diagnostic imaging

Summary of this inspection

Background to The London Bridge Hospital

The London Bridge Hospital is a private hospital operated by HCA Healthcare UK who also provide care at several other hospitals in the UK. The hospital opened in 1986 and became part of HCA in 2000. It is based in the London Bridge area in South East London.

The hospital provides a range of surgery and medical care, a level three critical care providing care to adults and several sites providing outpatients and diagnostic imaging. They therefore provide four of the eight core services that are inspected by the Care Quality Commission as part of its new methodology in hospital inspection.

The hospital is registered for 124 inpatient and 15 day care beds. It has four renal dialysis chairs, an endoscopy department and catheter laboratory. It has specialties including oncology, gastrointestinal surgery, cardiothoracic surgery, sleep disorders and epilepsy.

The hospital has a registered manager, John Reay, (CEO) who has been in post since 2001.

The nominated individual is Mr Michael Neeb.

Our inspection team

The team that inspected the service comprised of a CQC Inspection Manager, Margaret McGlynn , five CQC inspectors and specialist advisors with expertise in surgery, cardiology, oncology, outpatients and critical care.

An expert by experience spent time talking to patients to understand their experience of the care they had received. An expert by experience is someone who has developed expertise in relation to health services by using them or through contact with those using them – for example as a carer.

Why we carried out this inspection

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

How we carried out this inspection

To get to the heart of patients' experiences of care and treatment, we ask the same five questions of all services:

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

Before our inspection we reviewed a range of information provided to us about the hospital and the core services.

We carried out the announced part of the inspection on 21 and 22 September 2016, along with two unannounced visits to the hospital on 29 September and 6 October 2016. We spoke with 97 staff including medical staff, nurses, house keepers, radiologists, physiotherapists, occupational therapists, dieticians and clerical staff.

Summary of this inspection

We spoke with 28 patients and six relatives. We also received 20 'Tell us about your care' comment cards which patients had completed prior to our inspection. During our inspection, we reviewed 26 sets of patient records.

All comments we received were positive about the care and treatment patients had received whilst at the hospital. Staff were very positive about working in the hospital.

We conducted a focus group with consultants who worked at the hospital and interviewed the hospitals senior managers including the CEO, chief nursing officer, head of clinical governance and head of the medical advisory committee (MAC).

Information about The London Bridge Hospital

The hospital is registered for 124 inpatient and 15 day care beds. It has four renal dialysis beds, an endoscopy department and catheter laboratory for interventional procedures. There are six operating theatres. It is registered to provide the following regulated activities:

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

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

Activity (April 2015 to March 2016)

- In the reporting period April 2015 to March 2016 there were 18,569 inpatient and day case episodes of care recorded at the hospital; of these 0.1% were NHS-funded and 99.9% other funded.
- 100% of all NHS-funded patients and 30% of all other funded patients stayed overnight at the hospital during the same reporting period.
- There were 118,675 outpatient total attendances in the reporting period; of these 99.997% were other funded and 0.003% were NHS-funded.
- 686 doctors and dentists worked at the hospital under practising privileges at the time of our inspection. 10 resident medical officers (RMO) were employed by the hospital and worked on set rotas set in their area of work. The London Bridge Hospital employed 272.2 whole time equivalent (WTE) registered nurses and 33.9 WTE care assistants and operating department practitioners and as well as having its own bank staff. There was a further 517.3 WTE staff including porters, receptionist, hospitality and radiographers.

The accountable officer for controlled drugs (CDs) was the Chief Nursing Officer, Kerry Barnham-Smith.

The hospitals track record on safety covers the period April 2015 to March 2016. There was one never event reported to the CQC. There was a total of 820 clinical incidents, 641 were no harm, 151 were low harm, 19 moderate harm, three severe harm and six were reported as the death of a patient of which one was deemed preventable. The number of reported incidents was lower than other independent hospitals that the CQC holds information for. There were 278 non-clinical incidents reported across the hospital in the same timeframe. There were seven serious injuries reported to the CQC.

There was one incident of each of hospital acquired Methicillin-resistant Staphylococcus aureus (MRSA), hospital acquired Methicillin-sensitive staphylococcus aureus (MSSA), hospital acquired Clostridium difficile (c-diff) and hospital acquired E-Coli.

There were two complaints received directly by the CQC and a further 167 complaints reported to the hospital. This was similar to other hospitals the CQC hold information for.

There were several Services accredited by a national body:

Summary of this inspection

- Endoscopy Service: Joint Advisory Group [JAG] accreditation
- Pathology Service: Clinical Pathology Accreditation [CPA]
- Cancer Service: CHKS ISO 9001 accreditation
- Hotel Services: British Institute Cleaning Science [BICSc] accreditation
- Hotel Services: Chartered Institute of Environmental Health
- CSSD -British Standards Institution
- Theatres: Association for Perioperative Practices
- Investors in People Gold award
- Investors in People 15 year award
- Macmillan Quality Environment Mark

Services provided at the hospital under service level agreement:

- Air Quality Monitoring
- Ambulance Services Archive Services
- Biomedical Devices Management
- Blinds Cleaning
- Carpet Cleaning
- Coffee Machines
- Contract Cleaning
- Courier Services
- Deep Cleaning Services
- Health and Safety
- Housekeeping Services
- Infection control services
- Kitchen Ventilation Cleaning
- Laundry
- Medical Gases
- Patient Transfers
- Pest Control

What people who use the service say

People who spoke with us told us they were very happy with the care they had received. They told us that all staff had gone to great measures to make their treatment and time in hospital pleasant and comfortable.

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 was a hospital wide electronic incident reporting system and staff understood how to report incidents. These were reviewed and monitored and examples of learning were demonstrated. Staff felt confident in reporting incidents and there was a culture of openness.
- Most staff understood the duty of candour regulation and all staff understood the need to be open and honest with patients if something went wrong. We saw examples of duty of candour that had been carried out.
- Clinical areas we visited were visibly clean and tidy and a dedicated infection prevention control team regularly monitored infection control practises and risks associated with hospital acquired infection. There were low numbers of hospital acquired infections and surgical site infections across the services.
- Equipment was accessible to staff as required, was safety tested and well maintained.
- Theatres were not always storing large equipment in a safe manner in the department. This was raised during inspection and rectified on the second day. A long term solution had been identified.
- Medicines were stored securely and in ward areas were accessed by use of an electronic key system. Pharmacy staff were available to assist in all areas with any concerns, medicines reconciliation or patient discharge.
- Records were stored securely on an online system. Where paper notes were used these were scanned onto the computer so that all notes were instantly accessible online.
- Staff understood their responsibilities in relation to safeguarding and knew how to report a safeguarding concern in case of suspected abuse. The head of nursing was trained to safeguarding level four.
- Nurse and allied health professional staffing was adequate throughout the hospital and where there were gaps in rotas there were bank staff who were adequately trained to work in the clinical areas they were placed. Staff had appropriate mandatory training to allow them to carry out their role safely.
- The hospital employed its own Resident Medical Officers for each core service we inspected. These RMOs were highly trained in their speciality and on-call 24 hours a day seven days

Summary of this inspection

a week. Consultants were available for each speciality within 30 minutes of the hospital and some Consultants such as anaesthetics and intensivists stayed on site during their on call period.
- There was an emergency preparedness and response protocol which most staff knew how to access and put in place if required.

However:

- Not all consultants were undertaking the debrief stage of the five steps to safer surgery despite an action plan completed by the hospital to encourage its use.

Are services effective?

Good

We rated effective as "Good" because:

- Patient care and treatment was planned and delivered in line with current best practice, evidence based guidance and current legislation. National guidance such as NICE and the Royal Colleges was evident.
- There was a local audit system in place to audit areas of practice including diabetes management, infection prevention and control and the five steps to safer surgery including the WHO checklist. Where non compliance was noted, action plans with clear times for completion of change were in place.
- The hospital participated in a range of national audits including cardiac audits such as Transcatheter Aortic Valve Implantation (TAVI), NICOR and the Intensive Care National Audit and Research Centre, so that it could benchmark practice against other units in the UK. For those it could not participate it still collected data to internally assess practice.
- There were two pain management consultants in the hospital and pain link nurses available on each ward to assist staff in controlling patient's pain. Staff were trained in the use of specialised pain relief equipment and pharmacists could assist in symptom control medications for pain in oncology patients.
- There were 23 clinical nurse specialists within the hospital in areas such as nutrition, diabetes, gastrointestinal conditions and cardiac. Their role included assisting in caring for patients within their speciality, carrying out audits and teaching staff how to care for patients with complex specialist needs.
- There was a wide range of hot and cold meals and drinks and the hospitality team were available at all times. There were dieticians and specialist nutritional teams available to assess nutritional and hydration requirements.
- Consultants practised at the hospital using practising privileges. This involved a robust application process and was reviewed

Summary of this inspection

yearly. It included doctors completed revalidation and appraisals, CV, indemnity insurance and references. Any concerns about a consultants practice could be discussed at a decision making forum through the medical advisory committee (MAC).

- Nurses were well supported in completing their revalidation by the learning and development team. Doctors completed their revalidation with the responsible officer. There were significant learning opportunities for all staff to undertake in both clinical and non - clinical subjects such as renal dialysis, intensive care and customer service.
- There were a number of well attended multi-disciplinary team meetings to discuss patient care and treatment and these were well attended. We saw good multidisciplinary team working in all areas we visited whilst on inspection.
- Staff attended training on the Mental Capacity Act (2005) and Deprivation of Liberty Safeguards (DOLs). Staff we spoke to had a good understanding of how they would care for a patient who lacked capacity, how patients should be consented and what DOLS meant and how to implement this if required.

Are services caring?

Good

We rated caring as Good because:

- Patients received care from highly motivated individuals who wanted to provide the highest standard of care and treatment to each person they cared for.
- Staff were prepared to go the extra mile for patients by accommodating as many request as possible even if this meant staying behind after shift or it was difficult to organise.
- People were cared for holistically with staff taking into account social, spiritual and cultural needs at each stage of the patient journey.
- There was appropriate information available to patients in helping them to make and informed choice about their care. Patients felt they had time to ask questions about their treatment and discuss options.

Are services responsive?

Outstanding

We rated responsive as Outstanding because:

- Services were planned in a holistic manner to meet both the local and the international population the hospital served. Clinics such as the breast clinic offered a one stop service so patients did not have to return on several occasions.

Summary of this inspection

- There was a large team of allied health professionals including physiotherapists, occupation therapists, dieticians and radiographers. They worked as a team to provide a range of therapies to both inpatient and outpatients.
- There was no waiting list to be seen as an outpatient or admitted for care. Patients could be admitted on the same day or select a day suitable for them and staff told us there was never an issues in admitting at the requested time. Dedicated discharge nurses aimed to ensure a smooth discharge process for staff and patients alike.
- There was an onsite translation service and hospital signage for those patients who spoke Arabic. All other languages could be accessed via language line which staff used regularly.
- The hospital rarely admitted patients living with dementia or a learning disability but, most staff understood who to escalate concerns to if required and how they would care for these patients to ensure they did not suffer undue distress.
- Staff would make arrangements for families to stay with patients where possible and we saw examples of chefs catering specifically for patients requests and ward staff providing birthday cakes, party items and wedding celebrations.
- Complaints were dealt with by the patients experience manager and discussed at the weekly complaints, litigation, incidents and patient experience meeting. We saw that where complaints had been raised changes to practice had been made to rectify these.

Are services well-led?

Outstanding ☆

We rated well led as Outstanding because:

- The hospital used patient feedback to ensure that they were improving on areas of care that were not satisfactory for patients
- There was a clear and visible vision and set of values within the London Bridge Hospital. Staff understood and aimed to achieve the corporate and local visions and values in all aspects their work.
- There were strong and visible local and senior management teams and staff spoke very highly of them. All staff we spoke to felt they were approachable, open and listened to staff when they had concerns. We saw that the CEO knew staff in clinical areas by name and the Chief Nursing Officer did a daily morning walk round of the clinical areas.
- There was a strong governance structure which included clinical and integrated governance, the medical advisory committee, health and safety and workforce planning. All

meetings within the governance framework were well attended across the hospital. Feedback from the governance meetings was fed back to the weekly senior management team meeting and to the board. Feedback was also given to clinical and non-clinical staff in all areas in a variety of formats.

- The hospital actively sought patients and staff experiences of the hospital and where concerns were raised management would aim to make changes to improve care and working conditions.
- Staff were given opportunities to achieve recognition through employee of the month and some staff we spoke to told us of time they had received this award and been mentioned in the "Tooley Times" staff newsletter. Staff were very well supported in the development and career progression.
- We saw innovative practise in all areas we visited including new infection control trolleys in the CCU, live donor liver transplantation and HOT boards for staff engagement and patient safety.

Detailed findings from this inspection

Overview of ratings

Our ratings for this location are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Medical care	Good	Good	Good	Good	☆ Outstanding	Good
Surgery	Good	Good	Good	Good	☆ Outstanding	Good
Critical care	Good	Good	Good	☆ Outstanding	☆ Outstanding	☆ Outstanding
Outpatients and diagnostic imaging	Good	Not rated	Good	☆ Outstanding	☆ Outstanding	☆ Outstanding
Overall	Good	Good	Good	☆ Outstanding	☆ Outstanding	☆ Outstanding

Notes

Good

Medical care

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

Information about the service

The London Bridge Hospital (TLBH) provides a range of medical care services to both private and NHS patients. Medical services include renal dialysis, endoscopy, cardiology and oncology. They have a sleep assessment service and an epilepsy service available.

The hospital does not provide care to children under the age of 16 years.

There were 18,569 inpatient and day case episodes of care recorded at the hospital in the reporting period (Apr 15 to Mar 16). Of these, 0.1% were NHS funded and 99.9% were other funded.

We inspected the oncology ward, endoscopy suite, day unit, cardiology department, cardiac catheter laboratory, renal dialysis unit and cardiac physiology department.

We spoke with seven patients including their family members, 31 staff members including doctors, ward nurses, radiographers, dieticians, dialysis nurses, clinical nurse specialists, service managers, physiologists and therapists.

The dialysis unit operates from Monday to Saturday between the hours of 7.30am to 6pm with two sessions per day. Patients are offered the choice of a morning or afternoon session. The cardiac catheter laboratory offers a service from Monday to Friday with on-call cover out of hours and at weekends.

The oncology service's inpatient unit comprises of a 16-bedded ward and specialises in medical and surgical oncology, including breast and maxillofacial surgery and diagnostic and interventional radiology. Patients requiring symptom control are nursed on the ward. There is a dedicated consultant and symptom control clinical nurse specialist. Two clinical psychologists are available for patients who require counselling on a more formal basis.

The endoscopy suite operated from Monday to Friday 9am to 6pm. Patients undergoing endoscopy are admitted to the day care unit and have their recovery there following their procedure.

We observed interactions between patients and staff checked the environment and equipment and reviewed 11 care records. We received comments from people we spoke with during the inspection to tell us about their experiences. Before and during our inspection we reviewed the provider's performance and quality information.

Good

Medical care

Summary of findings

We rated medical care as Good because:

- The hospital had systems to minimise risks to patients. Staff knew how to report incidents and these were investigated, fed back to staff, lessons were learnt and learning was applied.
- Staff had an awareness of safeguarding and steps to take to report any safeguarding concerns to protect patients from abuse.
- An innovative electronic key system for medicines was introduced to prevent medicines errors and promote good practice.
- Patients who deteriorated were managed safely and effectively and there was good communication within the multidisciplinary team.
- Treatment was provided in line with national guidance and staff were aware of the National Institute for Health and Care Excellence (NICE) guidance related to all areas of medical care.
- Patients were complimentary about the care they received and patients with complex needs were supported and their families were encouraged to stay with them.
- All the patients we spoke with told us they had been provided with relevant information both verbal and written, to make an informed decision about their care and treatment.
- All of the patient feedback we received was positive including involvement in care and privacy and dignity
- Staff were seen to be kind and caring and their focus was on delivering individual patient care.
- Services were planned to meet patient's needs from both national to international patients and their families.
- Dialysis, endoscopy, oncology and cardiology care was planned and co-ordinated effectively with highly specialised staff providing patient care.
- Complaints were responded to and acted upon in a timely manner and lessons learnt and fed back to staff where required.
- There was strong, motivated and inspiring leadership at ward and departmental level which staff told us pushed them to be the best and provide the highest quality care.
- All staff spoke highly of the senior managers and told us they were very visible and approachable. We saw that the CEO of the hospital knew all staff by name during out inspection and there was strong clinical leadership.
- Staff were aware and passionate in delivery of the hospital's vision and values. The culture within all the areas was one of openness and honesty and staff were overwhelmingly proud and positive about their contribution to patient care.

Good

Medical care

Are medical care services safe?

Good

We rated safe as Good because:

Incidents

- From April 2015 to March 2016 there were 154 incidents in the inpatient setting; 120 were no harm, 32 were low harm, 2 moderate harm and all deaths are noted as incidents, expected and non-expected. There were a further 185 incidents in other services at the hospital. This was a lower number that other independent health services inspected.
- Incident reporting was completed via the computerised reporting system. The governance team within the hospital which included the chief nursing officer and medical governance lead received a copy of all incidents which happened within the hospital. The corporate governance team also received incidents reported by the hospital
- Staff we spoke to had full awareness of the processes to follow in order to report adverse incidents or concerns and told us the culture encouraged reporting
- Incidents were discussed at a weekly incident review meeting chaired by a member of the governance team. Attendance included ward managers, a physiotherapist, senior pharmacist and the training and development team. Learning from incidents was then taken back to clinical areas by the senior staff. We saw examples of changes following incidents included a new blood taking trolley to prevent incorrect blood sample labelling.
- "HOT" boards had been introduced on each medical ward and area which provided details of incidents, amongst other information such as policy change and risk registers, within the hospital and what learning had come from these. It allowed staff who were not on shift during ward meetings or briefings had time to read and learn from incidents
- Ward and renal dialysis staff discussed incidents reported in the previous 24 hours at a safety briefing meeting which followed the daily staff handover. Staff told us the aim was "to enable the team to proactively anticipate any risks to the quality of patient care prioritise and plan actions based on patient need and available resources"
- Staff understood the duty of candour process and the importance of being open and honest with patients in the event of something going wrong. On inspection we reviewed evidence that duty of candour regulation had been followed when incidents had occurred. 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.

Safety thermometer or equivalent

- Each department displayed clinical performance data on the notice boards in offices and staff rooms through a "safety cross" which was filled in every Friday in the ward areas.
- The service had monitored performance through a series of assessments to reduce risk to patients. These included falls, moving and handling, medication incidents, pressure ulcers and venous thromboembolism (VTE).
- The "safety cross" on the oncology wards were completed each day and reviewed by the nursing team at the beginning of each shift. In September 2016 there had been no falls across the two medical wards we visited, one pressure ulcer and one medication incident.

Cleanliness, infection control and hygiene

- All areas we visited were visibly clean and tidy.
- We were told the hospital had a formalised Infection Prevention and Control (IPC) team which included The Director for Infection Prevention and Control (DIPC) who was the Chief Nursing Officer (CNO) and a lead nurse who was supported by four consultant microbiologists.
- In the reporting period April 2015 to March 2016 there was no incidents of MSSA or MRSA, three incidents of e-coli and one of c-difficile across the medical services.
- The hospital had policies and procedures in place to manage infection control. Staff were able to access the policies and procedures which included hand washing and MRSA screening.

- Each ward and department had a designated IPC link nurse who had received further training in IPC to support them in their role to teach other staff and undertake audits on hand hygiene and other IPC audits.
- Staff told us that monthly IPC audits were carried out and information included in the Infection Control Portal in order to update colleagues and allow monitoring by senior managers. We saw hand hygiene audits for all medical areas within the hospital had achieved the hospitals target of 95% compliance between March and August 2016.
- Disposable aprons, face masks and gloves were readily available and we saw staff using these appropriately during inspection.
- We saw cleaning schedules and staff maintained a record to provide assurance of decontamination.
- We saw adequate hand washing facilities and hand sanitising gel was available for use throughout the hospital and observed staff and visitors using them.
- There was signage on the ward areas, toilets and bathrooms reminding people of the importance of hand washing.
- Clinical treatment rooms were clean and had adequate hand washing facilities available.
- A pharmacist had recently implemented an antimicrobial stewardship ward round to ensure that antibiotics were used effectively and safely. A local NHS trust had agreed to assist the hospital with any queries it may have on microbiology over the phone at any time.

Environment and equipment

- Nursing staff said they had sufficient equipment and were able to access it when required. Intravenous pumps were available and had been serviced and stored appropriately.
- Single use equipment such as syringes, needles, oxygen masks was available within the areas we visited, were stored correctly and in date.
- Equipment we saw had in date portable appliance testing (PAT). Staff we spoke with were clear on the procedure to follow if they identified broken or faulty equipment and who to report it to.
- Staff gave us examples of the introduction of specific equipment following moving and handling risk assessments. These included a special lift to move beds between wards and departments to prevent injury and battery operated equipment used by housekeeping staff which reduced the risk of trips from trailing cables. These machines were lighter and more compact for safe storage.
- Resuscitation equipment was maintained and ready for use in an emergency. Trolleys were checked daily and records we reviewed demonstrated that checks had been completed.
- We saw that mobility and manual handling assessments were carried out by nursing staff and where a hoist was required this was easily accessible by staff.
- Staff in dialysis and endoscopy services followed good practice with the management of waste and sharps. Sharps bins were located at the point of use and used appropriately.
- Staff told us that bariatric furniture and aids could be hired if required in advance of a patient admission.

Medicines

- Medicines (including controlled drugs) were stored securely in locked cupboards within a locked clinic room.
- There were appropriate facilities for the disposal of medicines for oncology ward patients; chemotherapy was not provided on the ward according to managers. However, patients who returned from chemotherapy with the intravenous medication attached was disposed of using a specially sealed bag and we saw this during inspection.
- Fridge temperatures were being recorded for medicine fridges across the areas we visited. All the readings gave assurance that the fridge temperatures had remained within the recommended range for the storage of medicines (2 – 8°c). The room temperatures were also monitored and were within the desired limits of 15ºC and 25 ºC.
- Medicines were stored securely across the hospital. In some clinical areas a key system had been implemented. This was a security feature for clinical treatment rooms and medicines cupboards. It was also installed on some controlled drugs (CDs) cabinets. It allowed senior staff to see who had opened specific medicines cupboards at a specific time. In addition, the key system removed the need for multiple keys and therefore staff could access medicines without delay.
- There were systems for the management of controlled drugs (CDs) in line with legislation. CDs were checked

daily by two registered nurses. The pharmacists carried out quarterly CD audits and told us they completed monthly follow ups on any areas that were not compliant.

- Each ward received a daily visit from a clinical pharmacist. Pharmacists spent time talking to patients about their medicines prior to discharge wherever possible. Pharmacists were also involved in multidisciplinary team meetings to optimise the use of medicines wherever possible.
- All prescription charts were clearly written and included information about any allergies, the patient's height, weight and date of birth. There was evidence that medicines reconciliation had been completed on all the prescription charts we reviewed and the pharmacist had screened each prescription on the chart.
- Before nurses were allowed administer medicines, they received mandatory medicines management training, followed by a test. Following completion of the written test their competency to administer medicines was assessed by a senior nurse. We saw completed competency booklets during our unannounced inspection.
- Chemotherapy was not given on the ward by ward nurses.
- Pharmacy staff participated in the Resident Medical Officer (RMO) training programme. The RMOs were encouraged to tour the pharmacy department as part of their annual educational programme.
- Staff understood and demonstrated how to report medicine safety incidents. There were investigated and learning fed back to staff via ward meetings or discussions with managers.
- There was an oncology pharmacist based on the ward who assisted with any oncology related medicine issues such as administration of chemotherapy. They could also assist staff in ensuring the correct symptom control medications were prescribed and administered to make patients as comfortable as possible.

Records

- Patients' records were retained in both paper and electronic format but all paper records were scanned onto the computer for ease of access. Computer records were only accessible if staff had access via password to the computer system.
- We reviewed eleven sets of patient records and found detailed information had been recorded. Information recorded showed patients had a pre-assessment and care plans had been completed.
- Risk assessments had been completed which included Venous Thromboembolism (VTE), pressure ulcer risk assessments, moving and handling, nutritional and falls risk assessment.
- Nursing and medical staff had completed accurate legible records which were up to date and stored securely either on computer or locked away if paper.
- Patients undergoing endoscopy were sent an on-line assessment which they had to complete and it was reviewed by the nurses from the pre-assessment team.
- Records of cardiology patients contained a multidisciplinary team brief and World Health Organisation (WHO) safety checklist carried out prior to each case and led by the consultant cardiologist. Endoscopy used the WHO endoscopy checklist and notes we reviewed had this fully completed.

Safeguarding

- Staff were aware of the corporate safeguarding vulnerable adult's and child policies and were able to name the leads for the hospital which included a named consultant and the CNO.
- Clinical and non-clinical staff had safeguarding training at the level appropriate to their clinical duties. At the time of inspection level two training was at 100% for renal, endoscopy and oncology nursing staff. The chief nurse was level 4 trained in child safeguarding and ward managers and floor managers were trained in level 3. There was always a manager with level 3 training on duty and we saw evidence of this in the safeguarding training
- Staff were required to complete a 500 word reflection following safeguarding training to demonstrate they have understood their training and would be able to recognise a situation that would require a safeguarding referral.
- Nursing staff were aware of their safeguarding responsibilities and had specific safeguarding training. They were able to describe different types of safeguarding concerns and abuse and could describe how they would respond if they witnessed or suspected abuse.

Mandatory training

- Staff were aware of the mandatory training they were required to undertake. Staff told us they could access training via the online learning system and training needs analysis was discussed during their annual appraisal.
- Mandatory training included equality and diversity, basic life support, ethics, fire safety, health and safety, infection control, duty of candour, information security, safeguarding adults level 1 & 2, manual handling theory and safeguarding children level 1 & 2. We saw that for nursing staff across the hospital we saw there was between 90-100% compliance in mandatory training.
- There were two practice development staff in post who monitored nurses training and facilitated attendances at external conferences and higher education.
- The hospital had processes in place to ensure consultants working with practising privileges undertook their mandatory training with their NHS employer as part of their appraisal system and this was reviewed by the Medical Director.
- All resident medical officers (RMO) were required to undertake mandatory training as part of their induction programme followed by annual updates via the hospital's online training system. Completion dates for training modules were recorded and monitored to check expiry dates. We saw that there was between 88% and 100% compliance with this.

Assessing and responding to patient risk

- A team of nurses carried out a pre-assessment prior to admission and this included a physical assessment and the patient's base line observations. This would ensure patients with underlying conditions had the correct preparation for any procedures they required.
- There were 23 neutropenic sepsis patient admitted from October 2015 to October 2016. There was a telephone assessment form used by nurses caring for oncology patients which would determine their need for admission if they were having a neutropenic sepsis. We saw this whilst on inspection. Nurses told us that if the patient lived far away and was acutely unwell they wold be asked to go to their nearest accident and emergency for immediate treatment. If they were admitted to the hospital staff would follow the neutropenic sepsis protocol and adhere to the Sepsis 6 guidelines.
- Staff told us about the introduction of the "Sepsis 6" pathway which heightened staff awareness of sepsis and the six steps which must be taken within 60 minutes when sepsis is suspected. Each member of staff had been provided with a card to use a resource and a sepsis trolley was located on the 4th floor ward and accessible to staff. We saw posters relating to "Sepsis 6" displayed in clinical areas.
- If a patient had an allergy the details were recorded by the nurse on two red bands which were be attached to the patients wrist or ankle. We saw these in use during our inspection.
- A monitoring system known as a national early warning system (NEWS) was used to identify patients whose condition was at risk of deteriorating. This involved patient's observations being completed and then totalled to give a score which would help to determine if they were unwell. These scores were recorded on a handheld computer and would alert the RMO, ward manager and the outreach team if a patient scored over a certain number.
- Patient records we reviewed showed NEWS observations were completed and appropriately escalated and had medical interventions in a timely way.
- We observed a meeting held prior to carrying out a patient procedure which was led by the consultant cardiologist. We were told a team brief was carried out and WHO safety checklist completed prior to each case by the multidisciplinary team and we saw two examples of completed checklists.
- The Endoscopy service used the World Health Organisation safety checklist and this had been audited regularly since its introduction. The paper based audit, in February 2016, showed that of 10 patients audited in February 2016 nine had a completed checklist. This was followed up at the Endoscopy Users Group and changes put into place to ensure the checklist was used on ITU patients undergoing endoscopy. In March 2016 there was 100% compliance rate.
- One of these audits using a retrospective notes audit showed that in February 2016 one (10%) WHO checklist had not completed. The action plan included discussion with intensive care and staff to ensure the checklist was fully completed even if the patient was in ITU. In March 2016 compliance was at 100%.
- Another endoscopy WHO checklist audit was completed in theatre at the time of the checklist being used and

was carried out by the learning and development team. The action plan following this showed improvement was required around distraction during the checklist and ensuring it was read out correctly.
- We saw records of risk assessments which had been completed which included Venous Thromboembolism (VTE), pressure ulcer risk assessments, moving and handling, nutritional and falls risk assessment.
- Patients saw their named consultant at each stage of their patient journey. Patient's needs were assessed throughout their stay and in line with their care pathway. A resident medical (RMO) was on duty 24 hours a day, seven days a week to respond to any concerns staff may have about a patient's medical condition.
- Staff were aware of how to respond to patients who became unwell and how to obtain additional help from colleagues in caring for a deteriorating patient. Staff had received training in basic and intermediate life support.

Nursing staffing

- All staff we spoke with said there were sufficient staff on duty to meet patient's needs. We saw rotas which showed there were sufficient staff on duty to have one nurse to four patients on wards, one nurse to three patients on the oncology ward.
- We saw that across the hospital there were 152.3 whole time equivalent nurses. On the oncology ward there was a vacancy rate of 13.8%. When there was vacancy or sickness the service filled these gaps with regular bank nurses who were familiar with the ward, departments and local procedures. Staff told us that this provided continuity of care to patients. We saw that bank and agency staff completed an induction form for each ward they worked on.
- The hospital employs twenty three nurse specialists in areas such as diabetes and nutrition to give patients specialised care.
- We were told that on a daily basis staffing levels were adjusted by the nurse in charge of each area in conjunction with the duty nurse manager to ensure that the staff available reflected the number and dependency of patients. There was no use of a nurse staffing acuity tool as we were told getting staff when required was not an issue within the hospital.

Medical staffing

- Consultants worked under a practising privileges arrangement. The granting of practising is an established process whereby a medical practitioner is granted permission to work within an independent hospital
- Resident Medical Officers (RMOs) were employed directly by the hospital or fully funded as research fellows through collaboration with NHS or research institutions. They provided 24 hours, seven days a week cover for all medical specialities.
- Staff told us the Medical Director was responsible for RMO's annual appraisal and supervised their ongoing training. We saw evidence of this during inspection.
- All clinical care was consultant led and staff told us they had no problems contacting individual consultants for information or advice. The Consultants had a buddy" system to ensure they had consultant cover if they were unavailable.
- RMO's liaised with consultants to ensure care reflected individual patient needs.
- The medical staff who undertook endoscopies also regularly performed gastrointestinal procedures within the NHS.
- There were out of hours on-call arrangements in place for consultant microbiologists who were linked with the local NHS hospitals.
- The hospital's senior management team was supported by a medical director, the chairman of the medical advisory committee and a medical governance lead.

Major incident awareness and training

- Staff we spoke with aware that there was a procedure for managing major incidents or an event that impacted on business continuity. Staff told us they would follow instruction from their senior manager.
- An Emergency Preparedness Resilience and Response (EPRR) policy was in place which was up to date. This policy was linked to the hospital's Business Continuity System and including the management of major incidents.
- A hospital wide fire alarm test took place on a weekly basis and staff knew when this was planned. Fire awareness training was included as part of the hospital mandatory training. All staff knew their responsibilities if there was a fire in the building and staff told us that they had participated in fire evacuation drills.

Good

Medical care

Are medical care services effective?

Good

We rated effective as good because:

- The hospital had policies and procedures in place that took account of evidence-based National Institute for Health and Care Excellence (NICE) guidance and national standards.
- There was an effective multidisciplinary approach to care and treatment with good communications between the teams and an out of hours services were provided when needed.
- Patients had comprehensive assessments of their needs, which included assessments of their clinical needs, physical health, nutrition and hydration needs.
- Ward staff had access to a full range of allied healthcare professionals such as occupational therapists, dieticians and physiotherapists to support patient care and treatment.
- Twenty three clinical nurse specialists were available to provide advice and support to staff including diabetes and nutrition.
- The hospital has been awarded the Joint Advisory Group (JAG) accreditation for its endoscopy service and the Macmillan Quality Environment Mark. The oncology service had CHKS accreditation.
- Staff were well supported with access to both internal and external training, clinical supervision and development.

Evidence-based care and treatment

- The hospital used a combination of NICE and Royal College guidelines to guide the treatment they provided. For example the national early warning system (NEWS) was used to assess and respond to any change in a patient's condition which was in line with NICE guidance CG50.
- NICE guidance was discussed at Multidisciplinary Team (MDT) meetings and updates were cascaded down from clinical nurse specialists to staff at ward and departmental level.
- The Medical Advisory Committee (MAC) meetings also discussed new guidance and best practice so that it could be implemented in the hospital.
- The hospital has been awarded the Joint Advisory Group (JAG) accreditation for its endoscopy service. JAG accreditation is the formal recognition that an endoscopy service has demonstrated its compliance to deliver against the measures in the endoscopy standards.
- Staff adhered to local policies and procedures. They told us the clinical policies and guidance were available on the hospital intranet.

Pain relief

- Medicines including controlled drugs were available to relieve pain if patients required them.
- Assessments of patient's pain were included in all routine recording of observations.
- We saw pain control medicines were recorded on the patient's drug administration charts and given when required.
- Patients were provided with a booklet which outlined the benefits of pain management and requesting pain relief.
- Staff told us there was a link nurse for pain relief or symptom control who was based on the oncology ward. This nurse could give advice on pain relief if required.
- The hospital offered both medicine and non-medicine based treatments which could help to prevent and manage pain.

Nutrition and hydration

- Patient's nutrition and hydration needs were assessed and were referred to a dietician if required.
- Patient records showed that fluid intake and output was monitored and recorded on fluid balance charts.
- The dialysis service had a specific menu designed for to suit the needs of people who have kidney problems, particularly those on dialysis. This included foods high in potassium, phosphate and salt.

Patient outcomes

- The hospital took part in national audits such as Patient Reported Outcome Measures (PROMS) from January

2016 to September 2016 and they were awaiting results from this. The Transcatheter Aortic Valve Implantation (TAVI) and the National Confidential Enquiry into Patient Outcome and Death (NCEPOD) which focused on patient outcomes. From 2014-2015 they submitted data for six patients for NCEPOD studies.

- The hospital cannot currently feed into the national diabetes audit as it is NHS only but it collecting evidence in line with this national audit. It showed that in September 2016 there was 100% compliance in availability of blood glucose charts and appropriate monitoring. It highlighted 100% documentation of blood glucose less than 3.9mmol and a 95% compliance of documentation by the diabetes team.
- An audit of the World Health Organisation (WHO) Safer Surgery Checklist was carried out in the endoscopy service. The paper based audit checked showed that of 10 patients audited in February 2016 nine had a complete checklist, . This was followed up at the Endoscopy Users Group and changes put into place to ensure the checklist was used on ITU patients undergoing endoscopy. In March 2016 there was 100% compliance rate.
- The live endoscopy WHO checklist audit undertaken by the learning and development team showed that there were distractions and poor calling out of the safety check. The action plan included discussion the team meeting about senior staffing supporting junior staff, a National Safety Standards for Invasive Procedures (NatSSIPs) group to be formed for audit support and feedback to consultants at the endoscopy user's group meeting.
- We saw evidence that there had been a cardiology and respiratory audit that indicated good practice around full completion of paperwork and compliance in areas such as sleep studies and stress echo's. Challenges included inadequate IT infrastructure and duplicated records. The action plan included spot checks of procedures and reduction in the numbers of duplicate records created.
- Nursing staff on the oncology ward explained how they discussed patients who might be in the last phase of life and focused on alleviating symptoms and supporting the patient and their family.
- The hospital was working with The Private Healthcare Information Network (PHIN) to improve reporting of patient outcomes across the independent sector. The information shared should improve transparency and be comparable with data supplied by the National Health Service (NHS). Results of this were not due out until after the inspection had been completed.

Competent staff

- New employees to the hospital underwent a corporate induction programme which included completing competency assessments for nursing staff.
- The hospital had a comprehensive induction system in place for all new members of staff. This was tailored to the role within each ward and department and the needs of individual members of staff. The programme included both practical skills and knowledge assessment.
- Specialist training was available in cancers and their treatment for oncology nurses. This was provided by a local NHS trust and three staff were due to start the course in January 2017. Renal nurses and endoscopy nurses had specialist training in their respective areas. A renal nurse told us they had been accepted on to a specialist university course for renal nursing. We saw specialist endoscopy competency checklists had been completed for staff working there.
- The managers we spoke to informed us that all staff appraisals were up to date. We saw evidence of this from data given to us by the hospital.
- The Medical Advisory Committee (MAC) was responsible for approving practising privileges for Consultants. New consultants were required to provide evidence of qualifications, training and registration. We saw evidence of this whilst on inspection.
- Pharmacy staff participated in the Resident Medical Officer (RMO) training programme.
- All revalidation dates and documents were held on a central computer system for both doctors and nurses. We reviewed the information and it was up to date. Human resources personnel could access this at any time and there were reminders for staff to ensure their revalidation was complete.
- Staff we spoke with told us that they had undergone competency assessments relating to their clinical practice. Whilst on inspection we saw competency documents completed specifically for renal dialysis, endoscopy and oncology.

- All registration documents were retained on a computerised system which would flag when a clinician's registration was close to expiry.
- Staff were able to access a range of courses outside of mandatory training. These included master's degrees, renal, oncology and endoscopy courses and leadership days. They received financial support and time to attend the programme. We saw evidence of this from the learning and development team.

Multidisciplinary working

- There were 11 MDT committees for a range of specialities within the hospital including renal, GI and breast. Meetings were held in the new outpatients Building and are well attended by consultants, nurses and other clinical staff.
- We saw evidence in patient's notes that they had input from a range of team members including specialist nurses, dieticians, physiotherapists, occupational therapists and oncology specialists in symptom control.
- Staff told us they felt the service worked as a unit and there was good communication between departments with good handover of patient information.
- Patient records showed that there was routine input from nursing and medical staff and allied healthcare professionals.
- Staff told us the endoscopy team met each morning to undertake a briefing session with the consultant and review the list of patient prior to the endoscopy list starting.

Seven-day services

- The oncology ward was staffed to provide nursing care seven days a week, 24 hours a day.
- A duty manager was available at the hospital as a point of contact for staff at all times and provided advice relating to patient queries and admissions.
- Resident Medical Officers (RMOs) provided 24 hours, seven days a week cover at the hospital for all medical specialities.
- Consultants provided 24 hour on-call cover for their patients and out of hours they were contactable by phone. The nursing staff told us they had no hesitation in contacting consultants at any time to discuss their patient's care.
- We saw the rota and were told by staff that an endoscopy consultant and endoscopy nurse provided out of hours on call and they would be supported by staff from the operating theatres.
- The cardiac catheter laboratory offered a service from Monday to Friday with on-call cover out of hours and at weekends.
- The dialysis unit operated from Monday to Saturday between the hours of 7.30am to 6pm with two sessions per day. Patients were offered the choice of a morning or afternoon session and doctors and nurses provided 24 hour cover.
- The pharmacy service was operational on weekdays from 8am until 8pm. A duty manager facilitated access to medicines when the pharmacy department was closed. Since May 2016, the pharmacy department have provided a three hour clinical pharmacy service on bank holidays. There was a pharmacist available via phone overnight to cover any queries.
- There were out of hours on-call arrangements in place for consultants microbiologists from a local NHS hospital.
- Allied healthcare professionals such as physiotherapists and radiographers were available and contactable out of hours.

Access to information

- Nurses had access to computers and there was guidance, information and policies available on the hospital intranet.
- We saw examples of patients being given leaflets such as patient MRSA screening information, dialysis treatment, pain control, pressure ulcer prevention and control of infection.
- Nursing staff and the consultant in the dialysis unit sent a discharge summary letter to the patient's GP detailing the treatment administered, medications and the results of the patient's last blood tests
- We were told by oncology ward nursing staff that patients were given written information at the time of their discharge from hospital and were provided with the contact details of nursing staff for further help and advice. What about information for their GP?

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

Good

Medical care

- Patients received information prior to their endoscopy procedure. This allowed patients to read the information and if understood give informed consent when they came to the hospital for their procedure. Four consent forms we reviewed were appropriately completed and signed and detailed the risks and benefits of the procedures.
- Staff reported they had attended training on Mental Capacity Act (2005) and Deprivation of Liberty Safeguards (DoLS) and data provided confirmed this. Staff we spoke with were aware of the requirements of their responsibilities as set out in the Mental Capacity Act and Deprivation of Liberty Safeguards (DoLS).
- We saw that "Do Not Attempt Cardio Pulmonary Resuscitation" (DNACPR) forms were completed with documentation of patient involvement in the decision and kept in the patient's notes. An audit completed between January and July 2016 showed that 100% of cases had the correct form in the notes and was completed by a Consultant. 90% had documentation that the decision not to give CPR was discussed with the patient or their family. The action plan following these included timely challenges of poor documentation should take place via a review by the practice development team.
- Patients told us nursing staff gained their consent before care or treatment was given. We saw consent to treatment forms had been signed by patients prior to medical/invasive procedures and paper copies were retained in the patient records.

Are medical care services caring?

Good

We rated caring as Good because:

- During the inspection we saw that staff were caring, sensitive to the needs of patients and compassionate.
- Patients commented positively about the care provided by staff and said they were treated courteously and respectfully.
- Staff supported people emotionally with their care and treatment as needed.
- Patients felt informed and involved in their procedures and care.
- Patients were contacted by the hospital after they had been discharged offering help and advice if required.
- Staff went to great lengths for patients for example those with terminal illness were given the chance to have parties with their families with their favourite food and films.
- Ward and catering staff arranged special events for patients and relatives; for example birthday parties and wedding celebrations.

Compassionate care

- Staff treated patients with dignity and respect and maintained patient's privacy. We observed all levels of staff respectfully knocking on bedroom doors and waiting for a response before entering.
- Patients in the dialysis unit and oncology ward found staff to be compassionate and caring. A patient in the dialysis service said "The staff are approachable and I feel safe in their care". A patient in the oncology ward said "The staff are flexible and give me all the time I need".
- We saw thank you cards and letters from patients throughout the service and one patient told us "the staff are compassionate and warm".
- We saw the annual patient survey report from June 2015 to June 2016 and noted that 98.9% of patients rated the overall quality of care at the hospital as "good" or "better". We saw that 98.0% of patients said they would recommend London Bridge Hospital to their family and friends.
- Patients we spoke with told us that they had received excellent care and could not fault the way they had been treated.
- All patients spoke positively about the care and support they had received. For example one patient commented "The care I have received here has been excellent and staff are so professional".
- Staff told us of occasion's where they had parties for patients with terminal illness. All their family could attend and bring lots of different foods and music. They also told us about a time that a member of staff had gone to collect a specific type of tea for a patient as they did not stock it in the hospital.

- Following inspection we were told that a clinical nurse specialist had organised for a patient in the last days of life to get married in the hospital. They organised flowers, a registrar and the patient was able to get married surrounded by family.

Understanding and involvement of patients and those close to them

- Patients in the oncology ward said stated that staff kept them informed about their care, involved them in any decision making and listened to them.
- Patients told us they were kept informed at every stage of their treatment and doctors and nurses took time to provide detailed information.
- One patient said "staff communication was very good and there was continuity of care at every stage of the process".
- All the patients we spoke with told us they had been provided with relevant information both verbal and written, to make an informed decision about their care and treatment.
- Staff told us that they encouraged on-going feedback and welcomed any suggestions from patients. Staff maintained "You said we did" posters which were displayed in the service's corridors and outlined the actions taken by staff following suggestions made by patients. Examples included the introduction of a "light bites" menu for patients who did not want a large meal at meal times.
- Patients also involved their close relatives as they wanted to. A patient said "My relative joins me for dinner in the evening".

Emotional support

- Patients were able to have emotional support from family at any time, as there were no restrictions to visiting times.
- Throughout our inspection we observed nursing staff giving reassurance to patients and additional support was given when required.
- A quiet room was available for patients and relatives if required.
- Nursing staff on the oncology ward explained how they discussed patients who might be in the last phase of life and focused on alleviating symptoms and supporting the patient and their family.
- We were told by nursing staff that patents were contacted after their discharge from the hospital. They were also given the contact details of the Oncology Clinical Nurse Specialist who was available to provide further help and advice.

Are medical care services responsive?

Good

We rated responsive as Good because:

- There were no waiting times for patients for treatment and the hospital told us no one had to wait for an admission to the hospital if they required it.
- Services were planned to meet people's needs. The flow of admissions and discharges through the hospital was well organised with discharge nurses to ease the discharge process.
- The needs of different people were taken into account when planning and delivering services. Staff took account of individual patient's spiritual, religious and emotional needs when delivering care and treatment.
- Ward and catering staff arranged special events for patients and relatives.
- Patients were aware of how to make a complaint or how to provide feedback about a service if required. Staff always listened to complaints, concerns and communicated lessons learnt.

Service planning and delivery to meet the needs of local people

- Patients were cared for in single rooms offering privacy and dignity.
- The majority of admissions to the wards were pre-planned so staff could assess and plan patient's care needs before treatment. This allowed staff to plan patient's care to meet their specific requirements including cultural, dietary, mental or physical needs.
- Patients told us that staff were welcoming to relatives and there were flexible visiting times.

Access and flow

Good

Medical care

- Our inspection did not highlight any concerns related to the admission, transfer or discharge of patients. The patients we spoke with did not have any concerns in relation to their admission arrangements or waiting times.
- Oncology patients who required admission to the unit for chemotherapy were booked in at their clinic appointment. For those requiring admission for emergencies such as neutropenic sepsis or symptom control the nurse in charge would prioritise oncology patients for beds on the oncology ward. They told us there had never been a situation where there were no beds however if this was the case they would ask a sister hospital in the HCA group to admit the patient for treatment.
- The Dialysis unit staff provided patients with weekly appointment cards and noted their preference for a morning or afternoon session. One patient commented "the care I have received here is excellent and I am able to access treatment at a time to suit me and my family".
- Endoscopy staff worked efficiently according to the patient pathway to ensure patients did not have to wait for their procedure. Patients were admitted to a single room and transferred to the day care ward following a short recovery in the endoscopy suite after their procedure.
- Discharge planning was initiated during admission and led by a discharge nurse who assisted ward staff in identifying whether patients were likely to require additional support at home when they were discharged.
- Staff told us about the introduction of the "Teletracking system" which indicated the details of each patient's arrival at the hospital. The system is also used to monitor internal hospital transfers and bed occupancy and the synchronised information can be seen by all ward and departmental staff. Housekeeping staff and porters are also informed of admissions via this system which helps to prevent patient waiting times.
- A Duty Manager was available at the hospital as a point of contact for staff and provided advice relating to bed management and admissions.
- The hospital told us that it does not have waiting times for patients, if a patient needs to be admitted this can be done immediately in consultation with the patients consultant and their availability. We confirmed this on our unannounced inspection that no data was kept on waiting times as patients did not have to wait to come into hospital.

Meeting people's individual needs

- Patients received information relevant to their procedure prior to their attendance. For example, the patients who attended the dialysis unit were provided with a folder which contained information related to catering arrangements, what clothes to wear and hospital procedures such as infection control.
- The service had a well-stocked supply of leaflets and patients could access those that suited their individual needs.
- Family and friends could visit patients on the ward at any reasonable time. Staff made arrangements for family members to stay with patients if they wished to do so and we saw evidence of this on our inspection.
- Staff told us the hospital had a service level agreement in place for multi-faith chaplaincy services with the local NHS trust. Patients told us that they had received a visit from the chaplain.
- Staff we spoke with told us that multi faith chaplaincy and bereavement services were available for patients.
- The hospital employs a Patient Experience Manager who presents all positive and negative feedback from complaints, concerns and compliments weekly to the complaints, litigation, incidents and patient satisfaction meeting.
- The chefs catered for all diets and were willing to prepare any specific foods to meet patient's preferences and needs such as coeliac disease, lactose intolerant as well as religious diets. A white board was located in the ward kitchen and included information regarding special diets for patients. The hotel services within the hospital received a five star food hygiene rating from the Environmental Health Officer.
- The hospital had an international service that served patients from the Middle East. All services had access to Arabic interpreters and staff could also access interpreters of other languages from outside the hospital when required via a telephone system.
- We saw a hearing loop was available in the registration department if a patient had hearing difficulties.

- Following patients requesting a larger complementary therapy service this has been introduced five days a week to allow patients time to holistic therapies for symptom and pain control alongside helping their emotional and spiritual well-being.
- There was a sleep psychotherapist for those patients undergoing sleep studies.
- There was a dementia link nurse who chaired a hospital wide dementia forum and assisted with dementia training. We saw minutes of the dementia forum from July 2016 which discussed dementia friends and dementia champions. Staff told us they rarely cared for patients living with a learning difficulty. A senior nurse told us that they would take the lead if a patient was admitted with a learning difficultly and also allow for their family stay to make them feel more at ease.
- Staff told us that two palliative care consultants could be called to assist with symptom control for oncology patients. These consultants met each patient and their family to discuss their chosen place of care and concerns around death and dying if no further active treatment could be offered. All members of the multidisciplinary team were informed of these decision and the consultants would attend MDT meetings.

Learning from complaints and concerns

- There were 167 complaints hospital wide between April 2015 to March 2106.Themes included fees and menu choice.
- A comprehensive complaints policy was in place and staff knew how to access this.
- There was a Patient Experience Manager employed who was available by phone and in person to avoid and deal with any complaints immediately. They were contactable by both staff and patients independently.
- One example of a change following a complaint was that a patient was moved away from a room near the kitchen as noise was bothering them.
- The Patient Experience Manager presented all positive and negative feedback from complaints, concerns and compliments weekly to the complaints, litigation, incidents and patient (CLIP) satisfaction meeting.
- Once a complaint was received there was a 48 hour response time for initial contact with the complainant and a 20 day response time for a final response. We saw that between January 2016 and August 2016 78% of complaints were responded to within the 20 day timeframe.
- All staff received information about the hospital's complaints procedure as part of their induction. The staff we spoke with were clear on the process and procedure.
- All staff told us they dealt with issues or complaints immediately and would be supported by senior managers.

Are medical care services well-led?

Outstanding ☆

We rated well-led care as outstanding because:

- There was a clear statement of vision and values, driven by quality, with defined objectives that staff understood and were passionate about working towards.
- The staff we spoke with described an open and honest culture and told us that leaders were highly visible and approachable. We noted that during inspection the CEO knew all staff members we encountered across the hospital on first name terms.
- Staff were happy to work within the hospital and staff satisfaction surveys across the hospital showed that 80% of staff overall would recommend HCA as an employer.
- Governance arrangements were robust and embedded within the hospital and ensured that incidents, complaints, audit results and policy development were proactively reviewed. Learning from incidents, complaints and audits was shared appropriately and all staff told us they were well informed about changes within the hospital.
- Managers had a shared purpose and were committed to providing high quality care, driving improvement for patients and inspiring their staff. All staff spoke highly of their management team and said they felt valued and part of a happy workforce. Managers aimed to motivate their teams to provide the best care possible. There was clear clinical leadership and effective working between managers and clinicians.

- Patients were encouraged to provide feedback about their experiences and where this was not the highest standard it was used to improve the service for example the inclusion of a light bites menu for patients.

Vision and strategy for this this core service

- The hospital's Chief Executive Officer outlined the HCA International Limited corporate mission – "Above all else, we are committed to the care and improvement of human life. In recognition of this commitment, we strive to deliver high quality cost effective healthcare in the communities we serve".
- Staff spoke passionately about the service they provided and the care they offered to patients and 90% of staff in the staff survey understood the vision and values of the hospital. All staff we spoke with on inspection were aware of the mission, vision, values and demonstrated commitment to them in their care practices and personal development plans.
- All staff demonstrated a commitment to providing quality and compassionate care for patients in an effective and efficient manner.

Governance, risk management and quality measurement for this core service

- There was a strong emphasis on governance within the hospital. There were weekly, monthly and two monthly meetings of several committees. We saw that ward managers form oncology, renal and endoscopy attended the weekly incident meeting and senior management team meeting, monthly clinical governance meetings and the Medical Advisory Committee (MAC).
- Staff told us that information was cascaded from these meetings to the medical services via monthly ward meetings which we saw minutes for, safety briefings following handovers which we witnessed on inspection and HOT boards which were notice boards that had been introduced to improve information sharing across departments and included the risk register, incidents and their learning and any new policies.
- There was a decision making group to discuss any areas of concerning consultant's practice and decisions around suspending or removing practising privileges. We saw that this information from this was fed back at a weekly incident discussion meeting. We saw that managers from the medicine services had used this in the past to voice concerns over a consultant's poor practice and took this to the MAC which then used the decision making group to suspend practising privileges.
- Corporate and clinical risk registers were maintained and reviewed regularly. We reviewed the risk registers for endoscopy, renal and oncology. Risks included administrations of medications, equipment usage, administration and disposal of cytotoxic drugs, syringe drivers, IPC and risks related to the sleep studies service. Where risks had been identified action plans had been put in place with dates for review and actions to be completed. Examples of actions included ensuring IPC audits were completed; correct patient assessment was thorough and correct staff training for use of IV medications and chemotherapy.
- There was a pharmacy risk register which enabled senior pharmacy staff to monitor identified areas of concern.
- We saw that arrangements for implementing and embedding learning from incidents across the service were robust. Feedback from hospital-wide meetings was distributed to staff.
- Consultants from a variety of specialities attended the Medical Advisory Committee meetings and we reviewed minutes of these prior to inspection. They were active in bringing about improvements in patient care and services..
- Staff we spoke with said they received feedback on the outcome of audits and what changes needed to be made. Renal staff told us about feedback at the monthly ward meetings which included feedback on health and safety audits, their daily central venous catheter audits and IPC audits.

Leadership and culture of service

- Staff had confidence in their immediate managers and said they were accessible and would act on issues brought to them.
- Data provided by the hospital showed there was low turnover of staff and staff told us that morale was positive.
- All the staff we met were welcoming, helpful and friendly. They said they were proud to work for the

service and 98% of staff in the staff survey said that they were committed to doing their very best for the hospital. 80% of staff overall would recommend HCA as an employer.

- Staff told us that were encouraged and supported to undertake further management training and had been successful in internal promotions.
- Staff were positive about the senior leadership at the service and told us they were visible and approachable. Local leadership was supportive and encouraging and motivated staff to provide the highest quality of care possible.
- Staff reported an open and transparent culture which was apparent during our inspection.
- During a consultant focus group medical staff were extremely positive about their working environment and their leadership. Many told us that they would not want to work in any other private setting as the care their patients received at the hospital was of such high quality.

Public and staff engagement

- Staff told us that they were able to meet with the registered manager and other senior managers who were very visible in the hospital.
- The consultants were positively involved in developments for the service and quality of care provided.
- Staff felt they could approach the senior management team with confidence that their issues or concerns would be dealt with confidentially in a respectful and compassionate manner.
- We were told that all new employees met the senior management team during their induction and staff spoken with confirmed this.
- Clinical supervision for staff was set up by the learning and development team. This allowed staff to have protected time to discuss any concerns or struggles they were having within the hospital. It was chaired by an external body to ensure impartiality.
- The registered manager and senior management team communicated regularly about developments and information was shared with the staff teams. The registered manager arranged a monthly lunch and all staff were invited to attend and welcomed this forum.
- Staff we spoke with said they attended team meetings, staff forums and we updated via hospital newsletters.
- The Medical Director and Chief Nursing Officer held a meeting with the RMO's every month to discuss their concerns and positive experiences.
- Staff told us that they had participated in the hospital's staff survey. We were told that the most recent staff survey had showed high levels of engagement across the hospital. The staff survey showed that 88% of respondents would recommend the hospital to family and friends and 85% said that they were proud to work for the hospital.
- Patients were encouraged to complete "you said we did" forms to drive change from patient's suggestions after their stay in hospital.
- Staff told us that they encouraged on-going feedback and welcomed any suggestions from patients. Staff maintained "You said "and "We did" posters which were displayed in the service's corridors and outlined the actions taken by staff following suggestions made by patients. We saw that an email service was introduced for patients to contact pharmacy with medications queries and new cold cap machine was introduced for the oncology patients.

Innovation, improvement and sustainability

- All staff were focussed on improving the quality of care that they were providing.
- An innovative electronic key system for medicines was introduced to prevent medication errors and improve patient safety.
- Staff felt performance and loyalty were recognised, for example staff had been successful in internal promotions and there was an employee of the month which was put in the "Tooley Times" newsletter and disseminated to all staff.
- Staff in the endoscopy department were setting up an audit system where angiography staff would complete reviews of their audits and vice versa to ensure an accurate and impartial audit system was in place. This was due to start by the end of 2016.

Good

Surgery

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

Information about the service

The London Bridge Hospital carries out general surgery, orthopaedic, cardiothoracic and ENT surgery. All surgery services are in the main building, except for the day surgery unit, which is based on the fifth floor of St Olaf's House. There are six theatres at the Hospital, two on the ground floor of the main building and four on first floor of the Main Building. Theatres are available for both elective and emergency surgery. Four theatres have laminar flow and two have laser capability. There are surgical wards on the second, fourth and fifth floors of the main building. The second floor has 29 individual, en-suite rooms for orthopaedic, spinal and neurological patients; the fourth floor has 24 individual en-suite rooms treating both surgical and medical patients; the fifth floor has 28 individual, en-suite rooms (three of which can be used by the critical care unit) for general surgery and cardiothoracic patients both medical and surgical. The Day Surgery Unit (DSU) in St. Olaf's house has 24 beds in single sex bays of 2 to 4 beds. There was also a catheterisation laboratory on the third floor of St. Olaf's house.

The DSU is open Monday to Friday 07:00 to 21:00 hours. The catheterisation laboratory is open Monday to Friday 07:00 to 21:00 and had on-call out of hours and weekend cover.

We visited the hospital during an announced inspection on 21 and 22 October 2016 and made one unannounced follow up visit to surgical areas on the 6 October 2016. We inspected all theatres, wards and the catheterisation laboratory. We spoke with 20 members of staff including consultants, the registered medical officer (RMO), nurses of all seniority, administrative staff, allied health professionals such as Occupational Therapists and Physiotherapists and senior members of staff such as service managers. We also checked equipment and six patient records. We observed interactions between staff and patients and attended two morning nursing handovers, an occupational therapists' morning handover and a theatre briefing. We followed two patients through surgery and observed a third surgical procedure.

Between April 2015 and May 2016, the London Bridge Hospital performed 6,513 operations. Of these 22% were General Surgery, 13% were knee procedures with high numbers of ENT Procedures, Orthopaedic-Upper and Gynaecological Procedures. There were 25 procedures carried out on children and young people between the age of 16 and 17. The Hospital does not carry out surgery on children under the age of 16.

Good

Surgery

Summary of findings

Overall, we rated surgery as good.

We rated the surgery service at London Bridge Hospital as good overall because:

- The surgery service at London Bridge Hospital had a good overall safety performance and patients were largely protected from harm.
- There were low rates of serious incidents and one never event (Never events are serious, largely preventable patient safety incidents that should not occur if the available preventative measures have been implemented by healthcare providers). there was extensive learning from the never event and steps taken to prevent reoccurrence. Staff understood the duty of candour and we saw good evidence of adherence to the duty of candour regulation.
- We found good processes for reporting and escalating incidents and good sharing of learning from incidents.
- There were good patient outcomes across surgical specialties and care was delivered in line with relevant national guidelines such as National Institute for Health and Care Excellence and the Royal College of Surgeons.
- The trust performed well in national clinical audits including cardiac surgery and the national joint registry.
- There were adequate amounts of both nursing and highly trained medical staff across the surgical areas to ensure patients were cared for as safely as possible.
- Patients had effective and timely pain relief and pain link nurses assisted staff in learning about pain management.
- Staff felt supported with excellent supervision and training opportunities, including funding for additional courses such as master degrees.
- There was good multidisciplinary team (MDT) working between doctors, nurses and allied health professionals both within in hospital and with local NHS trusts.
- Staff across the surgery service were friendly, caring and professional, and patients were treated with dignity. Staff often went 'the extra mile' to ensure that patient needs were met and patients were comfortable and informed about their treatment and care.
- We observed numerous positive, caring interactions between staff and patients.
- Patients that we spoke to consistently praised staff of all levels, in particular their caring attitude.
- Patient flow from admissions, through theatres and onto to surgery wards was satisfactory and bed availability was managed effectively.
- We found a strong and supportive local and senior management team, with well-established members of staff across surgery services. Staff were overwhelmingly proud and positive about working for the hospital.
- Senior staff, ward managers and matrons were highly visible on the wards. The consultant body within the service provided clear clinical direction and a 24 hours a day seven days a week service. Some told us they would not want to work in any other private hospitals, as the standard at London Bridge Hospital was so high.
- There were comprehensive and robust governance and risk management processes in place that involved the whole multidisciplinary team and fed back to both clinical and non-clinical staff to ensure a learning culture. Action plans were completed and staff were given responsibilities to ensure change was completed in their areas.
- Both patients and staff were given opportunities to provide feedback to the hospital. Where feedback was less that excellent the hospital managers would look at ways to improve care and working and provide solutions and improvements.

However;

Good

Surgery

- The five steps to safer surgery including the WHO Safety Checklist is a core set of safety checks, for surgical teams to use in perioperative environments and forms part of a 5-step process to make surgery safer. The Hospital's own audits indicated that end of list debriefings to complete the five steps were not consistently carried out.
- There were some issues with storage of large equipment in theatre corridors, particularly on day one of the inspection, however this was rectified during our visit.
- Staff did not know about any formal policy or process for supporting patients with learning difficulties.

Are surgery services safe?

Good

We rated safety as good. This was because:

- Staff followed the hospital policies and procedures to manage risks and protect patients from the risk of harm.
- The service had low rates of serious incidents.
- Staff understood their responsibilities to raise concerns and report incidents and there was evidence of learning from incidents.
- Staff understood the duty of candour. The duty of candour sets out some specific requirements that NHS providers must follow when things go wrong with care and treatment.
- Staff knew the procedure for reporting safeguarding and knew how to escalate any concerns to protect patients from abuse.
- All of the wards and theatres we visited were visibly clean and there was good compliance with hygiene processes.
- Equipment was well maintained and there was enough equipment to ensure patients received the treatment they needed safely.
- Nurse staffing levels was suitable to meet the needs of the patients, and increased according to the acuity of patients.
- There were enough nursing and medical staff, with appropriate training, within the departments to ensure patients received safe care and treatment.
- We found good completion of mandatory training with many staff also undertaking additional training.
- Medication was stored and managed according to appropriate guidelines.
- The hospital has a comprehensive major incident policy which is practised regularly. Staff understood the major incident policy and where to find it if it was needed.

However;

- Whilst we observed The World Health Organization (WHO) Surgical Safety Checklist being used in theatres, the hospital's own audits indicated that there was only 87% compliance with the checklist, in particular in respect of the debriefing at the end of the list.

- There were some issues with storage of large equipment in theatre corridors, particularly on day one of the inspection, however this was rectified during our visit.

Incidents

- The Hospital reported one never event in the last year. Staff reported the incident on the Hospital's electronic incident reporting system and a route cause analysis (RCA) investigation was carried out. We reviewed this prior to inspection. In response to this incident, the hospital purchased a new tray system which allowed for easier visualisation and weighing of each swab, and reduced the handling of contaminated swabs. We observed the new system in use during surgical procedures.
- Throughout surgical areas there were posters detailing this incident, explaining what had happened. The posters explained that it was the responsibility of every staff member to follow best practice in order to minimise the risk of reoccurrence.
- Staff we spoke to were aware of the incident and the learning from it. In addition, the Hospital followed the relevant Duty of Candour policy. The patient received both a verbal and written apology and an explanation of what had occurred and why.
- There were three falls in quarter one of 2016 and three in quarter two on the Level 5 Ward. We saw evidence that following a fall a patient had discussed their fall with the manager and senior management were investigating this further. Themes included introducing signs reminding patients to dry their feet thoroughly after a shower.
- Staff reported incidents via the computerised system. The governance team within the hospital, which included the head of nursing and medical governance lead, received a copy of all incidents which happened with in the hospital.
- Incidents were discussed at a weekly incident review meeting chaired by one of the governance team and we saw one of these whilst on inspection. Attendance included ward managers, a physiotherapist, senior pharmacist and the training and development team. Learning from incidents was then taken back to clinical areas by the senior staff.
- Junior staff confirmed that learning from incidents was brought back to the wards and shared with them at team meetings and were able to provide examples of this. For example, a number of members of staff told us that pharmacy staff were confused by nurses' handwriting. As a result, all staff on the wards were asked to write in upper case.
- We found evidence that learning from incidents was shared effectively. We saw learning was shared in staff memos and nurses told us feedback was discussed at handover and weekly ward and theatre meetings. We reviewed the minutes of the theatre meetings and saw that reported incidents had been discussed.
- Surgical wards held a "60 Second Safety Briefing". This was a period of time at the end of each nursing handover for staff to raise any safety concerns regarding the forthcoming shifts, supported by prompts from the ward sister. Prompts included risks arising from patients with similar names. Methods of identifying such patients were discussed amongst the team. At the briefings we observed, staff were confident in raising issues and their concerns were listened to and discussed.
- The weekly incident review meeting was held at a senior management level and was a way to feed back any changes from the complaints meeting at which complaints and incidents were discussed and action plans completed.
- Learning from incidents included redevelopment of local guidelines to prevent incidents from happening again. We saw evidence of changes to clinical practice following incidents including the introduction of new coloured drugs trays in theatres to prevent drug errors and specialist phlebotomy trollies for blood sample labelling.
- RCA training was being completed for senior clinical staff and support for completing these was provided by the governance team.
- The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain 'notifiable safety incidents' and provide reasonable support to that person. All staff we spoke to had a good understanding of the duty of candour. We saw examples of duty of candour letters and staff were able to recount incidents where the duty had been followed.

Safety thermometer or equivalent (how does the service monitor safety and use results)

- Senior staff conducted monthly audits of patient falls, pressure ulcers and catheter related urinary tract

infections (UTIs). Staff used a safety thermometer tool to measure and monitor common causes of harm to patients, such as falls, new pressure ulcers, catheter and urinary tract infections and venous thromboembolism (blood clots in veins). The audits showed that patients received predominantly 'harm free' care.

- There were "Safety Crosses" displayed in ward staff rooms detailing the number of incidents on the wards in respect of falls, hospital acquired pressure ulcers and medication incidents. The safety cross on level 2 ward had been updated weekly. At the time of our visit it indicated that there had been no reportable incidents that month. The safety cross on level 3 indicated that in September 2016 there had been no falls, one hospital acquired pressure ulcer and 1 medication incident.
- VTE risk assessments were generally well completed. All patients, on admission, receive an assessment of VTE and bleeding risk. Staff followed National Incident for Health and Care Excellence (NICE) clinical risk assessment guidelines.
- We saw VTE prophylaxis in the form of compression stockings prescribed in patient notes. Patients assessed as at risk of VTE are provided with a leaflet entitled Preventing Venous Thromboembolism (DVT/PE). This included an order form, to be completed by a nurse for compression stockings.

Cleanliness, infection control and hygiene

- The environment across the surgery wards and theatres was visibly clean. All floors in corridors were clean. There was no evidence of dust.
- We saw the Infection Control Precautions Policy and the Corporate Hand Hygiene Policy. These were detailed and up to date. There was also an Infection Control Annual Plan which set clear objectives for ensuring effective infection control.
- There was an Infection control audit plan in place. Where a ward scored less than 79% in an aspect of infection control action plans were put in place and a re-audit was carried out within one week. Where the score was less than 90% actions were put in place and re-audit carried out within one month.
- We observed good compliance with key policies on hand hygiene and personal protective equipment (PPE). There were hand hygiene stations throughout all surgical wards. We observed these being used by both staff and visitors. Signs on the majority of hand washing stations were dual language, in English and Arabic. Hand sanitising gel was available at the entrances and exits to all wards and a the hand washing stations.
- PPE such as gloves and aprons were easily accessible across the wards and theatres and we saw staff using these appropriately when delivering care. We noted all staff adhered to bare below the elbows guidance in clinical areas. There were signs indicating PPE must be worn on the doors of patients' at risk of infection.
- Equipment we reviewed was visibly clean. We saw that staff used green 'I am clean' stickers to indicate that equipment had been cleaned. These were in date at the time of the inspection.
- Infection prevention and control posters were prominently displayed throughout wards and in theatres.
- Cleaning rotas and duties were displayed clearly on ward information boards. We reviewed cleaning schedules which were up to date, fully completed and signed including who was responsible for cleaning different areas.
- We checked sluices on wards and in theatres and all were clean, tidy and well organised. The toilets and shower facilities we inspected and clean and tidy.
- Cleaning staff completed deep cleans of rooms after patients with infections were discharged. This involved top to bottom cleaning with disinfectant to ensure complete decontamination.
- In accordance with the hospital's admission policy, MRSA screening was carried out remotely, with patients sending their own swabs for testing.
- Across the hospital there was one incident of MSSA, one of MRSA, one of Clostridium difficile and four incidents of E-Coli in the reporting period.
- The rooms of patients where a potential infection risk was identified had signs were in place at the entrance, giving clear information on the precautions to be taken when entering the room. Where appropriate, these signs bilingual. We saw signs in Arabic and Russian.
- There were seven reported surgical site infections in total between April 2015 and March 2016, broken down as Orthopaedic/trauma x 2, Upper GI/colorectal x 2, Cardiothoracic x 1, Cranial x 1, Vascular x 1.

- There were no surgical site infections resulting from primary hip arthroplasty, primary knee arthroplasty, spinal, breast, gynaecological and urological procedures.

Environment and equipment

- All of the clinical areas such as theatres and wards we visited were calm, and quiet. The wards were well laid out with adequate space to move and no clutter or trip hazards blocking walk ways.
- The environment across the surgery wards and theatres was clean, tidy, well organised and generally clutter-free. However, on day one of the inspection, the corridors in the ground floor level theatres and recovery areas were cluttered with trolleys and equipment. This could have affected the ability to move patients in and out of surgery quickly and effectively, therefore affecting patient safety. Senior staff were aware of the storage issues in surgery. They informed us that there had been a delay in building improvements which meant that storage space was limited. They explained that steps were being taken in order to minimise the storage of equipment in corridors. Two rooms on the second floor ward were being used for the storage of non-essential equipment, with the possibility of more rooms being used for this purpose. When we re-visited the ground floor theatres on day two of the inspection, the corridors were less cluttered, with the majority of the equipment having being moved.
- Theatre infrastructure across main theatres and the day surgery unit was well maintained.
- All equipment owned by the hospital was subject to monthly audit by an external company. We reviewed a yearly summary of the audits carried out May 2015 to May 2016. The audit also records maintenance and repair action carried out, and a “to do list” of further maintenance for restoring equipment taken out of service. Some larger surgical equipment was hired from companies. We saw service level agreements that indicated that these companies were responsible for maintaining this equipment. Electronic equipment had up to date Portable Appliance Testing (PAT) test stickers.
- We saw resuscitation equipment available in all clinical areas with security tabs present and intact on each. Systems were followed for checking resuscitation equipment and we saw these were completed daily. Audit and policy documents were present, signed and up to date for all resuscitation trolleys that we checked. Theatre equipment such as surgical instruments were neatly stored and labelled in drawers. The theatre equipment storeroom was segregated and contained large pieces of equipment that were cleaned and stored away from theatres. Part of the room had racked shelving containing all disposable supplies.
- We visited the Central Sterile Services Department (CSSD) located adjacent to the ground floor theatres. The CSSD Manager detailed the process by which used equipment was brought to the CSSD, sterilised, packed and returned to theatres. We saw service level agreements between the CSSD and theatres. The standard turnaround for surgical equipment was 24 hours. However, at the request of theatre staff, the turnaround could be expedited to 12 hours or fast tracked to a turnaround of 4 hours. We reviewed completed fast track forms. The CSSD received the surgery list for the following day to ensure equipment would be available. We saw CSSD audits which confirmed that turnaround times were met.
- We reviewed audits for the checking of CSSD equipment which indicated that equipment had been regularly checked and maintained. There was always back up CSSD equipment available, should the primary systems break down.
- All of the staff we spoke to in theatres said that sterile equipment was readily available.
- There was a Theatre Users Group which met monthly to discuss issues in the theatre environment, including equipment. We reviewed the minutes of these meetings. The minutes of the meeting were fed back to the monthly team managers meeting alongside changes that were required.
- Staff told us that bariatric furniture and aids could be hired if required in advance of a patient admission.

Medicines

- Medicines, including controlled drugs (CDs), were stored securely in locked cupboards within a locked clinic room.
- There were appropriate facilities for the disposal of medicine, including sharps boxes which were appropriately signed, dated and sealed.

- Fridge temperatures were being recorded for the medicines fridge and these gave assurance that temperatures had remained within the recommended range for the storage of medicines (2 – 8°c).
- Ambient temperature readings of rooms were generally satisfactory, however on the first day of inspection; the reading in the clinic room on the orthopaedic ward, (Level 2) went up to 26°c. The clinical pharmacist had been informed of this and had asked the ward manager to ensure that nurses were not turning the air conditioning unit off.
- There were systems for the management of controlled drugs in line with legislation. CDs were checked daily by two registered nurses. The pharmacists did quarterly CD audits and monthly follow-ups on any areas that were not compliant. We saw the CD audits for March, April, June and July 2016. These indicated a compliance rate of over 75% in the majority of aspects of the audit. Where a department scored below 75%, actions were put in place to address the concerns. We saw action plans for addressing concerns highlighted in audits.
- The hospital had put a task and finish group in place for controlled drugs. This had led to the appointment of CD lead nurses.
- All permanent nursing staff and Healthcare Assistants (HCAs) on the surgical wards were provided with a special computerised key. This key could be used to access only the medicines and CD cabinets to which the staff member was granted access in accordance with their role and training. We observed these in use; an HCA's key could not access the CD cabinet, whilst a Senior Sister's could. The system also generated an electronic record of whose key was used to access each cupboard and the time and date that this had occurred.
- The last missed dose audit, for May 2016, indicated that only 2% of scheduled doses were missed. There was an action plan in place to ensure scheduled doses were not missed in future.
- Staff had access to the medicines policy on the intranet and the British National Formulary was in medicine rooms so staff could refer to these to ensure drugs were given correctly and safely.
- Nursing staff told us that drug stocks were good, and that there was no difficulty in ordering additional stock when required. We observed a staff nurse ordering out of stock medication for a patient from the on-site pharmacy.
- All prescription charts were clearly written and included information about allergies, height, weight, date of birth, and VTE risk assessments. There was evidence that medicines reconciliation had been completed on all the prescription charts and the pharmacist had screened each prescription on the chart.

Records

- Patient records were stored on the hospital's electronic record system. We accessed the system and reviewed five patient records, both electronic and paper. These provided a good description of care plans, observations and patient progress. Paper records related solely to nursing notes and were reconciled to the electronic record system at the end of each shift.
- Daily consultant notes were stored at the hospital. Hospital policy stated that should not be removed by patients. There was a procedure in place for instances when consultants took their paper notes with them, to ensure that they were returned and that the consultant was made aware of the policy regarding notes. All paper records were uploaded onto the computerised system.
- We reviewed four patient's nursing notes. These were clearly written and completed and included risk assessments and daily entries.
- Records were stored in a locked cupboard in the nursing stations and not left open or on display. The computerised record system required password access to ensure security. Staff members had unique accounts to ensure professional accountability. Temporary staff were also allocated logins.
- The nurse in charge checked the nursing notes daily at handovers, to ensure they were up to date and completed.
- Records were audited on a monthly basis. If a ward scored less than 100% in their record audits, this is fed back to the staff concerned and an action plan must be formulated to address the issue. All surgical wards scored 100% in the August 2016 audit.

Safeguarding

- Clinical staff at the hospital had adult safeguarding to Levels 1 and 2 and safeguarding children Levels 1 and 2 as part of their mandatory training. Ward Managers and

floor managers were trained to Level 3, meaning there was always someone of Level 3 safeguarding of adults and children on duty. The Chief Nurse had safeguarding Level 4.

- The August 2016 mandatory training record indicated that 96% of surgery staff had completed adult safeguarding to Levels 1 and 2 and 87% of surgery staff had completed safeguarding children Levels 1 and 2.
- The hospital had a policy in place to safeguard vulnerable adults and children. This was readily available to staff on the intranet. It followed guidelines from The Care Act 2014 and the British Medical Association Adult Safeguarding Toolkit. Staff were required to completed a 500 word reflection following safeguarding training to show they had understood their training and would be able to recognise a situation that would require a safeguarding referral. These are kept in staff files.
- There was a lead consultant within the hospital for safeguarding who assisted with any complex concerns.
- All of the staff to whom we spoke demonstrated a clear understanding of safeguarding and were able to give examples of instances when they would raise a safeguarding concern. No safeguarding concerns were flagged to the CQC in the last year.

Mandatory training

- All staff had a corporate induction and clinical staff then had a clinical induction completed at a corporate level. This had a multidisciplinary approach with pharmacists and physiotherapists attending to give some teaching sessions.
- Mandatory training compliance for surgical staff as of 3 August 2016 was as follows: Basic Life Support, 83%; Equality and Diversity, 89%; Ethics, 90%; Fire Safety, 92%;Health and Safety, 95%; Infection Control, 92%; Information Security, 91%, Manual Handling Theory, 93%.
- On the surgical wards, staff were required to complete their mandatory training in the months of January, February and March, regardless of when they had their induction. This allowed the ward manager to keep an effective record of staff members' mandatory training. In addition mandatory training records were stored on an online database, this automatically flagged to ward managers when staff needed refresher training.
- In addition, all staff had a "Learning and Development Passport" which included the dates and details of their qualifications and any additional courses taken including mandatory training.
- Nursing and HCA staff were given time to complete their training in work hours. Alternatively, staff were given the opportunity to complete online mandatory training at home, for which they would be remunerated.

Assessing and responding to patient risk

- VTE risk assessments formed part of the pre-assessment for surgical patients. Alternatively, where this has not been done, patients could be assessed by nurses on admission.
- All inpatient surgical wards used the National Early Warning Score NEWS system. All clinical observations were recorded onto a hand held computer and were then transmitted to a central database. If observations were outside of normal range, the system would alarm and the RMO, Ward Manager and critical care outreach team would be notified. With the RMOs agreement, the normal range for individual patients could be adjusted, to reflect their acuity and normal observations. We reviewed three patient observation records, these were fully completed.
- The hospital had a policy in place for following the World Health Organisation (WHO) safer surgery checklist. Theatres carried out monthly audits of the use of the completed WHO checklists. The audit for the WHO checklist for March to June 2016 was 91% for the sign in stage, 98% for time out and 96% for sign out with an overall compliance of 95%. We saw an action plan designed to ensure 100% compliance.
- In the three procedures which we observed, we saw the WHO checklist in use, with all of the surgical team taking part.
- The Level 5 ward had a falls prevention box, containing slip mats with attached alarms which trigger when a patient slips and anti-slip socks.
- Patients at very high risk of falls are assigned one to one care by an HCA.
- There was a Hospital falls Committee Meeting, at which all reported falls were discussed.
- Yellow signs were displayed outside the rooms of patients at high risk of falls. Further, such patients were checked hourly.

Good

Surgery

- The surgical wards had a Sepsis 6 trolley, this included oxygen, fluids and antibiotics. Sepsis 6 is a series of diagnostic and therapeutic steps to reduce the mortality of patients with sepsis. There was also a folder on the trolley detailing the Sepsis 6 pathway.
- All of the staff that we spoke to were aware of the process for escalating unwell patients to the RMO or other relevant clinicians.

Nursing staffing

- Nurse staffing budget was assessed on a yearly basis. Each area had a core of staff which was then supplemented as acuity required.
- Across surgery, the vacancy rate was high, with a 13.6% vacancy rate in theatres.
- Staffing levels were adjusted on a daily basis by the nurse in charge for each area working in conjunction with the Duty Nurse Manager according to the acuity of patients.
- Nurse staffing across the surgical areas was sufficient to ensure patient safety. On surgical wards there was a ratio of one qualified nurses to four patients.
- Nursing staff were required to demonstrate competencies including administering medication to individuals and administration of blood components. Nursing staff were compliant with demonstrating the competencies at the time of inspection.
- In theatres there were between 15.75 and 23.24% bank and agency nursing staff and between 0.86 and 6.86% ODP and HCA bank and agency staff per month in the period April 2015 to March 2016. There were no unfilled shifts.
- There were no unfilled shifts in the period between January and March 2016.
- Prior to booking bank or agency staff, managers offered established staff the opportunity to work the bank shifts as additional hours, provided that this did not mean that they worked over the European Working Hours Directive.

Surgical staffing

- Consultants worked for the hospital via practising privileges. This meant the consultants only worked at the hospital when they were seeing a patient under their care.
- There were 10 permanent Resident Medical Officers (RMOs) across the whole hospital who worked individually on a rotational basis, on-site for a seven day period. They undertook ward rounds on the surgery wards and could be contacted to assess and treat deteriorating patients.
- All RMOs were speciality trained year 4 or above.
- RMOs receive training as part of their induction and were required to undertake online training updates. RMOs were up to date with their training.
- Consultants were available on call out of hours and at weekends. There was a buddy system in place for surgeons to ensure that if one was unavailable there was another available to care for their patients.
- There were 24 hour on call rotas for anaesthetists, intensivists, interventional radiologists, interventional cardiologists, general surgery, cardiothoracic, renal, infectious diseases/microbiology and gastroenterology.
- We reviewed three practising privilege files whilst on inspection each of which contained a range of necessary documentation required by the hospital in order to practice safely.
- There was a flow chart circulate to all theatre staff at the theatre team meeting detailing the process for checking an unknown consultant's practising privileges.

Major incident awareness and training

- We saw the major incident policy for the hospital. The staff that we spoke to had a clear understanding of the policy and their role should there be a major incident.

Are surgery services effective?

Good

We rated the surgery service as good for effective. This was because:

- Care was delivered in line with relevant national guidelines.
- There were good patient outcomes across surgical specialties.
- The trust performed well in national clinical audits such as the national joint registry and cardiothoracic audits.
- All of the patients we spoke with said they had effective and timely pain relief. There were clinical nurse specialists to ensure patients had effective pain relief.

- Staff were well supported and trained and offered extensive opportunities to undertake additional relevant courses to improve their knowledge and skills and apply this to effective patient care.
- There was good multidisciplinary team (MDT) working between doctors, nurses and allied health professionals.

Evidence-based care and treatment

- All of the policies and procedures we reviewed were up to date, and had scheduled review dates clearly marked on them.
- Staff accessed policies and corporate information on hospital's intranet. There were protocols, policies and guidance for clinical and other patient interventions and care on the intranet.
- We reviewed a sample of trust policies for surgery and found appropriate reference to relevant National Institute for Health and Care Excellence (NICE) and Royal College guidelines.
- The Hospital employed the Sepsis 6 pathway, for managing patients with sepsis.
- Care was provided in line with NICE guidance for Acutely ill adults in hospital: recognising and responding to deterioration.

Pain relief

- Patients' post-operative pain medication was discussed with them as part of their pre-operative assessment and prescribed by the anaesthetist prior to their return to the ward. The efficacy of the pain medication was then measured using a pain scoring system on the ward.
- Pain was assessed using a 10 point scale for measuring pain in adults. This included observing the patient and identifying any behaviour that indicated pain. In addition, patients prescribed pain relief were provided with a leaflet entitled Your Pain Medication Explained. This gave details of frequently prescribed pain medication, their side effects and other information.
- Pain scores were record on the electronic records system and there were specific monitoring forms for patients with Patient Controlled Analgesia (PCA) (devices allowing patients to administer a controlled dose of pain relief as and when required), or epidurals (spinal injections).
- There was a dedicated pain link nurse for each of the surgical wards. In addition, there were two specialist pain consultants with practising privileges at the Hospital. During our visit we observed arrangements being made for one of the pain specialists to attend a patient to discuss her pain and analgesic medication.
- Nurses on surgical wards carried a Rapid Action Pain Response Card. This had the contact details for the pain CNS and a staged response action plan to be followed depending on the level of pain.
- Patients on the wards had access to medical input if required. During the morning handover on the Level 2 ward, we observed arrangements being made for a specialist pain consultant to visit a patient that afternoon to discuss her pain medication with her.

Nutrition and hydration

- The hotel services within the hospital received a five star food hygiene rating from the Environmental Health Office.
- Patients told us nurses ensured they were kept well hydrated. Hot and cold drinks were provided throughout the day.
- Inpatients chose their meal preferences from a menu at the beginning of each day a member of the catering team was available to discuss ingredients and allergies with patients and clarify any aspects of the menu.
- Dietary plans were included in patient care plans. Patients' needs were assessed by a dietician as part of pre-assessment.
- Nurses monitored patients' intake of food and health care assistants were instructed to assist patients who required additional help. The hospital also had a number of volunteers who helped patients with eating.
- We observed 'nil by mouth' signs in use on patient rooms. Nil by mouth patients were provided with nutrition via intravenous fluids.
- The nil by mouth protocol stated that patients should be nil by mouth for food for six hours and for fluids for two hours prior to surgery.
- Nurses monitored patient's hydration using fluid balance charts.

Patient outcomes

- Theatres carried out audits in line with the Human Tissue Authority (HTA) guidelines for: Valve usage, human tissue usage, training records, patient records, freezer defrost & check, expiry dates, unused human tissue, SOP on HTA incident reporting, temperature alerts, HTA Risk Assessment & Quality Assurance.

- The February 2015 audit for delays in return to the ward from theatre indicated 19% of patients were delayed returning to the ward. A delay was defined as a patient still being in the recovery unit twenty minutes after their first call to the ward. The hospital recognised that his had the potential to disrupt theatre access and flow and to place pressure on ward staff receiving the patients. There was a detailed action plan in place to address this delay, in particular, further more detailed audits to establish the reason for delays and themes causing delays, which could then be addressed. The 2016 audit had not yet been carried out.
- The orthopaedic department participated in the National Joint Registry audit. The hospital scored 90.9% in respect of the patient consent, above the national expected score of 85%.
- The Hospital participated in Society for Cardiothoracic Surgeons in Great Britain and Ireland audits for patient outcomes in cardiothoracic surgery. In the period April 2012 to March 2015 there was a survival rate of 97.85% for cardiothoracic surgical procedures.
- The Cath Lab submitted data to British Cardiovascular Intervention Society (BCIS) audits. For the period 6 July 2015 to 6 July 2016 (inclusive) the Hospital carried out 74 percutaneous coronary interventions of which 97.4% were an overall success. The Cath Labs also participated in BCIS's trans-catheter aortic valve implantation (TAVI) audit.
- The Hospital submitted data to the Private Healthcare Information Network.
- There were 57 unplanned readmissions to surgery. This was lower than average.

Competent staff

- One hundred per cent of staff had their appraisals in the last appraisal year (from June to May). There have been no appraisals in the current appraisal year.
- There was an 100% revalidation of professional registration for theatre nurses. The provider stated the number of theatre ODPs and health care assistants with more than six months service as of 1 April 2016 was 13.
- Consultant revalidation was part of the requirement for maintaining their practising privileges. If a consultant wanted to carry out a new procedure, this had to be agreed as part of their practising privileges through the medical advisory committee (MAC).
- Practising privileges were reviewed on an annual basis requiring evidence of their GMC registration, professional indemnity insurance, criminal record check (DBS), appraisal, Hepatitis B status, and registration with the Information Commissioners Office. We saw evidence that practising privileges had been suspended, not renewed or revoked due to poor outcomes, lack of documentation or lack of surgical activity. Appropriate terms and conditions were in place to ensure those who were granted practising privileges adhered to policies and procedures.
- RMOs underwent mandatory training as part of their induction.
- There are a number of clinical nurse specialists (CNS) who could be contacted to provide additional information and support to patients with specific conditions.
- We spoke to numerous staff who had undertaken additional courses funded by the Hospital, including Fundamentals of orthopaedic care, phlebotomy and pain management.
- We saw the hospital's dedicated training suite where all staff received mandatory training and training in using new equipment or techniques.
- The Hospital's Education, Training and Development Policy required Agency and Bank workers to ensure they met the required competency levels and provide evidence of this to their line manager at the Hospital.

Multidisciplinary working (in relation to this core service only)

- There was an effective multidisciplinary team (MDT) working environment within the surgery service. We found evidence of good multidisciplinary relationships supporting patients' health and wellbeing. We observed multidisciplinary input in caring for and interacting with patients on the wards.
- There were MDT meetings which included the clinical nurse specialists and various MDT staff.

- Patient records demonstrated input from allied health professionals including physiotherapy, dieticians, occupational therapists, pharmacists as well as the nursing and medical teams.
- We spoke with physiotherapists who told us that they felt part of the team caring for patients. They said that patients were appropriately referred to them by other professionals, although they would identify most of the patients themselves through their own ward round.
- Occupational therapists and physiotherapists attended the nursing handovers and gave input into discussions of certain patients' care where relevant. We observed this during our inspection.
- Occupational therapists and physiotherapists were actively involved with orthopaedic patients, including in their pre-assessment, as part of the orthopaedic 'rapid recovery' programme. This meant that patients' post-operative care plans could be developed with full patient input prior to surgery and commenced immediately after the procedure.
- Surgeons and surgical staff worked alongside the radiology team during some procedures. There are two hybrid radiology/surgery rooms, which allow for surgical intervention in radiology procedures.
- The Hospital had a number of service level agreements with the nearby NHS Trust.
- Following discharge, nursing staff were responsible for sending letters to patient's GP detailing the care they had received. Staff that we spoke with were clear about this and understood the process for doing so.

Seven-day services

- All theatres operated routinely Monday to Friday, with addition opening on weekends in case of an emergency. There was an on-call theatre team to facilitate this.
- Patients' own consultants were available on call. Consultants operated a buddying system to ensure that there was always consultant availability.
- Occupational therapist and physiotherapists worked Monday to Friday, but were available on-call on weekends where necessary.
- The Ward Managers worked Monday to Friday, generally 07:00 to 19:00. However, Senior Sisters worked on a shift basis, meaning that there was always a Senior Sister on duty on each of the wards, 24/7.
- A pharmacist visited each of the wards daily, Monday to Friday. The pharmacy service was operational on weekdays from 8am until 8pm. A duty manager facilitated access to medicines when the pharmacy department was closed. Since May 2016, the pharmacy department have provided a three hour clinical pharmacy service on bank holidays.

Access to information

- Notice boards along the ward corridors were neatly organised with information for staff and patients, including visiting hours, protected meal times and senior nurse and safeguarding lead contact details.
- All staff had access to computer workstations and to the hospital's intranet. Electronic patient records were easily accessible to authorised staff.
- We spoke with a new RMO undergoing induction. He was provided with the hospital's policy folder to read. This included up to date copies of all relevant policies.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Patients told us staff explained treatment and care and sought consent before proceeding. All patients we spoke with said they had been given information about the benefits and risks of their surgery before they signed the consent form.
- We reviewed patient consent forms for two patients. These were detailed and fully signed.
- The hospital's Consent and Capacity to Consent policy was up to date and had a scheduled review date for January 2019.
- The hospital's policy required all clinical staff to undertake Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS) e-learning as part of their induction. The training record indicated that 85% of relevant surgery staff had completed their MCA and DoLS training. The hospital told us that ongoing training was available and 90% of surgical staff will have completed their DoLs and MCA training by December 2016.
- Staff to whom we spoke had a good understanding of MCA and DoLS. They were aware of the hospital's policy in respect of MCA and DoLS and of how to access them through the intranet.

Good

Surgery

- There were translators available to ensure consent for patients who did not speak English. Where the language was not spoken by the translators, the hospital used the Language Line telephone translation service. The ward manager for Levels 2 and 3 was clear that consent must be provided directly by the patient and not via the interpretation of a friend or family member.

Are surgery services caring?

Good

We rated caring as good because:

- 88% of patients rated their care as 'excellent'
- We observed compassionate care being delivered.
- Patients told us of the caring attitude of staff.
- The emotional wellbeing of patients was discussed in staff meetings and staff made efforts to ensure patients felt cared for. For example, arranging a birthday celebration for one patient.

Compassionate care

- Inpatient survey results for June 2016 indicate that 80% of 344 inpatients rated their overall impression of nursing care as excellent.
- We observed numerous examples of compassionate care. We observed conversations between patients and staff of all grades. Staff greeted patients as they entered rooms, and called them according to their preference.
- The eight patients we spoke to all spoke very highly of the compassion and care demonstrated by staff. Direct comments from patients, which were representative of this feedback included: “staff are friendly and smiley”, “everyone is so kind”, “the staff are fun, yet professional” and that there was a “happy environment”. This was a common theme in all the feedback we received. Patients’ relatives and friends also provided positive feedback on the quality of care.
- Staff appeared to know patients and spoke to them about their personal interests. For example we observed on nurse asking a patient about their dog.
- Senior nurses and matrons were very proud of the quality and compassion of the care delivered by their staff. We saw evidence of many thank you cards from patients displayed around the nurses’ stations on wards.
- We heard the ward clerks speaking with visitors and telephone callers in clear, calm and polite way.
- We followed a number of patients in theatres during their procedures. We observed all staff interact with patients in a professional and pleasant manner. At all stages of the procedure, the patient was treated with dignity and respect.
- Patients told us nurses were responsive to their requests. Call bells answered promptly. One patient told us she “just pressed the buzzer and someone was here in five seconds”.
- Following our inspection, we were provided with examples of plaudits from patients. One patient wrote "I have just experienced brilliant service at the LBH involving replacement hip surgery. From reception to discharge it was extremely efficient and the nurses who attended me were exceptional." Another said that "the consultants, the anaesthetist and all the nurses could not have been kinder, more patient, caring or thoughtful".
- At the morning handover on Ward 2 we heard that a patient with complex needs had been taken out into the local community by an Occupational Therapist for a haircut in response to his request.
- We heard accounts form both patients and staff of patients being brought products they requested by staff. For example one patient suffering from constipation had requested a specific herbal tea, used as a remedy for constipation in her home country and this had been obtained for her. Another patient requested Horlicks at 11pm and an HCA went to purchase this for them.

Understanding and involvement of patients and those close to them

- All of the patients we spoke to said that they felt involved in their care. They said they were kept well informed regarding their care and were actively involved in all decisions.

Good

Surgery

- Patients we spoke to understood the cost of their care. The patient information pack contained details of care and accommodation costs.

Emotional support

- We observed patients receiving emotional support from staff.
- The emotional support needs of one of the patients on the level 2 ward were discussed during the morning handover that we attended.
- There was a psychologist who visits the surgical ward on Wednesday and was available on an as and when basis to support patients and their families. All of the staff we spoke to were aware of the psychologist support and knew how and when to seek it.
- We spoke to a patient who had passed his birthday in the hospital. The nurses on the ward held a birthday celebration for the patient and the catering team had made him a cake.

Are surgery services responsive?

Good

We rated responsive as good because:

- Access and flow throughout surgery and day surgery were highly effective. Waiting times for operations were rare and patients reported receiving treatment in line with the expected timetable.
- Where there were delays in surgery lists these were managed effectively and patients were kept informed.
- Staff made every effort to meet patient's individual needs.
- Patients told us that their personal needs had been listened to and catered for.
- Complaints were listened to and responded to and action taken on account of complaints and comments.

Service planning and delivery to meet the needs of local people

- Patients were cared for in single rooms offering privacy and dignity.
- The vast majority of admissions to the wards were pre-planned so staff could assess and plan patient's care needs before treatment. This allowed staff to plan patient's care to meet their specific requirements including cultural, dietary, mental or physical needs.
- Patients told us that staff were welcoming to relatives and there were flexible visiting times. There were also beds available for relatives who wished to stay in the hospital.

Access and flow

- Patients were admitted under the care of a consultant with practising privileges at the hospital. A consultant must be available throughout the patient's intended stay at the hospital.
- Patients under the age of 16 are not treated at the hospital; there is no other hospital-wide exclusion criteria. Consultants' individual exclusion criteria are set by themselves.
- Inpatients arrived at the hospital between 08.00 and 18.00 hours and were taken immediately to their rooms. There is an option for late planned admissions, whereby inpatients can arrive between 18.00 and 20.00 hours. Emergency patients are admitted out of hours by their consultant.
- Discharges were managed with the patients' input. Discharge letters were sent to the patients' GP and any other relevant practitioners.
- Where necessary, the hospital made contact with local social services to provide support for patients upon discharge. Staff that we spoke to were aware of how to do this.
- Discharge medicines were obtained in sufficient time in advance of the patient's discharge to prevent delays. On the Level 4 Surgery Ward, this was overseen by a discharge co-ordinator. Since the introduction of the discharge co-ordinator the patient satisfaction rate in respect of discharge times has risen from 56% in the last quarter to 86 % in the current quarter.
- Discharges for overseas patients were managed by the Embassy who they came under.

Good

Surgery

- Upon discharge, patients were provided with a discharge pack. This included a copy of the patient's notes; prescriptions; contact details; a leaflet on reducing the risk of blood clots and a freepost patient feedback form.
- In the past 12 months there were seven procedures cancelled for a non-clinical reason. All seven patients were offered an alternative appointment within 28 days.

Meeting people's individual needs

- The surgery wards included prayer rooms in addition to the chapel.
- There were permanent signs in both English and Arabic, reflecting the high number of Arabic speaking patients that the hospital serves. In addition, we observed temporary signs in Russian in and the rooms of Russian-speaking patients.
- The Hospital employs a number of in-house translators for the patients' most commonly spoken languages. The hospital also uses language line telephone service for all other languages. Staff we spoke to understood the use of Language Line. The Ward Manager for Levels 2 and 3 explained that where patients did not speak English a translator or Language Line was always used. He was clear that consent must be provided directly by the patient and not via the interpretation of a friend or family member.
- There was a service level agreement with the multi-faith chaplaincy services from the local NHS Hospital. In addition, nurses told us that they were aware of instances when faith leaders from outside organisations had been called to the hospital at the request of patients.
- The Hospital was registered with the Dementia Society. Dementia Society butterfly stickers were displayed in the rooms of patients with dementia as a visual reminder to staff.
- There was a link nurse for dementia for the Hospital. Patients with dementia were provided one to one HCA care. In addition, patients with dementia were offered the opportunity to wear a blue wristband so that when they are transferred to other clinical areas, staffs were aware, that the patient may need additional support.
- Each clinical department had a dementia champion who underwent a dementia departmental training course.
- When we spoke with staff about supporting people with learning disabilities, they were not aware of any specific policies or support in place, but said that they would seek support from the Director of Nursing.
- Information booklets about the hospital were available for patients. These included room facilities, meals, care expectations, health and safety, discharge and a patient guide which included information on charges, and complaints.
- There was no limit on visiting times.
- 74% of 344 inpatients who responded to the inpatient survey in June 2016 rated the friendliness/helpfulness of catering staff as excellent.
- Religious and other dietary preferences were catered for. 73% of 344 inpatients who responded to the inpatient survey for June 2016 rated "how we dealt with any special dietary needs as excellent.
- All areas of the hospital were accessible by wheelchair. Lifts were in place between levels and each part of the hospital was wide enough to accommodate a wheelchair.
- Patients with disabilities are provided with larger rooms on the wards to allow them better accessibility.
- We saw patients were provided with Zimmer frames, crutches, toilet frames and perching stools. In our presence, occupational therapists explained to patients how to use equipment and how to return items. They did this in a clear, patient and comprehensive way.
- A number of overseas patients on the wards had relatives staying with them. Larger rooms and additional beds were available to facilitate this.
- There was a chaperone service for both in patient and day surgery patients. Staff that we spoke to were aware of the chaperone service and where to find the policy.

Learning from complaints and concerns

- The hospital made available its complaints policy. Complaints received an initial response within two working says of receipt and a full response within 20 days.

Good

Surgery

- All patients we spoke to were fully aware of the complaints procedure, albeit that none we spoke to had any complaints.
- From January 2016 the Hospital as a whole had received 81 complaints of which 22 were upheld and 16 partially upheld. In respect of clinical concerns, the majority of these concerned clinical treatment. Overall the majority of complaints concerned decisions of the organisation.
- Complaints and incident reports were discussed at Medical Advisory Committee (MAC) meetings. We saw minutes of the MAC meetings which confirmed this.
- The feedback form provided to patients on discharge included questions regarding: consultants, nursing care, clinical services, accommodation, catering, discharge, general questions and a space for comments and suggestions.
- Staff told us that they did their best to deal with issues and complaints at ward level. For example, on patient had complained about the noise from the kitchen opposite their room, and had been moved.
- Many of the staff we spoke to across surgery had been promoted within the hospital. They said that they had been encouraged and supported to take on new challenges. The culture of promoting individuals and fostering skills within the hospital was reflected by the forward planning of the surgery ward manager.

Are surgery services well-led?

Outstanding ☆

We rated the surgery service at London Bridge Hospital as Outstanding for well-led. This was because:

- There was a clear statement of vision and values, driven by quality, with defined objectives that staff understood, embraced and were passionate about working towards.
- We found a cohesive, strong and supportive leadership team at both a local and senior level, with well-established members of staff across surgical services. The CEO knew all members of staff across the service by name which we observed whilst on inspection.
- The staff we spoke with described an open and honest culture and told us that leaders were highly visible and approachable. They felt able to voice concerns and told us they would get feedback on any issues they raised with management.
- Governance arrangements were robust and embedded within the hospital culture. It ensured that incidents, complaints, audit results and policy development were reviewed and learning shared appropriately across the multidisciplinary team and these were well attended by a range of hospital staff clinical and non-clinical.
- Staff were overwhelmingly positive about working within the hospital and staff satisfaction surveys across the hospital reiterated this. Staff told us they had a strong sense of pride about being a member of London Bridge Hospital staff.
- Ward managers and Senior Sisters were very visible on the wards and the consultant body within the service provided clear clinical direction. Consultants told us they would not work at any other private hospital as the standard of care at the London Bridge Hospital was the best they had seen,
- Staff throughout the surgical services that we spoke to had undertaken additional training, having been supported, encouraged and motivated to do so by their managers.
- One of the theatre perfusionists was being supported to undertake innovative research at the hospital and the results would be disseminated nationally once the research was complete.

Vision and strategy for this this core service

- There was clear corporate and local vision within the hospital. The vision was embedded across surgical service. All of the staff we spoke to were aware of the vision, their part in promoting it an told us they were motivated and inspired to work to this on a day to day basis.
- All staff across the hospital underwent a comprehensive corporate induction, at which they met the senior leadership team and received a copy of HCA founder's book to help them understand the ethos of the hospital. This was confirmed by staff that we spoke to and they told us it had been helpful to understand where the hospital had come from and the values of the founder.

- The Ward Manager for Ward levels 2 and 3 set out his vision for the wards. In particular, he told us that it was his intention for all surgical nursing staff to undergo training in mentorship in order to encourage learning and knowledge sharing throughout the service. At the time of the inspection, a number of the surgery ward staff were already undertaking mentorship training at London Southbank University, funded by the Hospital.
- Throughout staff areas there were posters setting out the hospital-wide corporate values. Staff were aware of the corporate values and appeared to respect them.

Governance, risk management and quality measurement

- There was a robust and embedded clinical governance structure and culture of identifying and managing risk. It included a range of committee meetings at both clinical and operation levels including executive meetings, consultant meetings, risk management, health and safety and clinical effectiveness. These reviewed performance and daily operations at the hospital including staffing levels, activity, incidents, risk registers, infection prevention and control, and audits. Each tier of meeting acted as scrutiny above it and challenged any poor practice or concerns identified and action plans were provided for local level staff to complete.
- There was both a corporate and clinical risk register for the hospital. Senior ward and theatre staff discussed risks with us that were on the clinical risk register. These included diabetes management, controlled drugs management and blood sampling. For all these risks action plans had been put in place and monitored which we saw on inspection.
- The risk register included a risk of incorrect procedure or other harm to patient from non-compliance with the Safer Surgery Checklist protocol and we saw that significant work had been done to improve the completion of the five steps to safer surgery. However, audits showed there was still low compliance with the debrief part of the checklist and we reviewed senior management meeting minutes which discussed new action plans to improve this.
- There was a local risk register for the core service. The risk register was up to date, and included review dates for risks. There were action plans in place to reduce the risks on the register. Risks were identified and escalated by all staff to the Ward Managers, who then attends a risk meeting with consultants, members of the senior leadership team and RMOs to discuss including an item on the Risk Register.
- We reviewed local risk assessments for the Level 2 surgical ward, in respect of administration of medication for December 2015. Both were signed and dated by the author, a reviewer, the Head of Department and the Integrated Governance Manager. The risk assessments included an initial potential risk score and an actual risk score, once controls had been put in place.

Leadership / culture of service

- All staff described an open and non – blame culture. They felt able to discuss concerns and issues they were having and felt safe and protected to do so.
- Staff had confidence in their immediate managers and said they were accessible and would act on issues brought to them. They told us they felt motivated to provide the highest quality of care possible and there was a strong emphasis on working as a team.
- Senior theatre and ward staff were visible throughout the inspection, including during the unannounced inspections, and staff reported that they were highly visible. Staff described managers and senior team members as approachable and very supportive.
- Senior staff knew junior staff across the surgery services and took an interest in their wellbeing. Staff we spoke to were clear about the management structure for their department and who they would contact in case of an issues. Staff told us they would feel confident to contact both local and senior management in case of any concerns.
- All the staff we met were very welcoming, helpful and friendly. They said they were extremely proud to work for the service and 98% of staff in the staff survey said that they were committed to doing their very best for the hospital. 80% of staff overall would recommend HCA as an employer.
- Many of the staff we spoke to across surgery had been promoted within the hospital. They said that they had been encouraged and supported to take on new challenges. The culture of promoting individuals and fostering skills within the hospital was reflected by the forward planning of the surgery ward manager.

Good

Surgery

Public and staff engagement

- Staff told us that they were able to meet with the CEO, Head and Deputy Head of Nursing and other senior manager who were very visible in the hospital to discuss both positive news and any concerns they had.
- The Senior leadership team held a monthly lunch to which all staff were invited to exchange views with the team. A number of the staff members we spoke to said that they had attended these meetings. They said that they did feel that they had a voice in wider corporate decisions.
- The consultants were positively involved in developments for the service and quality of care provided. Some told us they would not work in any other private hospital as the quality of care provided within the hospital was so high.
- Staff told us that they had participated in the hospital's staff survey. We were told that the most recent staff survey had showed high levels of engagement across the hospital. The staff survey showed that 88% of respondents would recommend the hospital to family and friends and 85% said that they were proud to work for the hospital.
- Patients were encouraged to complete "you said we did" forms to drive change from patient's suggestions after their stay in hospital.
- Staff told us that they encouraged on-going feedback and welcomed any suggestions from patients. Staff maintained "You said "and "We did" posters which were displayed in the service's corridors and outlined the actions taken by staff following suggestions made by patients.

Innovation, improvement and sustainability

- One of the perfusionists in theatres was being supported by the hospital to undertake research into cardiovascular innovations, in particular in respect of the efficacy of different drugs used in theatre. Support provided includes additional funding for equipment and free time to undertake research. The innovations have the potential to have a significant impact on cardiovascular surgery nationally.
- There were "HOT boards" in all ward staff rooms. These included details of risks, complaints, updated policies, the duty of candour, incidents, safeguarding escalation contacts and the service management team. Information on the boards was clearly displayed and up to date. It was the same in each area.
- There was an ongoing plan to modernise other buildings within the hospital. We were told that this would allow for more space, in particular storage space for the surgical service.

Outstanding ☆

Critical care

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

Information about the service

The Critical care services at The London Bridge Hospital (TLBH) consist of two units which are geographically separate.

The third floor has 12 individual rooms treating Level three and Level two patients. One room is a negative airflow pressure room used for isolating patients who have an infection and a further six Level three beds on the first floor. There are three additional beds on the fifth floor south that were upgraded in 2015 with the capability of accepting all patients from day case to Level three. All 21 beds have a ventilator to support level three patients. The third floor unit has been identified as the main unit.

'Level three' and 'Level two' refers to the acuity of a patient. A Level three patient will likely be ventilated and need intensive, 24-hour one-to-one care. A Level two patient is considered to be high dependency and requires significant nurse input and is usually cared for on nurse to patient ratio of two to one.

A critical care outreach team (CCOT) was available to assess deteriorating patients on the hospital wards and to follow up patients who were discharged from the critical care unit (CCU) and required less intensive care.

During the inspection, and in order to make our judgements, we visited the CCU areas. We talked with three patients and three relatives. At the time of inspection there were 15 patients with many on ventilators and sedated and therefore unable to communicate. We spoke with 18 staff including nurses, doctors, physiotherapists, support staff and managers. We observed the care provided and interactions between patients and staff. We reviewed the environment and observed infection prevention and control practices. We reviewed three care records and other documentation and performance information supplied by the hospital.

Medical staff cover in all critical care areas met the requirements of the Faculty of Intensive Care Medicine.

There was a 30% vacancy rate for nursing staff which was being addressed at the time of the inspection.

Between April 2015 and March 2016 the CCU occupancy rate was on average 79% and never exceeded 94%. For the same period 664 patients accessed the service. There were 42 deaths, 38 were expected and four unexpected.

Outstanding ☆

Critical care

Summary of findings

- Overall we rated the service as outstanding. Safe, effective and caring were rated as good and responsive and well led were rated as outstanding.
- Incidents were reported and staff received feedback and learning from incidents. Incidents had been rigorously analysed and staff led the changes in order to ensure they were not repeated.
- The CCU was clean and staff adhered to infection control policies and protocols. Record keeping was comprehensive and audited regularly. Decision making about the care and treatment of a patient was clearly documented using a multi-disciplinary approach.
- Staff used safety briefings, regular wards rounds, evidence based admission, transfer and discharge protocols and critical care outreach to ensure patients safety was assessed and responded to in a timely manner.
- Medicines including controlled drugs were held securely and appropriate records kept.
- Patients received treatment and care according to national guidelines such as the National Institute of Health and Care Excellence. Patients experienced good quality outcomes as evidenced by a range of national audits. The Intensive Care National Audit Research Centre (ICNARC) was also used as a basis to quality assure its critical care services. Multidisciplinary working was good..
- All staff had access to further development and clinical training and there was evidence of staff being supported and developed in order to improve outcomes for patients.
- All staff had received annual appraisals and over 90% of staff had completed statutory and mandatory training which was provided by the hospital.
- The services were flexible, provided choice and ensured continuity of care at a time that suited the patients. Staff went the extra mile to make sure patients' care was of the highest quality, timely and compassionate.
- Staff responded to patients' individual complex needs through daily multi-disciplinary team (MDT) working, regular ward rounds and robust assessments.
- Leadership at a local level was excellent and staff told us about being supported and empowered and enjoyed being part of a team. There was evidence of innovative multi-disciplinary working with staff working together to problem solve and develop patient centred evidence based services which improved outcomes for patients. Consultants were actively engaged in improving patient care and developing the service.
- The service had reviewed its governance arrangement in order to ensure it continually met best practice and ensured its systems were robust and fit for purpose.
- There was an open, transparent no blame culture. Staff were empowered to lead the way in making improvements to the service with the support of senior staff.

Outstanding ☆

Critical care

Are critical care services safe?

Good

We rated the service as good for safe because:

- This was because the CCU could demonstrate a culture of learning from incidents with a number of examples of changes being made following an incident. These incidents of learning were shared throughout the hospital.
- We saw records to confirm risks to people who used services were appropriately assessed and their safety monitored and maintained.
- Infection prevention and control policies and protocols were in place and regularly audited.
- The environment was clean, tidy and well maintained.
- There were four consultant intensivists leading critical care services. Medical staff cover in all critical care areas met the requirements of the Faculty of Intensive Care Medicine.
- Nursing care was delivered on a one to one basis with additional staff to support supernumerary working allowing time for the use of robust safety checks and training time.
- Staff used safety briefings, regular wards rounds, evidence based admission, transfer and discharge protocols and critical care outreach to ensure patients safety was assessed and responded to in a timely manner.

Incidents

- We found reliable systems and processes to keep people safe and safeguarded from abuse. Staff on the critical care unit (CCU) used an electronic reporting system to record incidents. Staff were aware of how to report incidents and staff told us that they received feedback in a timely manner.
- There was a good reporting culture within the service. Staff we spoke with fully understood their responsibilities to report incidents and near misses. All staff were aware of the incident reporting procedures and knew how to raise concerns. Resident Medical Officers (RMO) and nursing staff showed us how they reported incidents on an electronic incident reporting system. Staff said they were encouraged to report incidents and received feedback from an incident.
- Between April 2015 and March 2016 the CCU experienced 228 incidents. Of the 228 incidents 138 caused no harm, 42 minimal harm, five moderate harm and one caused severe harm. The hospital also recorded deaths as an incident and included 38 expected deaths and four unexpected deaths. The most commonly occurring incidents were due to laboratory investigations, supply or maladministration of medicines and pressure ulcer incidents.
- The CCU had developed new protocols due to lessons learnt following two recent falls incidents. This resulted in an increase in the role and numbers of 'runner' staff that ensured patient safety was maintained at all times and assisted in overcoming the challenges in nursing patients in single rooms.
- Incidents causing minimal, moderate and severe harm were investigated using root cause analysis (RCA) methodology. Unexpected deaths were reviewed via the monthly mortality and morbidly meetings. RCAs we reviewed demonstrated patients and their families were informed of the incidents and the outcome of the investigations.
- We saw evidence of incidents discussed at the monthly operational meetings and senior manager meetings.
- 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'andprovide reasonable support to that person. Staff we spoke with were not always aware of the terminology but understood what to do if something went wrong and how to report errors and near misses.
- We saw duty of candour cards used to communicate the principles of being open and honest and staff gave examples of incidents and how these had changed practice.

Safety thermometer

- The Safety Thermometer is a monthly point prevalent audit of avoidable harm including new pressure ulcers, catheter urinary tract infections (C.UTIs) and falls. Independent hospitals are not required to submit safety thermometer data.

- Safety Thermometer information for measuring, monitoring and analysing harm to patients and harm free care was collected monthly. We saw this information was displayed on the CCU, such as number of falls and pressure ulcers. Between April 2015 and March 2016 the CCU had experienced 11 pressure ulcers. Of these one was hospital acquired, nine were for those patients transferred into the CCU with a pressure ulcer and the final data was missing.
- We viewed three patients electronic records which confirmed all three patients had their level of risk assessed for venous thromboembolism (VTE) and were clear and evidence-based, ensuring best practice in assessment and prevention. VTE is the formation of blood clots in the vein. When a clot forms in a deep vein, usually in the leg, it is called a deep vein thrombosis or DVT. If that clot breaks loose and travels to the lungs, it is called a pulmonary embolism or PE.

Cleanliness, infection control and hygiene

- We saw staff consistently complied with hand hygiene practice. Adequate supplies of personal protective equipment (PPE) including gloves and aprons were available and we saw staff using these appropriately.
- There were dispensers with hand sanitising gel situated around the CCU including the main entrance to the units and inside rooms. Hand washbasins were equipped with soap, disposable towels and sanitizer.
- There was awareness amongst staff about infection control and we observed staff washing their hands, complying with the 'bare below the elbows' policy and using hand gel. We observed all staff using alcohol hand gel when entering and exiting CCU.
- We saw daily cleaning schedules carried out by the nursing and domestic staff and we were told that there was a cleaning protocol in place for equipment. Defined cleaning schedules and standards are recommended by the Department of Health 2014 document 'Specification for the planning application, measurement and review cleanliness services in hospitals'.
- TLBH had an Antimicrobial Stewardship Policy version two, dated February 2016 which included the principles, roles and responsibilities for antimicrobial stewardship and how these were to be adopted into practice. Antimicrobial stewardship' is defined as 'an organisational or healthcare-system-wide approach to promote and monitor the use of antimicrobials to preserve their future effectiveness". Staff could describe this and what their roles were.
- There was a quarterly audit programme led by the departmental Infection Prevention and Control Link person (IP&CL). The Head of Departmental (HoD) Manager had the responsibility of ensuring that allocated time was given to the IP&CL to undertake these audits.
- The HoD Manager and IP&C link person reviewed the outcomes of the audit and implemented actions where the tool had identified an area of concern ensuring that the tools were used effectively to ensure all infection risks to patients were minimised and enhancing the quality of patient care.
- These audits covered the environment, equipment, central venous catheter care, hand hygiene, sharps, personal protective equipment (PPE), waste disposal, enteral and parental feeding. For the period July 2016 all areas scored green which was within the 90% and above range for TLBH. This meant that these would only need to be audited as part of the general audit schedule.
- All of the equipment we examined such as vital sign monitors, mobile computers and infusion pumps were visibly clean. Staff would clean their own equipment as part of their daily safety checks. However we did not see any 'I am clean' labels in use to indicate when equipment on the main corridors was cleaned.
- We spoke with cleaning staff who showed a good understanding of separating different types of waste and the use of color-coding to dispose of waste and colour code mops for different areas. Waste segregation and storage was in line with Department of Health 2011 Safe Management of Waste guidelines.
- We saw disposable curtains were used around the cubicles on the six bedded unit. These were clean and stain free with a date of first use indicated on them. Linen storage areas were tidy and there was sufficient clean linen available.
- The CCU had no Methicillin-resistance Staphylococcus aureus (MRSA) bacteraemia and no C.difficile cases in the last six months.
- The CCU took its responsibilities for infection control seriously. For example there had been an outbreak of

Carbapenem resistant Klebsiella pneumonia at the beginning of 2016. The CCU worked with Public Health England in reviewing the problem and resulted in reviewing their practice with their overseas providers.

- Carbapenem resistant Klebsiella pneumonia is when bacteria such as Klebsiella pneumoniae produce an enzyme known as a carbapenemase, the class of antibiotics called carbapenems will not work to kill the bacteria and treat the infection.
- As a result of these infections, staff on the CCU had designed, developed and implemented a new infection control trolley for each individual patient room. These contained bespoke equipment such as gloves and gowns for each individual patient and reduced the number of times staff would have to enter and leave the room. Staff told us this reduced the risk of spreading infection.

Environment and equipment

- We saw evidence that the CCU complied with the national standards for intensive care Health Building Note (HBN) 04-02.
- The 12 bedded CCU was bright and well-spaced out, individual rooms were spacious although there was no natural light. There were 'smart' windows in each room which allowed the window to become either transparent or opaque when the need arose. This enabled privacy and dignity to be maintained when carrying our personalised care and gave the opportunity for staff to have sight of the patient and nurse at given periods during the day without having to enter the room.
- TLBH had an equipment maintenance programme. The CCU staff kept a log of all equipment used, where the equipment was located and could demonstrate all maintenance histories. Maintenance and servicing was planned and carried out in accordance with manufacturer guidance. Staff told us they had no problems in accessing equipment in a timely manner.
- Resuscitation equipment, for use in an emergency was checked daily by one of the supernumerary nurses. Equipment was documented as complete and ready for use. We reviewed documentation which showed that trollies were checked and logged on a daily basis.

Medicines

- Medicines were stored securely across the hospital and staff used an electronic key system which was a security feature for access to clinical treatment rooms and medicines cupboards. This allowed senior staff to see who had opened specific medicines cupboards at a specific time. The system also removed the need for multiple keys and therefore staff could access medicines quicker.
- Some prescription medicines were controlled under the Misuse of Drugs legislation 2001 and called controlled drugs (CDs). We examined the CD cupboards and found that storage was appropriate with no other items in the cupboards.
- A medication CD audit undertaken in July 2016 found CCU to be non-compliant in a number of areas such as incomplete entries in the CD book and errors not always signed and dated. A re-audit was undertaken in August 2016 which showed an improvement and resulted in the CCU being complaint with the standards.
- The CCU was part of TLBH pharmacy intervention audits which identified where specific pharmacy interventions were made which benefitted the patients. For example VTE thromboprophylaxis was stopped due to bleeding and on the advice of the pharmacist a different type of thromboprophylaxis was given.
- A patient on CCU was using specific ear drops for an ear infection. The pain from the ear was not resolving and the pharmacist suggested taking swabs to obtain sensitivities. This resulted in a change in ear drops and an improvement of the ear infection.
- The temperature of medicine fridges were monitored daily and complied with the Royal Pharmaceutical Society of Great Britain (2005) guidance. Medicines requiring refrigeration can be very sensitive to temperature fluctuation and therefore must be maintained between 2ºC and 8ºC. We saw all areas complied with this as daily temperatures were recorded. The room temperatures were also monitored and were within the desired limits of 15ºC and 25 ºC.
- We looked at three medication records which were completed comprehensively, dated, signed and had no missing doses.

Records

- Patient records were created and stored using a paperless electronic system that was compliant with General Medical Council (GMC) Confidentiality (2009) guidance. We looked at three sets of patient's records. These were comprehensive and well documented and

included diagnosis and management plans, consent forms, evidence of multi-disciplinary input, risk assessments and evidence of discussion with the patient and families.
- New folders had been implemented to support documentation for daily safety checks such as fridge temperatures and handover information.
- The CCU was part of the weekly records audit which ensured that quality checks were undertaken before scanning documents. This resulted in action plans being developed where non-compliance was found. CCU was found to be compliant with these standards.

Safeguarding

- TLBH had a safeguarding adult's policy. Safeguarding was part of mandatory training for all staff and this was monitored by managers.
- For the period up to August 2016, data provided by TLBH the CCU showed training in safeguarding adults level 1&2 was 94% and safeguarding children training level 1&2 was 87%. Staff vacancies contributed to these results and training to reach 100% was ongoing.

Mandatory training

- TLBH had an induction programme for permanent and temporary staff and a mandatory and statutory training plan. There was a combination of e-learning and face to face learning.
- For the period up to August 2016 data provided by TLBH the CCU showed training for basic life support was 93%, ethics 89%, health and safety 87%, infection control 83%, information security, manual handling, equality and diversity, fire safety were all 85% .

Assessing and responding to patient risk

- In November 2015 TLBH introduced a critical care daily safety briefing sheet. This included any staff sickness or training issues, any specific problems with individual patients, admissions, discharges and specific safety issues such as sepsis, breathing problems, risk of pressure injuries or any new equipment being used. This was attended by the RMOs, the duty hospital manager, senior nursing staff, outreach staff and some Clinical Nurse Specialists. Roles were the allocated for the day such as the lead for outreach, resuscitation lead and the runners' roles.
- Compliance with its use had been audited in March 2016 which resulted in a 58% uptake of the briefing sheet. However, we observed the daily briefing and saw documentation which showed these were continuing on a daily basis in the weeks prior to our inspection. A further audit was planned to ensure its usage was improving.
- This was followed up by a ward round at 9.30 am led by the consultant in charge which was multi-disciplinary and included senior nursing staff, occupational health staff, physiotherapists, dieticians, the diabetes nurse specialist and RMOs. The purpose for this was to update staff on the condition of individual patients over the night time period.
- The CCU had a Critical Care Outreach policy, version two, July 2016 which laid out individuals' responsibilities, criteria and processes for accessing the service, monitoring processes and training.
- Staff used the national early warning scores system (NEWS) to identify sick patients who were deteriorating. The criteria for outreach referral included all in-patients who triggered NEWS of five or more or three in one parameter. The CCOT could also be contacted regarding any in-patient who may be of concern.
- CCOT monitored this system and responded to patients across the hospital that may need to be admitted to critical care. The guidance and protocol used by ward staff for contacting CCOT and used by nurses to prioritise patients for review was well established and robust.
- We saw there was a policy for the Management of Sepsis Six and staff told us about this policy and knew how to recognise when a patient needed to follow the pathway. We saw Sepsis Six details were collated in the daily patients electronic care plan. The Sepsis Six is the name given to a bundle of medical therapies designed to reduce the mortality of patients with sepsis.
- The use of the 'Sepsis Six' bundle started in July 2016 and in that time 21 patients had been seen by the CCOT. Of those identified as having sepsis 15 of these patients had been admitted to the CCU.
- The CCU admission policy, first produced in April 2015 and updated August 2016 defined the criteria for people who would and would not benefit from admission to the CCU.
- The policy stated 'the decision to admit a patient to a critical care unit should be based on the concept of potential benefit. Patients who are "too well" to benefit or those with no hope of recovery to an acceptable quality of life should not be admitted'. The policy also

stated 'This is a clinical decision that can only be made for each individual patient at the time of referral. The refusal of an admission to a critical care unit on clinical grounds should only be made by the Intensivist on duty, in consultation with the patient/family and referring consultant'. Staff we spoke with were aware of this policy.

- We saw the CCU's 'Transfer of a Critical Care Patient to Another Hospital' dated October 2010. This covered individual responsibilities, risk assessments, safety and transfer of the patient, equipment, handover, medical summary and supporting documentation. Although this happened very rarely, staff told us about their roles and responsibilities when transferring a patient to another hospital.

Nursing staffing

- The current nursing figures for CCU were 83 with 25 whole time equivalent (WTE) vacancies of which 15 were filled and awaiting to commence employment. There was one ward manager, six senior sisters, 11 junior sisters, 48 staff nurses and one Health Care Assistant (HCA). These figures included the CCOT which was staffed 24 hours a day seven days a week.
- The CCU met the Core Standards for Intensive Care and at the time of the inspection the CCU had 15 patients across the two CCU areas. The CCU had 18 trained staff to cover 1:1 patient care, three additional trained nurses to carry out the daily safety checks and relieve breaks and one Health Care Assistant (HCA) who would work between the two units where necessary. There was a senior nurse manager and a member from the CCOT as additional cover. There was a designated supernumerary nurse in charge for every shift in line with the Standards for Intensive Care Services published by the Joint Standards Committee of the Faculty of Intensive Care Medicine and the Intensive Care Society (2013).
- For the period May 2016 to July 2016 the use of bank staff was 8.13% and 28% for agency staff. During the same period there was an average of a 2% sickness level for the CCU.
- The third floor unit was identified as the main unit where the allocation of staff took place at the start of each shift. Data produced by the CCU showed and staff told us that when there were more than ten Level three patients or 12 Level two and three patients the unit on the 1st floor would be opened. At the start of each shift staff were allocated to work in either the 1st or 3rd floor unit.
- Staff allocated to work on the 1st floor would go directly to the unit for their handover. The staffing on the 1st floor adhered to the critical care (CC) staffing guidance, with a nurse in charge, 1:1 for CC Level 3 patients and 1:2 for CC Level 2. The 1st floor unit was supported by a Critical Care receptionist and a HCA.
- Nursing staff conducted handovers twice daily with the whole team, at 8am and 8pm.

Medical staffing

- The CCU was under the leadership of four consultants in intensive care medicine. All the consultants also held NHS contracts. The consultant attended the unit as a minimum, once a day however in most instances they attended twice daily. There was frequent telephone contact with the RMO on duty dependent on patient acuity. They were required to be able to reach the unit within 30 minutes and met the Intensive Care Society Standard.
- All Registered Medical Officers (RMOs) were dual trained in intensive care medicine and anaesthetics. We saw rotas which demonstrated consultant intensivists were present and available on site to see all 'high risk' patients 24 hours a day and off site within one hour of being called, 24 hours a day, seven days a week.
- TLBH directly employed middle grade medical staff who had completed Foundation and Core training levels one and two. Research fellows were employed through honorary contracts and were required to have trained to a minimum of ST4. There were supplied through universities as part of TLBH. These were supplemented by Bank Research Fellows trained to ST 4 level and with agency RMOs when needed.
- We saw copies of the medical rota and staff told us the level of cover meant there was always a doctor present on the unit in an emergency.
- There was joint working with dedicated consultant medical staff and nursing from a local NHS trust when caring for patients undergoing live liver and kidney transplant surgery. There was a SLA in place. We were told this worked extremely well; staff on the CCU were competent to care for these patients under the supervision of the transplant team and the resident RMOs.

Outstanding ☆

Critical care

Major incident awareness and training

- There was a current Emergency Preparedness, Resilience and Response (EPRR) policy in place which included details of specific actions to be taken by each individual, establishing communication with the hospital command centre and using a 'communication cascade' to call in extra staff.
- The policy was up-to-date and fit for purpose. There was a box with instructions for staff in the case of an emergency. However not all of the staff we spoke with understood their responsibilities.

Are critical care services effective?

Good

We rated the service as good for effective because:

- The CCU staff used external evidenced based standards and information to monitor and benchmark their practice.
- Patients were treated according to national guidance, including those from the NICE, Core Standards for Intensive Care Units and ICNARC. Policies and procedures were based on current national guidelines.
- Staff were proud about their joint working relationships with other professionals. There were numerous examples of staff working in a multi-disciplinary way to the benefit of improving patient care.

Evidence-based care and treatment

- The CCU measured itself against the Core Standards for Intensive care Units and used ICNARC.as a benchmark for its performance. The CCU was fully compliant with these standards.
- Policies and procedures were available on the hospital intranet. We saw policies were based on research evidence. For example tracheostomy cares, care of the ventilated patient, admission, discharge and transfer of patients to other hospitals.
- The CCU had recently joined the North West London Critical Care Network and was currently participating in a self-assessment and peer review of the national critical care D16 standards. This was to be completed in early October 2016 and was led externally by staff from a local NHS Trust.
- We saw local policies and procedures for outreach activities and quarterly auditing of its outreach activity. For example between April and August 2016 CCOT had seen 147 (36%) of patients prior to planned surgical admission and 470 (65%) 24 hours after discharge from the CCU. The target was 100% and the team were working towards this.
- We saw examples of clinical audit where actions been taken to improve patient care. For example the audit of tracheostomy care and nursing records audits which demonstrated documentation could be improved
- TLBH participated in the provider level healthcare audit programme. Staff told us that they participated in all relevant audits such as record keeping.

Pain relief

- Patients could receive pain relief in various formats; patient controlled analgesia (PCA), epidural, intra-venous or orally. Staff told us pain relief medicines were reviewed frequently to ensure pain control was optimised and patients were weaned from analgesia when they were ready
- The CCU used one specific make of PCA pump which was in line with the rest of the hospital. This ensured there was a consistent approach in the use of the pumps and reduced the risk of any human error relating to their use.
- Pain was assessed at hourly intervals or more frequently for patients with pain control issues. A scale specifically for patients unable to communicate their pain was used for unconscious patients. We saw pain scores were documented on the electronic patient record.
- Pain management training for nurses was provided on analgesics, such as patient-controlled analgesia (PCA) pumps and epidural and local anaesthetic wound infusion. Nurses were required to complete a patient-administration competency assessment and competency checks on their use of equipment.
- Between January and June 2016 the CCU carried out a pain audit on a sample of 16 patients. Patients were asked about being prepared for any post-operative pain, how well their pain was assessed, how timely their pain was administered and how well staff helped to control their pain. The results showed over 50% of the 16 patients sampled rated their pain control as excellent with the other 50% rating their pain control as either good or very good.

Nutrition and hydration

- The CCU did not use the Malnutrition Universal Screening Tool (MUST) to assess patient's risk of malnutrition. A more individualised was taken. Dieticians told us that if a patient was at risk of malnutrition or had specific dietary needs they were referred to them and they would review the patient on an individual basis.
- We saw dieticians attended the daily CCU ward rounds so they would be aware of any concerns with nutrition or hydration of all patients resulting in no delay in initiating nutritional programmes.
- Dieticians also attended the CCU daily where patients were receiving parental nutrition. Parental nutrition is a method of getting nutrition into the body though the veins. Pharmacists were also involved with parenteral nutrition for patients as required.

Patient outcomes

- The CCU participated in local audits such as eye care, mouth care tracheostomy care and nursing /medical handovers. For example for patients being cared for with a tracheostomy an audit showed a high standard of nursing and medical care. However improvements were identified as needing addressing such as further attendance at tracheostomy training days and changes to the tracheostomy policy to reflect how often tracheostomies should be changed.
- Due to a number of hypoglycaemic incidents (low blood sugar levels) a task and finish group had been established to review and implement changes focused around the control of blood sugar levels and the management of insulin. This included working with the Diabetes Nurse Specialist to review way insulin was prescribed, reviewing the current guidance and instigate training and awareness programmes to reflect the changes. This resulted in the use a more individualised sliding scale programme of treatment for patients living with diabetes.
- The CCU contributed to ICNARC, which meant that the outcomes of care delivered and patient mortality could be benchmarked against similar units nationwide.
- ICNARC for the period April 2015 and March 2016 showed that less than 0.1% of transfers out of critical care were for non-clinical reasons, which was better than the national average of 0.4%.
- Unplanned readmissions were reported at less than 1% of total discharges in the twelve months prior to our inspection which was better than the national average of 1.2%.
- Mortality rates in the unit were around 1% which was similar to the national average for units of a similar size.
- In June 2016 the CCU had set up mortality and morbidity meetings. These took place monthly where individual patients were reviewed, discussed and changes were made to ensure learning would take place from each patient death where applicable.

Competent staff

- Staff had the skills, knowledge and experience to deliver effective care and treatment to patients.
- Appraisal rates for CCU staff were 100%. Staff revalidation was recoded on an electronic system run by the Human Resources department and included revalidation dates and PIN numbers for nursing staff.
- The CCU met the Core Standards for Intensive Care Units of a minimum of 50% nursing staff having a post graduate qualification in intensive care which was 64%.However, senior staff on the CCU were working towards a London based target of 70%. Senior staff told us in order to meet the London standard of 70% staff were undertaking an active recruitment drive of critical care nurses with a post graduate qualification as well as undertaking a training and development programme for current nurses to achieve post graduate qualification/ relevant university courses. Four nurses would qualify by the end of 2016 taking the CCU to 68% qualification compliance with a further four nurses due to start the course by the end of September 2016. This would bring the CCU to 75% qualification compliance by the summer of 2017.
- Staff could access other courses via a local university such as Intensive Care Core skills, module 3226 Intensive care core skills and mentorship modules.
- Staff within the CCU had completed additional training and leadership development. There was access to training in specialised equipment such as PCA pumps, ventilators and nutrition pumps. There was also training for parental nutrition, the management of difficult airways, cultural awareness, tissue viability and specific types of beds. All staff were Advanced Life Support (ALS) trained.

- The CCU worked with the NHS to facilitate students training programme within the CCU from a local University.
- New training programmes had commenced to ensure HCA Critical Care Bank staff had been trained and were competent in the use of the CCU's electronic assessment system. A rotating schedule between all sites had been initiated which allowed training to take place at each site.
- The CCU had one practice development lead (PDL) but this post was vacant at the time of the inspection. The CCU had a sister working in the role 22.5 hours per week and managers were in the process of recruiting to this position as a full time role.
- The sister covering the PDL post was responsible for overseeing new starters to the CCU and had developed an orientation manual specifically for the CCU. The PDL would support new staff and ensure they were confident to work in the critical care environment. New staff recruited to the CCU were already experienced critical care nurses and as such they would be a minimum of six days supernumerary to ensure they were fully orientated to the CCU.
- Staff from overseas were given up to six weeks supernumerary experience before being able to practice independently.
- Agency nurses also completed an orientation checklist booklet on their first shift and worked under the supervision of senior unit staff.
- TLBH had 23 clinical nurse specialists who acted as experts in specific fields and would attend the CCU either daily or when required. For example the Diabetes Nurse Specialist would attend the daily rounds and handover meetings and would review all patients' treatment relating to diabetes. Whereas the Liver Transplant Nurse Specialist would attend when a patient was due to undergo liver transplant surgery and support both medical and nursing staff.
- There were a number of link nurses such as tissue viability, infection control and diabetes. Link nurses acted as a point of contact for guidance and advice about specific issues.
- Consultants with practising privileges had their appraisals and revalidation undertaken by their NHS trust. We were shown evidence of this recorded on a spread sheet along with their insurance.
- RMOs were directly employed by TLBH and had access to a number of courses and training opportunities. For example difficult airway and airway simulation, hemofiltration (a kidney replacement therapy), treatment of hypoglycaemia (low blood sugar) and ALS training.
- RMOs told us they were well supported and had timely access to a consultant when needed.

Multidisciplinary working

- Staff were proud about their joint working relationships with other professionals. There were numerous examples of staff working in a multi-disciplinary way
- Daily ward rounds were undertaken seven days a week. Medical and nursing staff were involved in these together with physiotherapists and/or occupational therapists as required. We observed a good working relationship between ward staff, doctors, physiotherapists and the pain team.
- The CCU was working with an external NHS organisation to undertake a review of its critical care service using a set of quality standards relating to the NHS Outcomes Framework and adapted to the independent sector.
- We saw the CCU's 'Discharge from Critical Care' policy and staff told us about their roles and responsibilities when discharging patients back to the wards. Staff could tell us about this policy.
- We saw documentation by physiotherapists and occupational therapists being introduced at the bedside, and new bed space wall charts were being introduced detailing current therapy. The purpose of this was to enable more effective communication between the MDT staff members.
- We were told about excellent working relationships with the local NHS liver transplant team who would carry out live liver donation at TLBH when needed. They would attend with two surgeons an anaesthetist and an intensivist. The intensivists and anaesthetist would stay for as long as it took to ensure the patients were stable. They reviewed the patient on a daily basis until discharge.
- Data supplied by CCOT showed a year on year increase in the number of follow up visits within 24 hours of discharge from the CCU. For April 2015 to March 2016 the CCOT saw over 60% (470) of patients discharged back to a ward within 24 hours.

Seven-day services

- The hospital had a 24-hour, seven days a week on call service for imaging, Computerised Tomography (CT a

type of x-ray), pharmacy, intra- aortic balloon pump (a mechanical devise which helps the heart to pump blood), perfusion (a method of pumping blood into tissue), physiotherapy and theatres.
- There were also on call rotas for renal specialists, cardiologists, interventional radiologists, physiologists, general surgery, cardiothoracic, anaesthetics, endoscopy and senior nurse manager.
- The pharmacy service was operational on weekdays from 8am until 8pm.
- Physiotherapists provided a seven day service.
- The hospital also provided accommodation on site for any staff member that were called in and needed to stay overnight.

Access to information

- Patient admission details, including past medical history, operation notes and a social history, were recorded on the electronic patient record. Electronic records could be accessed via a staff log in on any computer, which had the relevant software installed. This meant staff could access the information from anywhere within the hospital.
- Consultants had access to electronic records and clinical tests at home which meant they could view tests and x-rays in a timelier manner.
- All agency and bank staff were issued with temporary log in details to enable them to access the information easily.
- There were computers throughout the CCU areas to access patient information including test results, diagnostics and records systems. Staff were able to demonstrate how they accessed information on the trust's electronic system.

Consent and Mental Capacity Act

- TLBH had consent to examination or treatment policy, version two, dated August 2016.
- The CCU had no recent examples of undertaking mental health capacity assessments. However we saw a Confusion Assessment Method (CAM) for the ICU flow sheet in use on the unit which assisted staff to recognise the different levels of delirium. We also saw training to understand and recognise the signs of confusion and delirium was in place.
- We saw staff used the Richmond Agitation-Sedation Score (RASS) which rated the level pf patient consciousness. We saw documentation to support that both the RASS and COM were used and audited. For example in July 2016 64 patients were audited and showed an overall average of 85% compliance with the use of the documentation.
- Staff told us they knew the process for making an application for requesting a DoLS for patients and when these needed to be reviewed.
- Take up of staff training on the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards was 94%.
- Where patients in ICU required "Do not attempt cardio pulmonary resuscitation" (DNACPR) was completed with documentation of patient involvement. In the year prior to inspection six DNACPR forms were completed. A hospital wide audit completed between January and July 2016 showed that 100% of cases had the correct form in the notes and was completed by a Consultant. 90% had documentation that the decision not to give CPR was discussed with the patient or their family. The action plan following included that timely challenges of poor documentation should take place via a review by the practice development team.
- Staff told us there were often cultural beliefs that made completion of DNACPR difficult. In these cases the team would involve a cultural specialist nurse to assist in difficult conversations and all staff had specialist cultural training in their induction.

Are critical care services caring?

Good

We rated caring as good because:

- Staff were caring and compassionate to patients' needs, and treated patients with dignity and respect and each patient had an individual room.
- Patient feedback was overwhelmingly positive about the care and treatment they had received.
- Patients and relatives we spoke to told us they received a good care and they felt well looked after by staff.
- Information about treatment and care was shared with patients, and patients and their relatives were able to ask questions. They were given contact details of critical care team to contact post discharge if required.
- Patients received holistic treatment considering not only physical need but emotional and spiritual needs.

Outstanding ☆

Critical care

Compassionate care

- Patients were treated with respect and dignity when receiving care and support from staff.
- One patient told us they felt their privacy had been well protected. Another stated, "It was a calm environment being in an individual cubicle in ICU & gave such privacy".
- Relevant inpatient survey results and how they related to this core service and patient experience showed 93% satisfaction with the care patents received.
- Following inspection we were provided with written feedback from patients. This included staff demonstrating "fantastic team work" and having "big hearts".
- Patients were able to access holistic therapies such as aromatherapy to support them during their stay in the CCU.

Understanding and involvement of patients and those close to them

- Patients told us they felt involved in their care and had been given the opportunity to speak with the doctors and other staff looking after them.
- One patient told us the side effects of some drugs were fully explained to them and the physiotherapist gave a good explanation of their rehabilitation responsibilities.
- We observed nurses, doctors and other professionals introducing themselves to patients at all times and explaining to patients and their relatives about their care and treatment options.
- One patient told us they were impressed with the co-ordination, communication and speed of laboratory tests.
- Staff had completed the development of a Patient Diary and were awaiting the final version to be printed before being used.

Emotional support

- One patient told us staff were very good and helped remove their anxieties.
- One patient told us they were well informed and found the translation service very helpful.
- The CCU had developed a new bereavement brochure to support patients and help families through difficult times. We saw that this included a follow up phone call from the hospital critical care nursing team to offer support and arrange any further contact that may be required.
- There was a multi-faith room available for use and families were offered access to a range of multi-faith leaders to support them if required.
- An annual memorial service was held for relatives and staff in remembrance of those who had died under the care of LBH to provide support for all those involved in the patients life and care.

Are critical care services responsive?

Outstanding ☆

We rated the service as outstanding for responsive:

- This was because patient's individual needs and preferences were absolutely central to the planning and delivery of tailored services.
- The services were very flexible, provided choice in almost all aspects of care and ensured continuity of care at a time that suited the patients and was timely.
- The service worked with NHS organisations and Embassies to plan patient care,
- All patients were admitted within four hours of the decision to admit and there were no delays in discharge back to the wards.
- Action was taken in response to complaints and where possible took responsibility to address issues immediately.

Service planning and delivery to meet the needs of local people

- The majority of patients cared for on the CCU were from overseas and it did not take emergency admissions from other hospitals or critical care units. The CCU provided care and treatment primarily to complex elective surgical, oncology and medical patients and accommodated patients from other wards in the hospital if their condition deteriorated or unexpected complications occurred following planned surgery.
- Critical care consultants worked with surgical colleagues in TLBH and other external NHS organisations to plan complex elective admissions. For example patients undergoing liver and kidney transplant surgery.

- Patients were invited back to give feedback on their experiences to ensure that hospital could identify changes to make the service more tailored to the needs of the variety of patient groups it cared for.

Meeting people's individual needs

- Staff on the CCU were proactive in understanding the needs of different groups of people and to deliver care in a way that met these needs. For example staff would travel abroad to plan patients care with the patients and families at a time that suited them in readiness for their surgery. This included people who were in vulnerable circumstances or who had complex needs.
- Some patients wanted their anonymity to be maintained and staff went to extreme measures to ensure this happed. Other patients needed their family to be with them 24 hours a day and again this was organized for the family.
- The CCU worked together with the MDT, including the physiotherapists and occupational therapists to undertake assessments of a patient's physical condition, functional abilities and any cognitive impairment. For example a very ill patient wanted to die at home and not on the CCU. Staff worked together with the patient's GP and community nursing staff to ensure this happened even though the patient was having continuous renal therapy, mechanical support with their breathing and continuous clinical monitoring. This was an extremely complex situation and the patient passed away peacefully at their home surrounded by their family.
- For patients living with dementia the Montreal Cognitive Assessment and the Mini-Mental State Examination were undertaken. The Mini-Mental state examination assessment was available in Arabic as well as 20 other languages.
- These assessment results were communicated with relevant staff, a treatment plan developed and patients were managed accordingly. Patients were then re-assessed two to three weeks later if necessary. We saw these in the patients' electronic record.
- Accommodation for relatives and visitors was limited however, staff directed relatives to differing types of accommodation near to the hospital. There was a family room and a multi faith room and a waiting area in a corridor outside the unit. The area had natural light, ventilation and facilities for drinks. An overnight room was available for relatives on an ad hoc basis.
- There was a designated Arabic interpreter on the CCU and for non-Arabic patients the CCU could access translation services.
- Patients who were able to eat and drink had a choice of food from a menu, which included vegetarian, gluten free, halal, 'easy to eat' and pureed options. Staff could order hot meals on demand from the hospital kitchen.
- When patients in the CCU were able to eat and drink the chef could visit them personally to discuss the menu and any meals they would like to order. Relatives of patients were offered free meals if required.
- One patient told us their breakfast of porridge and poached eggs was 'beautiful' and they were 'very impressed' with the quality of the food.
- Patients could access their pets and have them bought into visit if it was safe for them to do so. This provided emotional support to patients.
- Patients and their families could complete a "patient diary" that could be completed daily. Events or experiences could be documented to allow patients to see their journey through the hospital and what had been happening whilst they were in the CCU.
- Communication boards were available in each room to orientate patients to the date, time and who was caring for them on a daily basis to help them feel more at ease.
- There was a multi-faith room available for use and families were offered access to a range of multi-faith leaders to support them if required.
- There was a chaplaincy available through a local NHS trust and contact details of other counselling services were given to patients and families if required. They gave specific counselling contact details for children and young people if their family member had passed away.

Access and flow

- The CCU had an Admission to Critical Care policy dated August 2016 this included roles and responsibilities for individual staff, referral processes for planned and unplanned admissions and referral processes for admissions from other hospitals.
- Between April 2015 and March 2016 there had been no refusals to admit patients to the CCU.
- During the 9.00am briefing meeting booked beds would be discussed. All patients were categorised as needing

Level three care. There were no emergency admissions and as such beds were booked well in advance so any peaks in demand could be addressed in an effective and timely manner.
- All patients were admitted within four hours of the decision to admit and there were no delays in discharge back to the wards.

Learning from complaints and concerns

- Between December 2015 and June 2016 there were seven formal complaints attributed to the CCU. These complaints had been reviewed, managed in an appropriate manner and responded to within the hospital's timescales.
- The majority of complaints were dealt with on a more informal basis in that any complaints received would be addressed immediately. For example the housekeeper found some patients were complaining that the floor in the toilet area was wet. The housekeeper addressed this by changing her routine and cleaning the floor every 30 minutes until the busy time was over

Are critical care services well-led?

Outstanding ☆

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

- There was a clear vision and policies for the CCU which was led by a strong and visible management team and staff were motivated to work to achieve these on a daily basis.
- Staff we spoke with, minutes of meetings, monitoring data and audit of CCU practices demonstrated the robust and deeply embedded governance process within the CCU. Such processes were being reviewed to further enhance governance processes through use of for example morbidity and mortality meetings.
- Risks had been identified and were reviewed monthly with evidence of actions taken and risks reduced. There was an open, transparent no blame culture. Staff were empowered to lead the way in making improvements to the service with the support of senior staff.
- The CCU regularly took part in national research programmes which resulted in developing innovative and new ways of working and improving standards of care for patients.
- Staff were well supported by their local leaders and senior managers including the senior management team. There was a very high level of satisfaction with staff telling us they were proud of the organisation and enjoyed working within their teams.
- There was strong clinical leadership with consultants actively involved in service development.
- Patients had opportunities to give feedback on their patient experience whilst in the hospital. Any issues arising from this feedback was dealt with in a responsive manner and changes to care made where possible.
- Staff were involved in developing and improving the service.

Vision and strategy for this this core service

- There was a clear provider level vision and strategy, which incorporated all service areas including the CCU. Staff knew the vision and strategy and told us they aimed to work under the visions and values of HCA at all times. We saw that 90% of staff who participated in the staff survey understood the vision and values of the hospital.
- The CCU had a 'Critical Care Business and Service Line Plan" dated January 2016 which was reviewed monthly and refreshed annually. This plan identified the need to address the following challenges: increasing competition locally, nationally and internationally. Addressing the skills shortage across a number of clinical disciplines, particularly nursing and barriers to employment in Central London. Staff could tell us about these challenges.

Governance, risk management and quality measurement for this core service

- Governance and performance management arrangements were being reviewed as part of the hospital's continuous improvement programme and they reflected the changes in best practice guidance.
- The Chief Nursing Officer (CNO) was the overall lead for the CCU with a deputy nursing officer and a head of governance risk and quality manager. There was also a clinical nurse manager with day to day responsibly for CCU. A lead clinician for ICU was in place with three deputy clinicians who were part of the governance structure.
- There was a robust governance and risk management structure at corporate provider level to hospital and

department level. There was also a reporting structure for quality and risk management. We saw that CCU staff were involved in governance meetings such as incident meetings and complaint reviews.

- Mortality and morbidly meetings took place at local and corporate level. Infection prevention and control and resuscitation reported to the hospital clinical governance committee. The hospital clinical governance committee, standards progression board, health and safety, complaints meeting and senior leadership team, reported to the hospital's executive team and Medical Advisory Committee (MAC).
- Departmental and ward meetings took place monthly and any issues would be fed up through the senior manager team meetings and where necessary to the nursing and AHP committee led by the CNO or to the MAC lead by the medical director.
- The monthly critical care and management team meetings discussed issues such as critical incidents, risk, infection control, mortality and morbidity, clinical audit, safeguarding and local audits.
- The CCU had eight issues on its risk register, four were categorised as high risk, three as moderate risk and one as a low risk. The risk register was reviewed monthly and actions updated in order to reduce the risk. All risks on the register had action plans in place to reduce the risk and timeframes for completion of action plans.

Leadership / culture of service

- There was a well-established local leadership team, led by the clinical nurse manager, along with four lead consultant intensivists with support from senior sisters and a team of specialist RMOs and nurses.
- All staff we spoke with told us that the CEO and other leadership team were very visible and very approachable. The Head of Nursing did a daily walk round and asked staff if they were having any issues. Staff told us the CEO seemed to know every member of staff by name and often knew something about their personal backgrounds. They told us this made them feel valued. There was strong effective clinical leadership.
- Leaders motivated staff to succeed through empowerment. There was an open and learning culture and high levels of staff satisfaction across the CCU. Staff were proud of the organisation as a place to work and spoke highly of the culture. Changes within the service were driven by the staff. There were consistent high levels of constructive engagement with staff, including all equality groups. Staff at all levels were actively encouraged to raise concerns.
- We saw collaborative working between the medical team, nursing staff, pharmacy, physiotherapy, occupational therapy and dietitian teams. There was a real sense of listening to individual's actions and treatment regimes. For example we observed the physiotherapists and occupational therapists discussing each patient with the MDT and guiding them through the patient's rehabilitation pathway so all staff understood the effect some therapy may have on the patient. For one patient this meant their rehabilitation may result in needing more analgesia.
- Comprehensive and successful leadership strategies were in place to ensure delivery and to develop the desired culture. For example the CCU had an Inspirational Leadership Programme for the Critical Care Team Leaders which was led by the critical care manager.
- There was a Leadership Nurse-In-Charge Course, a comprehensive training package, correspondence between learning and development had taken place. All nurses in charge had completed this programme.

Public and staff engagement

- Staff received communications in a variety of ways such as newsletters, emails, briefing documents and meetings.
- TLBH had started to produce a Critical Care Quality Bulletin which was two monthly and sent to all ICU staff. The July 2016 edition contained information about the work taking place across the six critical care sites which included areas such as improving medicines management, initiating and trialling new quality ward rounds sharing of incidences across all sites and reducing the incidences of falls.
- TLBH had religious and cultural awareness campaigns which were a monthly feature to let patients and staff know the religious and cultural dates for the month ahead along with details of a selection of awareness days and months. Staff also undertook cultural training as part of their induction to ensure they had a deeper understanding of all patients holistic needs.
- TLBH participated in the provider patient survey and data demonstrated a 99% satisfaction with the hospital.

Outstanding ☆

Critical care

Innovation, improvement and sustainability

- There was joint working with the NHS demonstrating high quality outcomes for patients who required complex and demanding MDT working. For example Service Level Agreements with an NHS liver transplantation team resulting in TLBH being able to support liver transplant surgery.
- The overwhelming support staff received in order to improve and make changes to their practice leading to an empowered workforce being able to affect change. For example the development of an infection control trolley which worked towards reducing the of incidents of infections and the introduction of new protocols due to lessons learnt following two recent falls incidents resulting in expanding the role and numbers of 'runner' staff, which allowed staff more time to carry out individualised care.

Outstanding ☆

Outpatients and diagnostic imaging

Safe	Good
Effective	Not sufficient evidence to rate
Caring	Good
Responsive	Outstanding ☆
Well-led	Outstanding ☆

Information about the service

London Bridge Hospital provides outpatient and diagnostic imaging services at several locations including the main hospital buildings on Tooley Street (27 Tooley Street, Emblem House and St Olaf House), HCA at the Shard, 31 Old Broad Street and 120 Old Broad Street.

There were 118,675 outpatient attendances at the outpatient and diagnostic imaging department (OPD) between April 2015 and March 2016. This amounts to 86% of all attendances at the hospital. 223 of these patients were young adults aged 16 and 17 years. There were only three NHS patients during the period.

The outpatient and diagnostic imaging department (OPD) offers a range of specialist clinics. Service type as a percentage of total outpatient visits include musculoskeletal 25.9%, digestive diseases 12.2%, general medicine 10.4%, radiology 9.6%, cardiac 8.7%, oncology 7%, urology 4.9%, Ear, Nose and Throat (ENT) 4.7%, gynaecology 4.4%, breast 2%, dermatology 3.3%, endocrinology 1.5%, rheumatology 1%and other 4.3%.

The main hospital offers diagnostic imaging services on the first floor. OPD services at St Olaf House include the London Lupus centre, cardiology outpatients and consulting rooms. OPD facilities at Emblem House consists of consulting rooms, there are no treatments carried out at this location due to planned refurbishment.

HCA at the Shard has 78 consulting rooms, 12 treatment rooms and several phlebotomy rooms spread over three floors. The facilities at this location include a café, main reception and registration area on the fourth floor. The physiotherapy unit, including a gymnasium and the diagnostic imaging unit are on the fifth floor. Specialist clinics at The Shard include orthopaedics, neurology, dermatology, rheumatology, endocrinology, orthopaedics, ENT and maxillofacial, colorectal, urology, women's health, gynaecology and breast, urology, GI digestive diseases.

31 Old Broad Street consist of 10 consulting rooms, one treatment room, one phlebotomy room and a diagnostic imaging department. 31 Old Broad Streets offers a range of clinical services including orthopaedic clinics, breast surgery, foot and ankle clinic, genito-urinary medicine , hand and wrist clinic, knee clinic, neurology, rheumatology, vascular and sports and exercise medicine.

The OPD at 120 Old Broad Street consist of eight consulting rooms, one hand therapy unit, three treatment rooms, phlebotomy rooms and one audiology room. Key services include dermatology and gynaecology.

Imaging services were provided at the main hospital, The Shard and 31 Old Broad Street. Imaging and scanning services include magnetic resonance imaging (MRI), ultrasound, x-ray, computed tomography (CT), mammography, fluoroscopy, dual energy x-ray absorption (DEXA) and nuclear medicine.

Physiotherapy services offered at the Shard include manipulation and mobilisation techniques, postural advice, treatment and rehabilitation for soft tissue and sport injuries, clinical pilates, acupuncture and Ultra Violet B (UVB) phototherapy. The unit has a multi-sport gymnasium for patient rehabilitation.

The inspection included a review of all the areas where patients received care and treatment. We inspected the imaging department at London Bridge Hospital and OPD services at St Olaf House and Emblem House. We also inspected the OPD at The Shard, 31 Old Broad Street and 120 Old Broad Street.

Outstanding ☆

Outpatients and diagnostic imaging

We visited the OPD on 21/22 September 2016 during our announced inspection. We also visited during an unannounced inspection on 29 September 2016.

We spoke to nine patients and reviewed six patient records. We spoke to 28 members of staff including managers, medical staff, nursing staff, health care assistants, therapy staff, radiographers, administrative staff and domestic staff.

Summary of findings

Overall, we rated the OPD as outstanding because:

- We saw excellent local leadership within the department and staff reflected this in their conversation with us. There was a positive, open and non-blame culture in the OPD and staff said they could raise concerns with the leadership team. Staff were overwhelmingly positive about working in their areas and were very proud of the services provided. Staff said they were motivated to go the extra mile to make sure patients received the best care and are safe.
- The OPD had implemented a number of innovative services and developed these to meet patient's needs. Staff had been encouraged to contribute to developing and improving services.
- There was a culture of enhanced training and development opportunities for staff. There were several examples of staff who had progressed through the ranks to senior positions. Staff said they were supported in their role and the opportunities for development motivated them in their work.
- Clinics and services were developed to meet the needs of patients. OPD services were provided in four locations in line with patients' demand and for their ease of access. Feedback from patients were taken into consideration when designing new clinics and locations.
- There was no waiting list to be seen as an outpatient. Patients were offered the most convenient appointment with their preferred consultant. This could also be the same day or next day appointment.
- There were effective systems in place to protect patients from harm and a good incident reporting culture. Learning from incident investigations was disseminated to staff.
- Patient records were comprehensive, with appropriate risk assessments completed. Medicines were stored safely and securely.

Outstanding ☆

Outpatients and diagnostic imaging

- Staff used evidence based care and treatment in line with national guidelines and local policies. Staff were competent in their roles and a number of staff had completed further training and development.
- Patient feedback for the services visited were consistently positive, patient satisfaction survey results were positive and patients felt supported. Confidentiality, dignity and privacy was respected by staff.
- Staff were aware of people's individual needs and considered these when providing care. The department dealt with complaints and concerns promptly, and there was evidence the OPD used learning from complaints to improve the quality of care.
- There were effective and robust governance processes and risks were proactively reviewed. Where concerns were raised or audits showed non-compliance action plans were completed and staff given responsibilities and times frames to implement change.
- There was evidence of staff engagement and changes being made as a result of concerns. Patients were also engaged through surveys and feedback forms and the response showed high satisfaction with the service.

Are outpatients and diagnostic imaging services safe?

Good

We rated safe as good because:

- Staff were aware of how to report incidents and learning was disseminated to staff.
- All areas visited were clean and tidy. Staff had access to personal protective equipment and hand gel dispensers were available in all areas visited.
- The environment was suitable for the services offered. Staff had access to a wide range of specialist equipment and equipment were adequately maintained. Resuscitation trolleys were available at all locations visited and had been checked daily.
- Medicines were stored safely and securely.
- Patient records were comprehensive, with appropriate assessments completed.
- There were effective systems in place for safeguarding vulnerable adults and children.

Incidents

- There were 86 clinical incidents and 50 non-clinical incidents in the OPD between April 2015 and March 2016. The rate of clinical incidents was lower than the rate of other OPDs in similar independent hospitals. The rate of non-clinical incidents was similar to the rate of other OPDs. All incidents were reported as low harm or no harm.
- Staff reported incidents electronically on a datix system and could show us how to report incidents. They told us they received feedback on individual incidents they reported and on trends within the hospital. Senior staff shared information about incidents and learning at handovers, on the staff notice board and at meetings.Senior staff attended incident review meetings every Thursday and discussed trends at the meetings.

- Staff were familiar with the duty of candour regulations and were able to explain what this meant in practice. They identified the need to be honest about any mistakes made, offer an apology and provide support to the affected patient.

Cleanliness, infection control and hygiene

- All areas of the OPD in all locations we visited were visibly clean and tidy. Domestic staff understood cleaning frequency and standards. They said they had received appropriate training required for the role. All the toilets we viewed in all locations visited were clean and tidy. Hand hygiene instructions were provided above the sinks in the toilets. Toilets with baby changing facilities had separate nappy bins.
- Personal protective equipment (PPE), such as gloves and aprons were available in all clinical areas in all the locations visited. All staff observed the 'bare below the elbow' policy and we observed them using PPE when required.
- Equipment used in the OPD in all locations we visited including diagnostic equipment and trolleys were clean. Staff used 'I am clean stickers' to indicate an item of equipment was cleaned and decontaminated. We saw there was a checklist for cleaning each piece of equipment and all equipment were cleaned as scheduled. All the sharps bins inspected were properly assembled, labelled and signed and filled below the line indicated on the bin. Patient privacy curtains in the treatment rooms and other clinic areas were clean and labelled with the date they were last changed.
- We saw domestic staff used the correct colour of waste bags for clinical and domestic waste. Waste was disposed in a secure area in all locations and there was a separate area for disposing clinical waste.
- The hospital published an annual audit programme for infection control standards in practice. The results for the first quarter (January to March 2016) showed a thorough audit of several areas in each outpatient department.
- Emblem House achieved 100% in six of the eight areas audited including general equipment, specialist equipment, specimens' transportation, sharps, PPE, domestic waste handling and disposal. It achieved 99% compliance for the environment and 97% compliance for hand hygiene.
- St Olaf's House achieved 100% in seven of the eight areas audited including general equipment, specialist equipment, specimens' transportation, sharps, PPE, domestic waste handling and disposal and hand hygiene. It achieved 97% compliance for the environment.
- 31 Old Broad Street achieved 100% compliance in seven of the nine areas including kitchen, general equipment, specialist equipment, sharps, PPE, domestic waste handling and disposal and hand hygiene. It achieved 99% for the environment and 80% for specimen transportation. 120 Old Broad Street achieved 100% in all the nine areas audited.
- The imaging unit at the main hospital site achieved 91% for the environment, 84% for the kitchen, 95% for sharps, 96% for departmental waste handling and disposal and 97% for hand hygiene. It achieved 100% in four areas including general equipment, specialist equipment, PPE and isolation.
- Each floor on the Shard was audited separately. The fourth floor of the OPD at The Shard achieved 100% in all eight areas audited including environment, general equipment, specialist equipment, specimens' transportation, sharps, PPE, domestic waste handling and disposal and hand hygiene.
- The fifth floor achieved 100% for five of the eight areas audited including, general equipment, specialist equipment, specimens' transportation, sharps and PPE. It achieved 97% for the environment, 90% for departmental waste and disposal and 86% for hand hygiene.
- The sixth floor of The Shard achieved 100% in four of the eight areas audited including general equipment, specimens' transportation, PPE and domestic waste handling and disposal. It achieved 95% for the environment, 80% for specialist equipment, 95% for sharps, and 90% for hand hygiene.
- The imaging unit on the fifth floor of the Shard achieved 100% in four of the eight areas audited including specialist equipment, PPE, hand hygiene and isolation.

It achieved 96% for the environment, 92% for general equipment, 95% for sharps and 90% for departmental waste and disposal. The imaging unit on the sixth floor achieved 100% in six of the eight areas audited including environment, general equipment, specialist equipment, PPE, domestic waste handling and disposal and isolation. It achieved 95% for sharps and 97% for hand hygiene.

- The physiotherapy unit at the Shard achieved 91% for environments, 83% for departmental waste handling and disposal, 90% for hand hygiene and 94% for physiotherapy treatment areas. It achieved 100% for specialist equipment, PPE and isolation.
- The hospital undertook monthly hand hygiene audits based on the standards of the World Health Organisation's "five moments to hand hygiene". The audit reporting of hand hygiene between January and June 2016 showed that all OPD areas except one achieved over 95% hand hygiene compliance. The OPD on the fifth floor of The Shard achieved 87% hand hygiene compliance. The area of concern identified was lack of lotion availability and lack of hand hygiene posters in public toilet areas. The report indicated that adequate hand lotion was available and signage had been displayed by the time of publication in August 2016. We observed that there were hand lotions and signage in public toilet areas during our inspection.
- Hand hygiene compliance at the Shard in September 2016 was 100%.
- All OPD staff had completed mandatory training for infection prevention and control.

Environment and equipment

- All areas of the OPD in all locations we visited including main hospital building, The Shard, 31 and 120 Old Broad Street were tidy and suitable for the services offered. The reception areas were spacious and had adequate seating arrangements.
- All equipment checks at all locations were up to date. Staff maintained a reliable and documented programme of checks including portable appliance testing (PAT). All the equipment we inspected had maintenance stickers showing they had been serviced in the last year.
- A resuscitation trolley was available in all locations visited. The equipment on the resuscitation trolley had been checked daily and daily check logs were signed and up to date.
- The resuscitation trolley on 120 Old Broad Street and 31 Old Broad street had tamper proof grab bags, tamper proof first aid kit, tamper proof anaphylaxis kits, tamper proof hypo box with information providing details of the content of the box and dates of expiry. The crash trolley at 31 Old Broad street also had a stethoscope, blood pressure cuff and oxygen set. Daily checks were all completed in both locations. Clean and dirty utility rooms were locked and there were warning signs of liquid nitrogen on the door to the dirty utility room. Once opened, we saw that the rooms were tidy and well arranged and all hazardous substances were stored securely.
- There were also resuscitation trolleys at the main London Bridge Hospital buildings and at The Shard. We saw that daily checks were completed.
- Radiology staff had access to protective equipment to carry out x-rays and scans. Lighting above the x-ray and scanning rooms indicated when the rooms were in used.
- Diagnostic equipment used in the department included a fluoroscopy (an equipment that uses X-rays to obtain real-time moving images of the interior of an object). This equipment had dose modulation to appropriately manage or reduce radiation doses.
- Patients checked into the physiotherapy department through the receptionist. The unit had swipe access doors. The physiotherapy department had 12 clinic rooms and two UVB rooms. The department also had a gymnasium where patients could exercise under supervision from staff. There was a cleaning rota in place and all equipment had stickers indicating they had been serviced in the last year. There was a resuscitation grab bag on the corridor. This was checked daily and documented by clinicians. There was also an emergency manual handling pack within the unit containing slide sheets.
- All store rooms we observed were tidy and the contents were neatly arranged. We noted that hazardous

substances were locked in a COSHH (Control of Substances Hazardous to Health) Cupboard and handled in line with the control of substances hazardous to health regulations 2002.

- There were checklists for oxygen and suction and all had been completed daily.
- There were phlebotomy rooms at St Olaf house, The Shard and at 31 and 120 Old Broad Street. Drawers were well arranged and labels on drawers identified what was in each drawer. We saw that blood bottles were in date.
- Consulting rooms were clean with hand washing facilities, domestic and clinical waste bins and hand gel. Specialist equipment in consulting rooms (for example, ultra sound scan) had been serviced by the manufacturer. Senior staff confirmed that staff were routinely trained to use equipment.
- We noted that the corridors on second floor of St Olaf House (liver suite) and Emblem House had carpet flooring. However, the consulting rooms had laminate flooring. Staff told us there were no procedures carried out in Emblem House. Both Emblem House and St Olaf House were being prepared for refurbishment.

Medicines

- There was safe management and storage of medicines in cupboards in a locked room in all of the locations we visited. The medicines refrigerator's temperature was checked daily and was within correct limits. Ambient temperatures of rooms where medicines were stored were checked and recorded. These measures ensured the medicine's potency. Nursing staff knew the actions to take if the fridge temperatures were not within an acceptable range. The OPD did not keep controlled drugs in the department.
- Random samples of medicines and IV fluids were in date. Flammable medicines were kept in a lockable fireproof cabinet. Weekly checks were completed for contents of the cupboard.
- Emergency cardiac arrest and anaphylaxis drugs were kept on the resuscitation trolley and were checked daily. Anaphylaxis is a life threatening allergic reaction that requires immediate treatment.

Records

- Patients notes were stored on an electronic record system accessible at all locations. We looked at a random sample of six patient notes. All records had details of the patient's consultants and all assessments were signed and dated by staff. Notes of operations carried out were scanned onto the system. The records included prescriptions, x-rays and blood results.
- The records captured all patient information. We saw the records had details of all tests carried out, medicines, medical order history, all assessments and reports. The allergy statuses of all patients were recorded. Pain scores were recorded were relevant and a treatment plan was recorded. Consent was obtained for all procedures in the records reviewed. In addition, staff recorded pre-procedure vital signs and the start and finish time.
- Consultants and their secretaries had access to the electronic record system.
- We observed that the electronic record system was secure and staff logged in to access the records. In addition, we observed staff logging out when they finished accessing the electronic system.
- There was no instance in the last three months, where patients were seen in the OPD without relevant medical records. In the event that records were not available, administrative staff would contact the referring clinician or hospital for the necessary information. Medical records from previous visits, along with any diagnostics and test results were available for every patient on the hospital's electronic record system.
- We reviewed the result of the OPD physiotherapy records of 10 patients who attended the unit in February 2016. The audit showed an overall compliance of 91.78%. However, results of the audit showed that two sets of notes did not comply with the requirement to document gained consent on every entry. One note was not clearly legible. One note did not have time documented on every entry and two sets of notes did not have a problem list documented. Immediate action was taken to inform the OPD physiotherapy team of the standards that were not fully complied with and to recommend that these standards were met for every entry into patient's records. A new assessment

paperwork was to be developed and barcoded to improve the likelihood of therapists writing problem lists. The deadline for completion was in November 2016.

- All OPD staff (including therapy and diagnostic imaging staff) had completed the information security training.

Safeguarding

- There were appropriate systems and processes for safeguarding patients from abuse. Staff were aware of their responsibilities to protect vulnerable adults and children. They understood safeguarding procedures and how to report concerns.
- The hospital had a dedicated safeguarding lead that could provide advice or guidance to staff. staff knew who the safeguarding lead was.
- Up to date policies on safeguarding for both adults and children were available to all staff on the hospital's intranet.
- All OPD staff had completed the safeguarding adult level 1 and level 2 training. Eighty nine per cent of non clinical staff and 99% of clinical staff had completed the safeguarding children level 1 and level 2 training.
- Sixty six per cent of all OPD registered nursing staff had completed level three safeguarding training. The hospital informed us that all 16 -18 year old patients were pre-identified for consultation and have a level 3 trained staff member allocated to them. All duty managers and sisters had completed level three training.
- The hospital had an up to date chaperone policy. Staff were available for any patient requiring a chaperone. Notices offering a chaperone to patients were on display in both the waiting areas and corridors of all locations.

Mandatory training

- Two dedicated education leads dealt with the staff training and made sure staff were up to date with their training. Most staff were up to date with their mandatory training with overall compliance at 98%. Mandatory training included basic life support, equality and diversity, ethics, fire safety, health and safety, infection control, information security, manual handling theory, safeguarding adults level one, two and three and safeguarding children level one, two and three.
- Staff informed us that they received an email reminder to book for training when their training was about to expire.

Assessing and responding to patient risk

- Staff could escalate concerns to the Resident Medical Officer (RMO) and the patient's consultant.
- The hospital had a standard operating procedure for admitting patients from the OPD at the Shard to the main hospital at London Bridge. This involved consultant request for patient to be admitted after which the patient would be risk assessed in order to establish the need for transportation.
- If a patient required urgent transfer to an appropriate NHS emergency department, they would use the 999 system to call an ambulance and the attending doctor would alert the receiving hospital. The hospital had a cardiac arrest team, which stabilises patients prior to transfer out of the hospital.
- All clinic rooms and toilets had an emergency alarm button and pull cords. Staff carried bleeps for such an emergency. Response times were audited during the daily checks.
- The OPD used a situation, background, assessment and recommendation (SBAR) tool to assess deteriorating patients and escalate for assistance.
- Ninety one per cent of OPD staff had completed the basic life support training.

Nursing and allied staffing

- A clinical nurse manager led the nursing team for all locations. There was a deputy clinical manager for 31 and 120 Old Broad Street. The nursing team consisted of one clinical nurse specialist, four sisters, six senior staff nurses, 27 staff nurses, 18 healthcare assistants (HCAs), two phlebotomists and a healthcare support worker. There were three vacancies for nursing staff (or a vacancy rate of 7.5%) at the time of the inspection. HCA Healthcare bank staff were used to cover staff shortages in the department. In addition, some staff also opted to work overtime.
- A physiotherapy and occupational therapy manager led the physiotherapy team. The team also had a deputy physiotherapy manger, a lead clinical physiotherapist, a

clinical specialist physiotherapy , 16 senior physiotherapist and a physiotherapy assistant. They were supported by three senior occupational therapist and one occupational therapist.

- An Imaging manager led the imaging and diagnostics team. There were eighty eight staff in the imaging department. These included the imaging manager, a deputy imaging manager, forty senior radiographers, 12 superintendent radiographers, 10 radiology department assistants, four staff nurses, one HCA and one radiography assistant. They were supported by 10 administrative staff members.
- Staff at all locations we visited felt there were adequate staffing numbers to support the team.
- We observed a handover at the Shard. In attendance were the OPD manager, the physiotherapy and occupational therapy manager, head of imaging, the RMO, nurses, physiotherapists, pharmacists and staff from imaging department. Staff discussed the cases planned for the day including diagnostics, minor procedures, gynaecology, urology, colorectal clinics, Ear Nose and Throat (ENT) and orthopaedics. The responsible person in charge of each floor was allocated during the meeting. The handover also included allocation of roles in an emergency.
- We also observed a handover at 120 Old Broad Street attended by six members of staff. The handover was comprehensive and staff discussed patients attending the department in the afternoon. Three nurses were on shift in the morning and in the afternoon.

Medical staffing

- The OPD had a RMO who was provided through an agency under contract. RMOs worked on a 12-hour shift from Monday to Friday. The hospital had 686 consultants who worked for the hospital via practising privileges. OPD clinics were consultant led and each consultant saw each patient on their specific list.
- Consultants had a buddy who could take over care temporarily in their absence. Staff confirmed they had not had any problems contacting consultants or their buddies. Staff told us clinics rarely ran late and patients were seen in a timely manner.
- The chief executive officer and the Medical Advisory Committee (MAC) managed practicing privileges for consultants.

Major incident awareness and training

- The hospital had an emergency preparedness, resilience and response (EPRR) policy and staff could access the policy on the trust's intranet. A hard copy was also available on site. It included action cards, which explained roles in the event of a wide variety of incidents and scenarios. This covered a number of incidents including major incident or emergency; chemical, biological, radiation, nuclear and explosive (CBRNE) incidents; and infectious disease outbreak.
- Staff knew what to do in the event of a fire or emergency evacuation. Each department had a fire marshall and a duty manager's log recorded details of the fire marshall for all areas each day. This included bleep numbers for key staff. All OPD staff had completed mandatory training in fire safety.

Are outpatients and diagnostic imaging services effective?

Not sufficient evidence to rate

At present we do not rate effectiveness for outpatient and diagnostic imaging services in acute independent hospitals but during our inspection we noted the following good practice:

- Staff delivered care based on a range of best practice guidance.
- Clinics were consultant led and patients were cared for by appropriately qualified staff who had received an induction to the unit and achieved specific competencies before being able to care for patients independently. A number of staff had completed further training and development.
- There was good multidisciplinary team working in place.
- Staff had a good understanding of the need for consent and systems were in place to ensure compliance with the Deprivation of Liberty Safeguards.

Evidence-based care and treatment

Outpatients and diagnostic imaging

- Policies were developed in conjunction with national guidance and best practice evidenced from professional bodies, such as the Royal College of Nursing, National Institute for Health and Care Excellence (NICE) and the Royal College of Radiologist (RCR). All the guidelines we reviewed were easily accessible on the trust's intranet and were up to date.
- Adherence with guidelines was encouraged through the development of proformas and algorithms to prompt use of best practice guidelines. For example, we saw evidence of the use of The OPD used an adapted World Health Organisation (WHO) surgical checklist which met national guidelines.
- The department undertook clinical and non-clinical audits. These included infection prevention and control, medicines management, procedure checklists, documentation audits and radiology procedures.
- An audit of 28 procedure checklists in the OPD in July 2016 showed that all the correct checks had been completed for the procedures reviewed.
- An audit of verbal consent in 144radiology procedures between January to August 2016 showed that verbal consent was recorded in 93.1% or 134 of the procedures reviewed. Following the audit an action plan was implemented to disseminate findings across the department, encourage consultants to achieve 100% compliance across all procedures and encourage attending staff to remind consultant of the requirement to record verbal consent. The deadline to repeat the audit is in January 2017.
- An audit of physiotherapy documentation for patients attending the department in February 2016 showed 91.78% compliance with an action plan implemented to improve the service.

Pain relief

- Appropriate pain relief was available to patients in the OPD. However, staff told us they provided medication only on prescription from a consultant or Resident Medical Officer (RMO).

Patient outcomes

- Staff told us diagnostic test results were available in a timely manner. The hospital's service standard required diagnostic test results to be available within 48 hours for all modalities. The timescale for mammograms was within five days. Exceptions to these service standards include results requiring double reporting which should be available within five days. Where a specific radiologist had been requested by the referrer, this could lead to an extended reporting time, of which the referrer was made aware.
- An audit of 50 reports was conducted across imaging modalities undertaken in August 2016. Ninety per cent of all results included within the audit were available within 48 hours. Fifty-six per cent of the results were available within six hours. All reports were available within four days.
- Test results could be viewed on electronic systems in all locations. A radiology report review of errors in 2015 showed that of the 1109 reports reviewed, there were no clinical errors and there were only 53 grammatical errors.
- Physiotherapy staff conducted case studies of individual treatment plans. Anonymised case studies of individual treatment plans were displayed within the department. These outlined objective findings, management and key learning points. An anonymised case study of an individual treatment plan for a patient with vitiligo (long-term condition that causes pale, white patches to develop on the skin due to the lack of a chemical called melanin) showed gradual improvements in the skin condition following Ultra Violet B (UVB) treatment.

Competent staff

- All new nursing staff and HCAs had completed an induction programme. They went through a probationary period and were initially supernumerary until they were judged competent to work unsupervised. New members of staff were required to complete mandatory training as part of their induction.
- In addition, the OPD organised a school of outpatients, which delivered training to staff on different topics twice a month. Courses offered in September 2016 included platelet rich plasma (PRP) and diabetic link nurse. We saw that a calendar was in place with courses scheduled till the end of the year.

Outpatients and diagnostic imaging

- A number of staff including physiotherapy and imaging staff had completed masters degrees, attended external training opportunities and had been able to implement this development in their practice.
- All nursing staff and HCAs had received an appraisal in the last one year. Nursing staff revalidations were at 100%. There was a 100% completion rate of validation of registration for doctors working under practising privileges.
- Radiographers had been trained to use specialist equipment and worked in specific areas were they had received the training, for example, MRI, CT scan, general x-ray and mammography.
- RMOs had completed an induction programme when they started in the hospital. They were also required to have completed mandatory training.
- Appraisals and re-validation were monitored and requested where renewal was required. Medical Advisory Committee minutes confirmed discussion of the removal of individuals where they had not provided the required information.

Multidisciplinary working (related to this core service)

- The department had a tissue viability nurse and clinical nurse specialist (CNS) in breast care. In addition, they had access to the hospitals multidisciplinary team (MDT) team including 23 CNS, oncology nurses, breast consultants and surgeons.
- Nursing staff confirmed they had good working relationships with consultants and could easily ask for help. They also had good relationships with the physiotherapy and imaging team. They had quick access to diagnostic test results, which were saved on the electronic system and accessible to all staff in all OPD locations.
- Physiotherapy staff confirmed they had access to consultants and regularly liaised with them in relation to patient care.
- The OPD held a general multidisciplinary team (MDT) meeting every week. This was attended by the RMO, consultants, nurses, radiology staff and physiotherapy staff. In addition, there were up to 15 specialist MDT meetings. These included breast care, cardiac, haematology, oncology, lower limb, spinal, thoracic, hand and upper limb, urology, vascular, orthopaedics amongst others.
- A multidisciplinary team of radiographers, radiologist consultants, surgeons and nurses worked together to carry out treatments and procedures in hybrid laboratories and other imaging units.

Seven-day services

- The Shard operated between 8am to 8pm, Monday to Friday.
- OPD services at the main London Bridge Hospital opened Mondays to Thursdays 8am to 8pm and Fridays 8am to 7pm.
- The OPD held weekend dressing clinics at St Olaf building. The clinics were opened between 9am and 1pm on Saturday, and between 9am and 23.30pm on Sunday.
- 31 and 120 Old Broad Street opened from 8am to 8pm, Monday to Thursday and 8am to 6pm on Friday.
- The Imaging department opened from 8am to 8pm, Monday to Friday and from 8am to 7pm on Friday. It was opened for MRI on Saturday between 9am and 2pm.
- Physiotherapy and occupational therapy services was available from 7.30am to 7.30pm, Monday to Thursday and from 8.00am to 5.30am on Friday.
- The London Bridge pharmacy department opened from 08.30am to 7.30pm Monday to Friday and from 09.00 am to 13.00pm on Saturdays. The Shard pharmacy was opened from 8.00am to 8.00pm Monday to Friday. On call, pharmacists were available 24 hours a day, seven days a week. The RMO and duty manager had access to the pharmacy and key medications required out of hours.

Access to information

- Staff had access to relevant guidelines and policies on the hospital's intranet.
- Diagnostic imaging used a picture archiving and communication system (PACS) which meant that staff could view images on any computer in all locations.

Outpatients and diagnostic imaging

- Staff had access to patient's notes and could contact the patient's consultant if necessary. Discharge letters were sent to patients' GPs following discharge from the hospital.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Staff had access to best practice guidance and local mental capacity policies on the unit. Staff were clear about their responsibilities in relation to gaining consent from people, including those people who lacked capacity to consent to their care and treatment. Our review of medical records showed well documented consent forms were completed.
- Staff were aware of their responsibilities under the Mental Capacity Act (2005). They were able to talk about the deprivation of liberty safeguards and how this would impact a patient on the unit. Staff told us they had not come across a patient who lacked capacity. Staff could demonstrate an understanding of the hospital's policy but told us they have not had to put this into practice.
- Overall, 93% of OPD staff had completed the Mental Act Capacity and Deprivation of Liberty Safeguarding training. All physiotherapy staff and 91% of nursing staff had completed the training. 92% of radiology staff across the locations had completed the training.
- We examined six patients' notes and found consent forms we saw were all completed correctly.

Are outpatients and diagnostic imaging services caring?

Good

We rated caring as good because:

- The OPD provided a caring and compassionate service, which involved patients in their care.
- Confidentiality and dignity was respected by staff and patients felt supported by staff.
- Patient satisfaction surveys were positive and positive feedback from patients was consistent in all areas visited.
- Staff provided emotional support to patients and there were bi-monthly patient group meetings, which provided opportunity for patients to talk to others who had similar experiences.

Compassionate care

- Patient, family and friends feedback was mostly positive. During all our observations, we saw staff treat patients and visitors with warmth and care. We observed staff interactions with patients; they were courteous, professional and demonstrated compassion to all patients. Throughout our visits we saw staff stopping to speak with patients and directing them to the right locations.
- Patients said they were happy with the care provided and that they were treated with dignity and respect. Patients who went through minor operations said the operation went smoothly and was arranged to their convenience. Patients described the care provided as "efficient and of high quality", "very very good" and "very comprehensive".
- Concierge staff met and welcomed visitors to the OPD and directed them to the relevant unit. We observed them helping patients.
- Staff at all levels were satisfied with the quality of care provided to patients and felt they had enough time to care for patients.
- In August 2016, the overall patient survey results for the OPD showed that 96% of patients would recommend the hospital. Seventy per cent rated the quality of service as excellent, 17% as very good and 10% as good. All patients confirmed they were given enough privacy when discussing their condition and treatments. Ninety seven per cent of patients confirmed they were "definitely" treated with respect and dignity while 3% indicated they were treated with respect and dignity "to some extent".
- Following the inspection, we were provided with copies of correspondences from patients thanking the provider for their care. One of the correspondences indicated that staff acted "beyond the call of duty".

Understanding and involvement of patients and those close to them

- Patients and their relatives reported they were involved in their care and were given explanations about their treatment. They said staff explained procedures and obtained their consent before conducting them. Patients said the consultants were thorough, they spent time to explain procedures to them and they felt comfortable and reassured. They felt they were given clear and adequate information. We observed staff introducing themselves to patients before attending to them.
- Administrative staff explained the payment options to patients and they were advised to read the registration form and sign. We noted that the registration form contained a declaration by the patient to be personally responsible for any costs associated with their procedure if those costs were not covered by medical insurance, insurer or third party guarantor (except NHS patients).
- Following the inspection, we were provided with further examples of how staff had supported patients. On one occasion, staff guided an anxious patient regarding diagnostic test results and admission procedures. The patient and family reported they were happy and felt supported.
- On another occasion, staff assisted a patient who arrived in extreme pain to obtain prescribed medication and to go through urgent diagnostic tests. The patient was admitted to the main hospital and accompanied by a nurse. The patient expressed gratitude for the support provided.

Emotional support

- Staff told us upsetting or unexpected news was delivered sensitively and in appropriate private surroundings. They had dedicated clinical nurse specialists (CNS) who provided emotional support in dedicated counselling rooms to patients.. The counselling rooms were located next to consultant rooms so that patients did not have to go back to the waiting area following their consultation. Patients also had access to a psychologist where required.
- Patients in the breast care clinic had access to pink buddies. Pink buddies were patients and ex patients who made themselves available to support new patients. There were bi-monthly patient group meetings, which provided opportunity for patients to talk to others who had similar experiences.
- Reception staff told us they sometimes saw patients who appeared anxious due to the nature of their visits. They told us they approached them and directed them to staff who could address their particular concerns. During our visit, we saw staff routinely spoke with patients in the reception area to address any concerns they had.

Are outpatients and diagnostic imaging services responsive?

Outstanding ☆

We rated responsive outstanding because:

- Clinics and services were developed to meet the needs of patients. OPD services were provided at four locations to meet the demand of patients and for their ease of access. Gynaecology and urology treatment rooms were equipped with en-suite facilities to protect the privacy of patients as well as their convenience.
- Patients were seen promptly following their referral and the OPD provided same day or next day appointments. The service audited waiting times at the clinics and the average waiting time was less than five minutes in line with the hospital's target.
- All waiting areas were furnished to a high standard. Patients had access to tea and coffee making facilities as well as a water dispenser. Reception areas were equipped with satellite television and there was a range of information leaflets available to patients on a wide range of topics.
- Concierge staff welcomed visitors to the hospital and directed them to the right department. Patients with mobility needs were assisted by staff.
- Patients had access to a one stop breast clinic at the Shard and at 31 Old Broad Street. The Clinic offered rapid access to tests, advice, diagnosis and treated

patients with problems and conditions concerning the breast.The OPD held weekend dressing clinics at the main London Bridge Hospital location in line with patients' recommendations.

- Staff had access to translators when needed, giving patients the opportunity to make decisions about their care.
- Staff dealt with complaints appropriately and improvements were made as a result.

Service planning and delivery to meet the needs of local people

- In February 2016, the provider opened an additional OPD location over three floors at The Shard. This included an imaging department to facilitate onsite rapid diagnosis and an outpatient physiotherapy department and rehabilitation gymnasium.
- Senior staff informed us the needs of patients are taken into account when planning locations of services. The department provided services from four locations for patients' ease of access.
- Staff told us that patients were usually seen promptly following their referral. Patients were given the next available appointment with their chosen consultant.
- During our inspection, we observed a relaxed atmosphere in the outpatient area. The waiting areas were not overcrowded and clinics were running on time.
- The OPD at the Shard was designed based on feedback from patients. We observed that the gynaecology and urology treatment rooms were equipped with en-suite facilities in order to protect the privacy and dignity of patients as well as their convenience. This enabled patients to change into a gown, store their clothes and use the toilet facilities without having to go out of the treatment rooms.

Access and flow

- Patients were referred to the OPD by their GPs. There was no waiting list to be seen as an outpatient. Patients could book an appointment at any of the OPD locations by submitting a form online or by making a telephone call. Patients were offered the most convenient appointment with their preferred consultant. This could also be a same day or next day appointment. The OPD did not audit referral to treatment times as
- The OPD had a performance target of less than five minutes waiting time. The OPD performance dashboard showed that between January and August 2016, patients at The Shard waited for less than five minutes each month except in May when the average waiting time was eight minutes. The average waiting time at the main London Bridge Hospital locations was less than five minutes during the inspection period.
- The OPD kept a log of late running clinics and recorded reasons for the delay. An audit of late running clinics in 2016 showed that the total number of late clinics at The Shard was 17 out of 715 (2.4%) clinics booked. St Olaf House and 31 Old Broad Street had no late running clinic. Emblem House had two out of 19 (10.5%) late clinics and120 Old Broad Street had four out of 193 (2.1%) late clinics.
- They implemented an action plan in the event of persistent lateness. These included reporting any consultant running late on three separate occasions on datix, with reasons given. Any consultant consistently running late without justifiable cause was referred to the CEO for an agreement on how performance could be improved. In addition, any consistent delay due to operational issues would result in a review of clinic times to identify and remove any internal barrier.
- Between August 2015 and August 2016, 84% of 164,158 inbound calls were answered within 25 seconds. Calls that were not answered within the 25 seconds margin were deferred to a call answering service. Of the 16% of calls that were deferred to the call answering service, 9% of callers left a message and received a call back. However, 7% of callers either hung up or did not leave a message.
- Most patients we spoke to confirmed that they found it very easy to make an appointment and they were seen quickly on their arrival. However, one of the nine patients we spoke with said they found it difficult to make an appointment, as the lines were busy. However, they were able to get an appointment within 10 days once they got through.
- There were no clinic cancellations reported in the last one year.

Meeting people's individual needs

- Concierge staff welcomed visitors to the hospital and directed them to the right department.
- The hospital provided face to face interpreting service in Arabic. Staff confirmed they could access the hospital's Arabic interpreting services. They said they used the language line for other languages.
- There were sufficient chairs in the waiting areas at all locations visited to suit individual needs. We saw there was a range of information leaflets available to patients in the waiting area on a wide variety of topics. There were also magazines at the reception which patients could read whilst waiting for their appointments.
- Reception areas were equipped with satellite television. In addition, patients had access to tea and coffee making facilities as well as a water dispenser.
- Patients had access to a café on the 4th floor of the Shard and were provided vouchers depending on the treatment they received. Relatives had access to the café at a subsidised rate.
- The hospital had a dementia policy in place. However, staff informed us they rarely had instances of patients attending with dementia or learning disabilities in the OPD.
- Patients who arrived at the Shard went to the fourth floor for their registration before proceeding to the floor of their appointment. However, patients with mobility needs were assisted by porters and had direct entrance access to the floor of their appointment. Orthopaedic patients at the Shard had direct access to the fifth floor were the clinics were based.
- Patients had access to a one stop breast clinic at the Shard and at 31 Old Broad Street. The Clinic offered rapid access to tests, advice, diagnosis and treats patients with problems and conditions concerning the breast.
- Patients had access to a weekend dressing clinic at St Olaf building.
- Patients diagnosed with breast cancer were provided with an information booklet with links to other charitable organisations that provided cancer support. The information packs also contained information about self-image, body image and how to look and feel good. The CNS discussed the content of the information pack with patients.
- We noticed a toilet on the fourth floor of the Shard had baby changing facilities. However, there was no sign on the door confirming this. Staff told us a sign had been ordered following feedback from patients.
- Patients had Wi-Fi access at all locations whilst at the OPD.

Learning from complaints and concerns

- Patients were provided with feedback leaflets and comment cards, which encouraged them to report concerns, and provided details of how to make a complaint. We saw the OPD patient questionnaire provided an opportunity for patients to give information about their opinion of staff, cleanliness of the environment, their appointment and to make suggestions. There was a patient feedback box at all the locations visited were patients could drop their questionnaires and comment cards.
- Information leaflets in all reception areas in all the locations visited provided details about the complaint process. It also provided details about the independent sector complaints adjudication service.
- There were electronic touch pad stands in each area of the OPD in all locations visited. The touch pad had signs directing patients to provide feedback about their care.
- There were 62 complaints made about the OPD between September 2015 and August 2016. Six of the complaints related to 120 Old Broad Street, four to 31 Old Broad Street, 18 to Emblem House, 14 to Olaf House and 20 to The Shard. All complaints were resolved locally within the hospital's timescales.
- Staff informed us they tried to resolve complaints informally. However, if patients wanted to raise it further, they escalated complaints to the patient experience manager. We saw evidence that learnings from complaints were used to improve the service. For example, the OPD ensured that patients were informed of cost implications prior to their treatments. This was also included in patients' registration forms. This was in response to several complaints about the cost of treatments.

Outstanding ☆

Outpatients and diagnostic imaging

Are outpatients and diagnostic imaging services well-led?

Outstanding ☆

We rated well-led as outstanding because:

- The leadership team had a clear vision and strategy. The hospital's vision was highlighted in four words "Exceptional people, Exceptional care". All staff we spoke to were aware of the hospital's vision and committed to working to achieve it both individually and as a team.
- The management team had oversight of the risks within the services and had plans to mitigate them. There was a robust governance system and staff were involved in facilitating governance meetings and feedback to staff. The hospital was well supported by an active medical advisory committee.
- We saw excellent leadership within the OPD and staff reflected this in their conversations with us. Staff at all levels were overwhelmingly positive about the executive team and departmental heads. Staff told us managers were very visible and approachable and they could raise concerns with the leadership team.
- The leadership team at all levels were proactive and looked for opportunities to improve patient care.
- Staff were positive about working in their areas and were proud of the services provided. Staff said they were motivated to go the extra mile to make sure patients receive the best care and are safe
- There was a culture of enhanced training and development opportunities for staff. Staff said they were supported in their role and found opportunities for development motivated them in their work.
- There was evidence of good staff engagement and changes being made as a result. Patients were also engaged through surveys and feedback forms.
- The OPD had implemented a number of innovative services and developed these to meet patient's needs. Staff had contributed to developing and improving services.

Vision and strategy for this core service

- The hospital had a clear vision and strategy, which incorporated all service areas including the OPD. The hospital vision was highlighted in four words "Exceptional people, Exceptional care".
- Its mission highlighted its commitment to the care and improvement of human life. In recognition of this commitment they strive to deliver high quality, cost effective healthcare in the communities they serve. The hospital's mission, vision, values and strategic framework were outlined in several hospital publications including the staff newsletter.
- All staff we spoke to were aware of the hospital's vision, they were passionate about the care provided to patients and the opportunities they had working in the hospital.

Governance, risk management and quality measurement for this core service

- The Chief Operating Officer (COO) was the overall lead for the OPD. The OPD clinical nurse manager, imaging manager, and physiotherapy and occupational therapy manager reported to the COO. The deputy clinical manager for 31 and 120 Old Broad Street reported to the OPD clinical nurse manager.
- There was a clinical governance structure which included a range of meetings; clinical governance meeting, senior management meeting, incident meeting, infection prevention and control committee meeting and Medical Advisory Committee (MAC) meetings. These reviewed performance and daily operations at the hospital including staffing levels, incidents, risk registers, infection prevention and control and audits. The chief operating manager represented the OPD on the committee along with departmental heads.
- There were also monthly OPD meetings. A review of the meeting on 24th August 2016 showed that meeting discussed training of staff, health and safety, infection control, the upcoming CQC inspection, incidents, complaints and compliments received from patients. It also discussed policy updates and proforma forms.
- The unit maintained a risk register, including concerns and assessments of potential risks on the unit. Mitigating plans were in place and staff were aware of

the risks in their area. Senior staff routinely discussed risks at clinical governance meetings. Staff we spoke to could discuss risks with inspectors and what was being done to mitigate these risks.

Leadership / culture of service

- Staff told us the leadership team were highly visible and approachable. They told us the executive team knew staff by name and communicate with staff. Staff said the chief executive officer (CEO) attended staff induction sessions. Staff also spoke highly of their local managers and the support they provided to staff.
- Staff at all levels reported a positive culture within the OPD locations. Staff said they had not experienced any discrimination and they had been supported to maintain work /life balance. The hospital had an anti-bullying policy in place and staff said they worked in a healthy environment. Staff said it was a nice place to work and there was a friendly atmosphere in the OPD.
- Staff informed us they were able to make suggestions to improve the service and provided us with examples when their suggestions were used to improve the service. For example, staff were involved in the design of the OPD at the Shard. In addition, the infection control lead informed us she was able to effect the purchase of specialist steam cleaning equipment for the department.
- Staff at all levels spoke highly of their opportunities for training and self-development. They also spoke highly of the diversity of specialities in the hospital. Senior staff across nursing, physiotherapy and imaging teams informed us they promote from within were possible. We spoke with a senior sister who commenced employment at the hospital as a HCA whilst training as a student nurse. We were also provided with an example of a concierge staff who went on a clinical support workers course to become a health care assistant (HCA). Deputy managers within the physiotherapy department started as therapists.
- Administrative staff had access to finance courses and training in reception and booking. Nursing, therapy and imaging staff had access to post graduate training. Two imaging staff were on postgraduate training and one had completed post graduate training the previous year. Two of the radiographers were previously administrators in the hospital. Staff provided examples of administrative staff who had completed NVQ 3 training and other relevant clinical training to become HCAs.
- Following the inspection, we were provided with further examples of career progression within the OPD. These included a concierge staff who had become an healthcare assistant and a healthcare assistant who rose through the ranks to become the business registration manager.
- The OPD had diverse members of staff from different backgrounds. Black and ethnic minority (BME) staff informed us they had equal opportunities with other staff members and we observed that there were several BME staff in senior positions.
- Staff said they were motivated to go the extra mile to make sure patients receive the best care and are safe.
- Staff confirmed the department was open and transparent and they could raise any concerns with senior staff. Staff understood their responsibility under the duty of candour and we noted that information about the duty of candour regulations was available on the staff notice board in all locations visited.

Public and staff engagement

- The hospital monitored patient satisfaction from patient surveys, comments and feedback forms. Outcome from patient surveys were used to improve the service. For example, Patients had complained about the inconvenience of moving from the gynaecology treatment room to the toilet. As a result, gynaecology treatment rooms at the Shard were designed with en-suite facilities thereby eliminating the need for patients to leave the suite.
- Staff told us there was a strong social side to the team. They had regular social activities and meals. These included the hospital's Christmas party, summer family barbecue and departmental parties.
- Staff said they were happy with their work packages, which included staff discounts at the canteen, health insurance, life insurance and access to the gymnasium.
- Staff at all locations had access to a staff room equipped with sink, microwave, kettle and fridge. Staff also had access to a changing room. There was

information on the staff notice board with details of link nurses. The board displayed minutes of departmental meetings, organisation chart, safeguarding escalation flow chart and upcoming training courses. The board also displayed information about duty of candour, incidents, the risk register and performance against set targets.

- The hospital ran a monthly staff newsletter called Tooley Street Times. The newsletter has different sections including career spotlight were a member of staff provides an interview about their career path and role in the hospital. The September issue featured a senior nurse from the OPD.
- Staff participated in the hospital's staff survey. The most recent staff survey showed high levels of engagement across the hospital. Seventy nine per cent of staff surveyed would recommend the hospital as an employer. Ninety eight per cent indicated that they were committed to doing the best for their hospital. Ninety three per cent would be happy with the standard of care for a relative or friend. The results of the survey were not broken down for the OPD.
- The OPD recognised outstanding staff contribution through the employee of the month award. The hospital also organised events to celebrate outstanding staff and long service.

Innovation, improvement and sustainability

- The hospital had purchased specialist diagnostic equipment including ultrasound equipment, dexa scanner, 3 Tesla (3T) MRI scanner, digital surgical specimen imaging system amongst others in the last one year.
- The physiotherapy unit also had a gymnasium (gym) available for patient use under guided supervision from a physiotherapist. Equipment within the gym included an anti-gravity treadmill which could be set to allow patients to exercise without weight bearing.
- A hybrid catheterisation laboratory enabled consultants at the hospital to image any part of the body and supported the integration of interventional and surgical teams, performing complex medical procedures.
- The hospital had a refurbishment programme to upgrade Emblem House and St Olaf House. This included an upgrade of outpatient facilities within the two buildings. Plans to refurbish the buildings included creating treatment rooms, nursing room and phlebotomy rooms.
- Following the inspection, the hospital provided details about the patient management flow system used to streamline patient flow within the department. The system enabled staff to track patients within the department and provided real-time performance dashboard to measure performance against the department's KPIs

Outstanding practice and areas for improvement

Outstanding practice

- An electronic key for use when obtaining and dispensing medication had been introduced to make medicines management safer. It allowed staff to see which member of staff had accessed medicines cupboards and reduced delays in patients receiving their medications.
- The hospital employed its own RMOs who were highly trained in the speciality in which they worked. Consultants were available for both their own patients and on an on-call basis for example on call intensivists and anaesthetists. Consultants on call would stay on site in the hospital if required.
- We found excellent multidisciplinary team (MDT) working with close collaboration between all staff including live donor liver transplants in conjunction with a local liver specialist team.
- A clinical perfusionist within theatre was being supported to undertake innovative research which would have results published nationally once it was complete.
- HOT boards were available in each clinical area which provided a standard set of information including risk registers, new policies and procedures, incidents and learning from these and new complaints. It allowed staff to learn about risk management and quality improvement and encouraged them to learn about other services within the hospital.
- The hybrid catheterisation laboratory allowed consultants to perform complex medical procedures by both imaging and intervention supported by surgical teams in one session.
- Staff were encouraged and motivated to take part in learning opportunities provided by the hospital. Learning included masters degrees, specialist training in renal, intensive care and cardiac conditions.
- There were no waiting times for patients to be seen in a clinic or admitted to hospital if a procedure was required.
- Leadership at both a local and senior level was visible and motivational and staff were overwhelmingly positive about the support they received from their managers. The felt that they could raise issues in a timely manner and their concerns would be listened to and acted upon.

Areas for improvement

Action the provider SHOULD take to improve

- Continue to work to ensure the five steps of the five steps to safer surgery including the debrief after surgery are fully embedded.
- The hospital should ensure that staff are aware of who to contact and how to care for the needs of patients living with a learning disability when they are admitted to the hospital.
- Equipment in theatres should be stored in a safe manner to ensure that patient safety is not compromised within the theatre department.