The London Clinic

Quality Report

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

Ratings

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

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

As a charitable hospital since 1935, The London Clinic is governed by the Trustees of The London Clinic Limited. The hospital provides a range of services to the local population of London, as well as overseas patients. The hospital has on average 23,000 inpatient episodes and 110,000 outpatient attendances.

The hospital is licensed to provide diagnostics and screening; treatment of disease, disorder or injury; surgical procedures; management of supply of blood and blood derived products.

The original hospital at 20 Devonshire Place has seven main and three additional operating theatres, and six dedicated specialty wards for a range of surgery, including: urology, gynaecology, thoracic surgery, orthopaedics and spinal procedures. They also provide neurosciences and digestive diseases treatment and care, and have an Intensive Care Unit.

The Duchess of Devonshire Wing provides a dedicated cancer centre, including a radiotherapy department, a medical oncology inpatient ward, a breast and reconstructive surgical ward, medical and haematology oncology, chemotherapy outpatients (including apheresis) and a stem cell transplant unit.

We carried out an announced inspection on 22 to 24 November, and an unannounced visit on 1 December 2016. The inspection covered medicine, surgery, critical care, end of life and the outpatients and diagnostic service.

To get to the heart of patients' experiences of care and treatment, we ask the same five questions of all services: are they safe, effective, caring, responsive to people's needs, and well-led?

Where we have a legal duty to do so we rate services' performance against each key question as outstanding, good, requires improvement or inadequate.

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

We rated The London Clinic as good overall. Medicine, Surgery and Critical Care and outpatients were rated as good overall. Surgery needed to make some improvements in the safety domain.

The outpatient services were rated as outstanding for effective and good for the remaining three domains we currently rate. We rated end of life care services as outstanding for responsive, caring and well-led, and outstanding overall. The London Clinic had responded to the withdrawal of the Liverpool Care Pathway by introducing an evidence based individualised care plan. Staff had access to a well-resourced and highly knowledgeable team who were described as being visible. The palliative and specialist care team were held in high regard by referring clinicians, nursing and allied health staff. The appointment of a substantive consultant was seen as pinnacle in driving the end of life care agenda across the London Clinic.

We found good areas of practice including;

- Patients received individualised care in a compassionate and caring manner. They were treated with dignity and respect and their choices and preferences were taken into account at all stages.
- The service was accessible, whilst taking into account any precluding risks. Patient's preferences and choices were respected with regard to their admission, treatment and care. They were consulted throughout and kept informed of their progress and changes in treatment, including any risks and the management of these.
- There was a range of expert clinical and other support for patients who required additional input to enable their individual needs to be met.
- Staff understood their responsibilities to report adverse events and felt able to do so in an open and honest way. They received feedback on investigations and applied changes to their practice as a result of the associated learning.

Summary of findings

- There were well established governance arrangements for overseeing quality and risk. Actions arising from audit and day to day monitoring of required standards contributed to service improvements.
- Staff were provided with mandatory safety training, which included infection prevention and control, and basic life support, the Mental Capacity Act, and Deprivation of Liberty Safeguards.
- Patient risk assessments and safety checks were carried out. There were formal procedures which enabled staff to identify and respond to sepsis or a deterioration in the patients' health.
- The staffing arrangements including the skills of such individuals supported the delivery of safe, effective and responsive treatment and care.
- The international office managed all aspects of the overseas patients and their hospital admission and repatriation. Interpreter services were readily available, along with information in other languages.
- Staff demonstrated adherence to the principles of the Mental Capacity Act (2005), and consent processes were embedded in practice.
- A multidisciplinary approach across the service facilitated the delivery of a responsive service in the majority of areas. Patients were cared for by a range of professionals who co-ordinated care, through discussion and on-going engagement. This was overseen by consultants with practising privileges, each of whom were responsible for their own patients, supported by a resident medical officer and suitably skilled clinical staff.
- A number of theatre staff had received additional training to fulfil the role as first assistants.
- There was provision for medical cover at an appropriate level of seniority 24-hours, seven days a week. Emergency and general procedures were established for out of hours.
- Staff had access to resources to enable them to provide an effective and responsive service. In addition to on-site services such as pharmacy, physiotherapy, pathology and diagnostics, this included professional guidance, a range of equipment, information technology, and clinical expertise. Staff also had access to additional training to support the development of competencies.
- Prescribed medicines were managed safely, medicines were stored in locked cupboards or temperature controlled environments in the majority of areas.
- The environment in which patients received care was visibly clean and staff were supported by professional guidance to follow infection prevention and control practices, which were subject to monitoring.
- Staff reported their local leadership within departments was good. Managers were approachable, supportive and staff were proud to work at the hospital. Staff understood the values of the hospital and were keen to ensure patients received the best care.
- There were opportunities for professional development and staff were recognised for their contributions. The hospital actively engaged with staff through open staff forums, and valued their contributions and feedback.

We identified some areas where improvements could be made as follows:

- The completion of surgical safety check lists in theatres was not to a consistent standard.
- Information provided by consultants in order to update their practising privileges was not always complete.
- Greater consideration should be given to evaluating clinical outcomes across all specialities

Amanda Stanford
Deputy Chief Inspector (I)

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Medical care	Good	• Electronic patient records were shared by doctors, nurses and other healthcare professionals in an accessible manner, which contributed to the provision of on-going care. • Staff were knowledgeable about the hospitals safeguarding policies and clear about their responsibilities to report concerns. • The hospital used a combination of professional guidance produced by the National Institute for Health and Care Excellence (NICE) and the Royal Colleges. • Nursing staff in oncology and endoscopy informed us they received specific training. Nursing staff had access to a practice development nurse who provided clinical support and development. • Staff treated patients and visitors with compassion and care. Staff interactions with patients were courteous and professional. • Patients told us they were happy with the care provided and that they were treated with dignity and respect. • The hospital undertook its own patient satisfaction survey; the results from the six month period from April 2016 to September 2016 showed that 99% of patients were extremely likely to recommend the service to others. • The diagnostic imaging department used their own satisfaction survey. The results showed a consistently high level of satisfaction with the service. • Patients we spoke with felt well informed about their care and comprehensive information regarding care and treatment was provided throughout their stay. staff explained clearly the nature of tests required and the purpose of clinical observations. • Cancer patients had access to counselling services and could also be referred to local NHS community support teams with links to other community based organisations.

Summary of findings

- We saw patients had their needs assessed. Patient records contained a range of risk assessments which were correctly completed and reviewed as required.
- Inpatients had single rooms that provided privacy and comfort with ensuite facilities. There was no restricted visiting times for patients.
- Patient admissions were planned for a mutually convenient date.
- All patients were admitted under the care of a named consultant. The consultants reviewed patients prior to commencement of each treatment and provided a 24 hour on call service as and when required.
- Intentional rounds were undertaken regularly by nursing staff to monitor patients welfare and any change in the patient's clinical condition.
- We observed call bells were answered quickly. Patients told us staff answered bells straight away.
- Patients whose first language was not English had access to interpreters. Leaflets were available in both English and Arabic.
- Staff told us managers were supportive and approachable, they also felt they had opportunities for personal development and when they raised concerns they were listen to and their concerns addressed.
- Staff were very proud to work for The London Clinic; they were enthusiastic about the care and services they provided for patients. They described the hospital as a good place to work.

However

- The inpatient medical services assessed patients by using the Early Warning Score system (EWS). The audit calendar and records audit did not include an audit of EWS to identify deteriorating patients. This meant compliance with evidence based practice and patient outcomes in this area was not measured.

Surgery

Good

- A handover was held at the beginning of the day and night shifts, staff discussed each patient, documenting any concerns or issues that had arisen.

Summary of findings

- Staff could access local policies and procedures electronically through the provider's intranet.
- Patients told us their call bells were answered very promptly.
- Family members were able to stay in the hospital with the patients. Beds and food were provided for them so they could be with the patient at all times.
- The provider conducted controlled drug audits, which showed an improvement in performance and detailed action plans to address any concerns identified.
- Patients we spoke with told us staff involved them and their relatives in discussions about their care and they were involved in the decision making around such treatment and care.
- Dates for surgery were booked around patients' and the consultant's schedule.
- There were translators for numerous languages employed directly by the hospital.
- There were quarterly specialist nurses forums. These forums were used to ensure that nursing staff kept up to date with service developments.

However

- Completion of surgical safety checklists was not always consistent.

Critical care

Good

- The new team structure that had been introduced placed issues of safety such as safeguarding and infection prevention and control at the forefront of nursing practice.
- The new unit had been designed to ensure the safest possible care, including highly effective isolation rooms.
- There were embedded systems and procedures to ensure positive outcomes for patients and to maintain quality of life.
- There was effective multidisciplinary team working across the unit, to ensure the best possible care for patients.
- The unit participated, and scored well in the Intensive Care National Audit and Research Centre (ICNARC) audit.
- Local policies and procedures on the unit were in line with national guidelines.

Summary of findings

- We observed positive, caring interactions between staff and patients and their families.
- Patients we spoke with were overwhelmingly positive about the care they received and the attitude of the staff.
- Patients and family members confirmed they had been kept informed of their progress and treatment options.

However

- There was some poor practice with respect to storage of specific medication and accessibility to medicines by non-authorised personnel via key passes provided. Both of these issues were resolved during the course of our inspection.

End of life care

Outstanding ☆

- There was evidence of a good incident reporting culture; incidents were discussed at the End of Life Care Steering Group.
- Anticipatory medicines were routinely prescribed. Pain management and symptom control protocols were well established and were seen to be evidence based, in line with national standards.
- Records were up to date, well completed and readily available.
- Care was based on ensuring the person remained as comfortable as possible, at all times. Proactive, anticipatory care plans were put in place to ensure that non specialist staff were aware of the best way to manage symptoms.
- Symptom assessment tools had been introduced to help support non-specialist staff to effectively and safely manage the dying patient.
- An end of life care resource folder had been developed and was available and used on all wards.
- Staff knew the palliative care team members and the consultant by name. Staff told us they were visible and responsive when called to see a potential end of life care patient or a patient requiring symptom management.
- Arrangements were made quickly and effectively if a patient wanted to be discharged home to die.
- Care of deceased patients appeared to be good and in line with expected standards.

Summary of findings

- Arrangements were in place for the repatriation of foreign nationals when requested via contact with the Embassy concerned and the hospital's own international team.
- Accommodation was made available to families so they were able to stay at the hospital with their family member during their last days.
- A counsellor was available for both patients and their families.
- Patients and relatives could access the hospital's Chaplaincy service for the multiple faith groups.
- There was an End of Life Care Steering Group, which reviewed the service.

Outpatients and diagnostic imaging

Good 

- There were reliable systems, processes and practices in place to protect patients from avoidable harm and abuse.
- Patient areas were visibly clean and tidy and staff complied with infection prevention practices.
- There was evidence of treatment across outpatient's services that were delivered in line with national guidance and best practice.
- Staff had access to provision of evidence-based advice, information and guidance.
- Staff with specialist skills and knowledge supported their colleagues to provide advice or direct support in planning or implementing care.
- Appropriate referrals were made on to specialised services to ensure that patients' needs were met.
- Patients had access to medical care 24 hours a day, seven days a week, either in outpatient clinic times or via the resident medical officer.
- There were systems for clinical staff to securely access patient tests and imaging results.
- There was a clear hospital vision and set of values which staff were aware of, and aligned to their work.
- Staff were able to raise concerns, which in turn would be escalated to the clinical governance committee.
- The hospital was supported by an active medical advisory committee, which regularly monitored consultants' fitness to practice.
- Patients we spoke with felt able to raise any concerns they had with their consultants.

Summary of findings

- There were governance arrangements in place and performance, quality and safety were regularly monitored.
- The senior management team demonstrated effective leadership and were supported by a committed and competent management team.

However,

- Structures to monitor the governance and risk management systems were not always effective enough. For example, the hospital did not have a robust enough system of audit in place. This meant improvements were not always identified or action taken

Summary of findings

Contents

Good

The London Clinic

Services we looked at

Medical care; Surgery; Critical care; End of life care; Outpatients and diagnostic imaging.

Summary of this inspection

Background to The London Clinic

The London Clinic is a charitable hospital. Treating 23,000 inpatients and 110,000 outpatients per year, it is the largest independent hospital in the UK comprising 220 beds for inpatient and daycase procedures. The hospital provides services to local and international patients.

The hospital is registered to provide the following regulated activities:

- Surgical procedures
- Diagnostic and screening procedures
- Treatment of disease, disorder or injury

The hospital is based over a number of sites. 20 Devonshire Place has six dedicated specialty wards, including ENT/Ophthalmology, Neurosciences, Digestive Diseases, Urology/Nephrology, Gynaecology/Thoracics and Orthopaedics/Spinal and an Intensive Care Unit. The also provide hydrotherapy and physiotherapy services. There are two floors dedicated to endoscopy, radiology, nuclear medicine and breast screening. There are 10 theatres in total, seven of which are classed as main operating theatres.

The Duchess of Devonshire Wing at 22 Devonshire Place is the dedicated cancer centre. The radiotherapy department, a medical oncology inpatient ward, a breast and reconstructive surgical ward, medical and haematology oncology, chemotherapy outpatients (including apheresis) and a stem cell transplant unit are all housed there.

The London Clinic Eye Centre is based at 119 Harley Street and comprises ophthalmic consulting and treatment rooms.

Consulting rooms are located at 5 Devonshire Place, 145, 120 and 116 Harley Street. The services comprehensive laboratories are also located at 116 Harley Street. The administration building is located at 1 Park Square West.

During the inspection, we visited the wards, theatres, pharmacy, the oncology service, endoscopy, outpatients and radiology. We spoke with staff including; registered nurses, health care assistants, medical staff, operating department practitioners, and senior managers. We were able to speak with two patients.

There were no special reviews or investigations of the hospital ongoing by the CQC at any time during the 12 months before this inspection. The hospital was last inspected in March 2014, where it was found the hospital was meeting all standards of quality and safety it was inspected against.

Between July 2015 and June 2016, the hospital facilitated 5,899 inpatient discharges; 17,684 day-case discharges and 43,490 outpatient attendances. All care was funded through non-NHS means (self-pay, insurance or international embassy funding).

The ten most common medical procedures between July 2015 and June 2016 included:

- Chemotherapy sessions (7,957)
- Endoscopy procedures (6,712)
- Endocrinology tests (3,991)
- Inpatient oncology admissions (2,619)
- Intensive care admissions (699)
- Haemo-oncology treatments (673)
- Liver procedures (491)
- Apheresis (stem-cell collections) (434)
- Radiotherapy treatments (317)
- Dialysis (110)

There were 734 doctors and dentists with practising privileges at the hospital. Of these, 10% carried out 100 or more procedures between July 2015 and June 2016; 21% carried out between 10 and 99 procedures; 18% carried out between 1 and 9 procedures and 51% did not undertake any activity.

Between July 2015 and June 2016, 212 doctors or dentists had their practising privileges removed and 11 had been suspended. No medical practitioners or dentists were under supervised practice during the reporting period. The hospital reported three individuals had had their privileges removed as a result of concerns; 16 had retired; seven had voluntarily surrendered their privileges; seven had failed to submit the required documents and 179 had been removed because of low activity.

Summary of this inspection

Our inspection team

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

- Palliative end of life care Consultant
- Nurse manager in palliative end of life care
- A board level director
- Medical director
- Consultant surgeon
- Theatre nurse specialist
- Consultant Dermatologist
- Medical nurse
- Consultant cardio-radilogist
- Critical care nurse

Summary of this inspection

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?

Good

We rated safe as good because:

- There were systems for the reporting and investigation of safety incidents that were well understood by staff
- Staff could demonstrate their understanding of the duty of candour and provide examples of its implementation.
- There were arrangements to transfer patients whose care needs exceeded what the hospital could safely provide, and saw that staff used these processes when patients' conditions required this.
- We found suitable medical cover at all times from a range of junior medical doctors and on-call consultants and noted arrangements for consultants to provide cover for absent colleagues.
- There were sufficient numbers of nursing and support staff to meet patients' needs.
- We saw there were efficient and effective methods for the handover of care between clinical staff.
- There were arrangements in place for keeping patients safe from the risk of avoidable harm. The London Clinic had undertaken a number of initiatives to improve overall patient safety including introduction of a falls team, enhanced oversight of VTE assessment and use of prophylaxis and introduction of individualised care plans for end of life care patients.

However

- Within surgery, the completion of surgical safety checklists was not always consistent and was an area for improvement.

Are services effective?

Good

We rated effective as good because:

- We found there were arrangements to review guidance from national bodies such as the National Institute for Health and Care Excellence (NICE) and that care was delivered in line with best practice.
- There was a system for reviewing policies and these were discussed at the medical advisory committee (MAC) and other governance forums at the hospital.
- Care was continually monitored to ensure quality and adherence to national guidelines to improve patient outcomes.

Summary of this inspection

- Patient outcomes were good when benchmarked against national standards. There were no concerns regarding rates of unplanned admission, return to theatre or transfer to another hospital.
- We found arrangements that ensured that doctors and nurses were compliant with the revalidation requirements of their professional bodies. All consultants had clear practising privileges agreements which set out the hospitals expectations of them, and ensured they were competent to carry out the treatments they provided.
- Systems for obtaining consent were compliant with legislation and national guidance, including the Mental Capacity Act (2005), and these were adhered to by staff.

Are services caring?

Good

We rated caring as outstanding because:

- Staff routinely went above and beyond what was expected of them to meet the individual needs of patients.
- Staff treated patients with a high level of respect. Staff were compassionate and placed patients at the centre of care planning and care delivery.
- There were multiple examples of where staff demonstrated going the extra mile to support patients and other staff members.
- Patients who shared their views and experiences with us consistently reported they had been treated by staff with dignity respect, compassion and that their expectations had been exceeded.

Are services responsive?

Good

We rated responsive as good because:

- Services were planned to meet the needs of patients.
- We saw that some services operated in the evenings and at weekends to give patients flexible access to these services.
- Patients were assessed prior to admission to ensure that hospital could safely meet their needs.
- There was a robust complaints procedure, which was well publicised and understood by staff. Complaints were investigated, actions taken to resolve issues and there was learning evident from the content of complaints.

Are services well-led?

Good

We rated well-led as good because:

Summary of this inspection

- We found that staff were conversant with the corporate vision and values and strove to demonstrate these in their daily work.
- There was an appropriate system of governance and managers knew the key risks and challenges to the hospital and were taking steps to mitigate the impact of these.
- Practising privileges were received, authorised and granted in conjunction with the Medical Advisory Committee and kept under review.
- There were clearly defined and visible local leadership roles and managers provided visible leadership and motivation to their teams.
- Managers were aware of the need to develop their service and to ensure its sustainability by responding to new market developments.
- We saw examples of initiatives that were introduced to improve patient experience and to ensure the safety and quality of care kept pace with new developments and growing expectations.

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	Good	Good
Surgery	Requires improvement	Good	Good	Good	Good	Good
Critical care	Good	Good	Good	Good	Good	Good
End of life care	Good	☆ Outstanding	☆ Outstanding	Good	☆ Outstanding	☆ Outstanding
Outpatients and diagnostic imaging	Good	N/A	Good	☆ Outstanding	Good	Good
Overall	Good	Good	Good	Good	Good	Good

Good

Medical care

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

Are medical care services safe?

Good

We rated safe as good.

Incidents

- There were well established systems for the reporting of incidents, for reviewing these, conducting investigations and communicating learning as a result of findings. Staff we spoke to knew how to report incidents; staff gave examples of incidents they had reported and of the learning and feedback they had received as a result. Staff were aware of their responsibilities and the role they played in developing a learning culture within the hospital.
- There were no incidents classed as 'never events' reported in the reporting period July 2015 to June 2016. Never events are serious patient safety incidents that should not happen if healthcare providers follow national guidance on how to prevent them. Each never event type has the potential to cause serious patient harm or death but neither need have happened for an incident to be a never event.
- There were 881 clinical incidents reported across the hospital between July 2015 and June 2016, 42% (371 incidents) occurred in surgery or inpatients and 7% (58 incidents) occurred in other services or specialities including medicine.
- One incident was reported as leading to “severe” harm in the reporting period July 2015 to June 2016 in medicine. This related to a removal of a venous catheter, the investigation was on-going at the time of the inspection.
- There were 144 (97.2%) incidents classed as either low (121) or moderate (23) harm across the hospital. These had been considered through the reporting and investigation process.
- There were 415 non-clinical incidents reported across the hospital between July 2015 and June 2016; 41% (171) of these were non-clinical incidents reported by surgery or inpatients via the hospital's incident reporting system.
- It was noted on the clinical dashboard for the hospital that for quarter 3 of 2016, 211 incidents had been reported for the quarter across the hospital. This had been RAG rated as red, likely due to the total number of incidents reported within a given quarter. However, it is the view of the Commission that simply considering a high number of reported incidents as being red rated is contradictory to the encouraging of an open and learning culture. Importantly, the provider should, and currently, they do, consider the level of harm caused by the incidents. The Commission would expect to see a year on year increase in the number of incidents reported (subject to clinical activity), with an overall reduction in the number of incidents resulting in harm. This would demonstrate an organisational culture which encourages staff to be open and transparent, and which reflects a culture of open incident reporting.
- There had been 87 incidents reported as resulting in low risk and 24 rated as moderate risk across the hospital in

quarter 3 (2016). We considered the percentages of incidents reported for the preceding four quarters and noted that whilst there had been an increase in incidents being reported quarter on quarter, there had been an overall reduction in the number of incidents resulting in moderate, high or severe harm. This suggests that staff were reporting more near miss or low harm incidents, which further suggests incident reporting was encouraged across the hospital. We calculated the following:

- Quarter 3 2015 - 144 incidents reported of which 79% resulted in low risk; 20% moderate risk and 0.7% in severe harm
- Quarter 4 2015 - 145 incidents reported of which 87% resulted in low risk and 13% in moderate risk.
- Quarter 1 2016 - 174 incidents reported of which 82% resulted in low risk and 18% in moderate risk.
- Quarter 2 2016 - 181 incidents reported of which 88% resulted in low risk, 11% in moderate risk and 1% in severe harm.
- Quarter 3 2016 -211 incidents reported of which 89% resulted in low risk and 11% in moderate risk.

- Due to the management structure of the hospital, incidents were not always divided in to clinical speciality. However, all Incidents were discussed on a weekly basis at the Quality Review Group; a meeting chaired by a senior, non-clinical executive. The allocation of a non-clinical representative as chair ensured that all elements of learning were identified for incidents as it allowed for additional probing questions to be posed to investigators. The chair of the incident panel was supported by senior clinical staff including the medical director and the Matron. Incident trends were identified during the weekly meeting and enabled better organisational oversight of incidents. Examples of where thematic concerns had been identified at the Quality Review Group, and had subsequently led to new ways of working included recognition of medication errors or near misses associated with two similarly named medicines. The organisation launched their SALAD initiative (Sound alike, look alike drugs), which raised the profile of those drugs which sounded similar but in fact had very different clinical uses.
- Incident outcomes and residual action plans were also shared at the Medical Advisory Committee so as to ensure consultants working at the hospital were sighted on incidents and the relevant learning.
- Staff confirmed they used an online computer incident reporting system to report incidents, which they told us was easy to use.
- Investigations were undertaken into incidents classified as moderate or serious harm and a root cause analysis (RCA) was undertaken. The hospital provided details of an RCA into a hospital acquired venous thromboembolism. We saw learning points had been identified which included supporting nursing staff on the oncology ward to review appropriate VTE assessments.
- An incident policy (including serious incidents) was available on the hospitals intranet site and staff knew how to access it.
- Incidents and safety matters were discussed and reviewed at the daily operational meeting attended by the senior management team. Minutes from clinical governance meetings showed clinical incidents were reviewed and discussed.
- Morbidity and mortality cases were discussed within the hospital's multidisciplinary team meeting programme or the clinical governance committee meeting. For example, information provided by the hospital demonstrated cancer morbidity and mortality death cases had been discussed as part of the MDT breast meeting in November 2016 following a patient's death.
- From November 2014, NHS providers have been required to comply with the duty of candour regulation 20 of the Care Quality Commission (Registration) Regulations 2014. The duty of candour is a regulatory duty that rates openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain notifiable safety incidents and provide reasonable support to that person.
- Staff were aware of their responsibilities under duty of candour, which ensured patients and/or their relatives were informed of incidents that affected their care and treatment and they were given an apology. We saw the principles of the duty of candour had been applied in relation to an incident we reviewed.

Good

Medical care

Clinical Quality Dashboard or equivalent (how does the service monitor safety and use results)

- The hospital used a quality dashboard for measuring, monitoring and analysing patient harm. It measured the proportion of patients that experienced 'harm free' days from pressure ulcers, falls, urinary tract infections in patients with a catheter and venous thromboembolism.
- Patients had venous thromboembolism (VTE) assessments completed on admission. VTE screening rates for the period July 2015 to June 2016 showed 89% of patients had an assessment on admission. The hospital supplied details of four VTE prophylaxis audits undertaken between July 2015 and May 2016. This showed there had been an increased use of VTE prophylaxis from 87% in July 2015 to 96% in May 2016.
- There were 26 incidents of venous-thrombus embolus (VTE) or pulmonary embolism (PE), of which two related to medicine reported in the period July 2015 to June 2016. Again, it is important to note that whilst CQC does not hold benchmark information associated with VTE, a high proportion of activity at The London Clinic was associated with oncology and cancer treatment. It is universally recognised there exists an increasing incidence rate of VTE amongst this patient group and so total numbers should be considered with caution. That said, The London Clinic have bench-marked the number of VTE cases they reported for 2015 with national performance. The London Clinic reports a VTE occurrence rate of 0.4% versus 0.7% nationally. The executive team recognised that even more work could be done to further safeguard patients including the establishment of a service to reduce VTE, which included: improved training and understanding of VTE assessment and use of prophylaxis; improved audit tool; increased scrutiny of performance of VTE assessment and management at the Clinical Governance meeting.
- There were 15 incidents of hospital acquired pressure ulcers, none of which were reportable grade 3 or 4. The hospital had a tissue viability nurse to provide guidance and support to nursing staff. Suitable equipment was available to patient at risk.
- There were 24 falls related to medicine in the reporting period July 2015 to June 2016. The hospital recognised the need to reduce the overall fall rate amongst patients and had introduced a falls prevention group. Following the introduction of the group, the hospital reported an overall reduction of falls of 7.4 per month in 2014 to a current rate of 1.60 monthly. This compares extremely favourably with the national comparative data of 6.63 falls per 1000 occupied bed days.

Cleanliness, infection control and hygiene

- There were formal policies and protocols to support staff in ensuring the environment was suitably clean and for maximising infection prevention and control.
- The hospital reported one incident of Meticillin sensitive Staphylococcus aureus (MSSA) between the reporting periods of July 2015 to June 2016. The service had seen a year on year reduction in the number of cases of MSSA identified. In the 2016 quality account, the hospital reported a 60% reduction in the number of MSSA cases when compared to 2014 and were continuing to show further reductions year on year.
- The hospital reported no cases of Meticillin resistant Staphylococcus aureus (MRSA) reported during 2014 and 2015. Two cases of MRSA had been reported in 2016 (July and September 2016).
- Due to the high case mix of cancer patients being treated at the hospital, a comprehensive Escherichia coli (E.coli) monitoring and screening programme existed. The hospital reported 19 incidents of E-Coli of which 13 related to medicine patients between the reporting periods July 2015 to June 2016. The hospital provided an action plan for 2016 and 2017 to reduce E-Coli bacteria. The actions for completion in 2016 had been completed by the target date and actions for completion in 2017 had been RAG rated (red, amber, green). It is important to note that CQC does not currently hold any benchmark information associated with Escherichia coli (E.coli) infection rates for independent acute hospitals. We have however considered the case mix of the hospital, and are aware of the high risk factors associated between cancer and the acquiring of community E.coli infections. The hospital has continued to report year on year reductions in the overall number of E.coli cases reported with 2016 seeing a reduction of 21% when compared to 2014.
- The hospital reported 12 incidents of Clostridium difficile (C. difficile) of which seven related to medicine

between the reporting period July 2015 to June 2016. A complete RCA was conducted for each confirmed case of C.difficile with no evidence of cross transmission between patients during 2016.

- All the patient rooms we visited were visibly clean. We observed support staff cleaning throughout the day and undertaking this in a methodical and unobtrusive way. Rooms were cleaned in accordance with the daily cleaning schedules we reviewed. We saw the daily cleaning schedules were up to date and signed on completion of work.
- The day unit was cleaned overnight and staff were able to bleep housekeeping for spillages or any urgent cleaning that needed to be done. Housekeeping services were also available at night if required on the wards.
- Cleaning equipment followed the National Reporting and Learning Service's (NRLS) national colour coding system for cleaning equipment, to ensure equipment was not used in multiple areas, therefore reducing the risk of cross-infection.
- We observed green 'I am clean' labels were in use to indicate when equipment was cleaned.
- There were clinical bins in patient's rooms as well as bins for used personal protective equipment (PPE).
- In the endoscopy department disposable curtains were utilised and the date was recorded of when they were last changed.
- We observed sharps management complied with Health and Safety (Sharp Instruments in Healthcare) Regulations 2013. We saw sharps containers were used appropriately and they were dated and signed when brought into use.
- Adequate supplies of PPE such as gloves and aprons were readily available in all clinical areas we visited. We observed staff using this appropriately when delivering care. We noted all staff adhered to the "bare below the elbows" hospital protocol in clinical areas.
- Hand hygiene audits were undertaken monthly by infection control link nurses. The London Clinic (TLC) also undertook the World Health Organisation (WHO) five moments of hand hygiene audit every four months. The WHO hand hygiene audits for November 2015, February and June 2016 showed the oncology inpatient ward and endoscopy consistently score 85% or higher. The oncology day ward scored 72% in November 2015, 83% in February 2016 and 89% in June 2016. Action plans were in place to address areas of non-compliance where the scores were below the hospitals target of 85%.
- We observed the endoscopes management was compliant with ISO 13485:2013 & EN ISO 13485:2012 for decontamination and high level disinfection of flexible endoscopes and accessories.
- The hospital had regular infection control committee meetings attended by senior management which included the endoscopy department nurse manager. There were standard agenda items and action points were identified and reviewed.
- Infection control training formed part of the mandatory training programme for staff. Data provided by the hospital showed 80% of clinical staff across the medical wards and endoscopy had completed infection control training. This was marginally below the hospital target of 85%.

Environment and equipment

- The oncology ward had 18 ensuite single rooms, two of which were suitable for accommodating patients receiving radio-nucleide therapy.
- The oncology day department had 22 ambulatory day care bays. Each bay had an equipment check list, which staff signed off, and we observed the bays were cleaned between patients.
- Resuscitation equipment was stored on a resuscitation trolley, readily available and located in a central position in each of the areas. The equipment was checked daily, fully stocked and ready for use.
- We saw Electrical Medical Equipment (EME) had a registration label affixed and was maintained and serviced in accordance with manufacturer's recommendations. We also saw safety check labels were attached to electrical systems showing they were inspected and were safe to use.

Good

Medical care

Medicines

- There were two medicine related incidents reported in endoscopy between March 2016 and June 2016. One had been attributed to as an incorrect label and the other was not categorised. Both incidents were recorded as no resulting harm to the patient.
- There were 11 medicine incidents reported in chemotherapy inpatients and day cases and two in oncology between March 2016 and June 2016. These were recorded as omitted or delayed medication (3), and incorrect labelling (1), incorrect method of administration (1) or other (6). All the incidents were recorded as no harm.
- Medicines were stored securely on the chemotherapy day and inpatient unit. Separate fridges were used to store chemotherapy and the temperatures of all fridges were monitored to ensure they remained within safe limits.
- The hospital provided details of a controlled drug audits and the results of these. The audit had included the endoscopy, oncology and day wards. We found that action plans were in place to address areas needing improvement.
- All chemotherapy was prescribed electronically according to agreed protocols. A clinical pharmacist screened all prescriptions and the medicines were prepared after the patient's blood test results had been checked. Chemotherapy was delivered by nurses trained to do so using a closed system.
- Intrathecal chemotherapy was prepared and supplied separately following national guidelines. (Intrathecal administration is a route of administration for drugs via an injection into the spinal canal, or into the subarachnoid space so that it reaches the cerebrospinal fluid).
- New chemotherapy protocols were drawn up by a senior pharmacist, checked by a second pharmacist and signed off by the consultant. The provider's oversight of medicines was managed by the following processes. Medicines management, auditing requirements, and drugs reviews were managed by the hospital's dedicated pharmacy services, led by a consultant pharmacist. The hospital had a three stage approval process for any new drugs to be administered, with oversight from the pharmacy team.
- Patient Group Directives (PGD) were used by approved nursing staff to prescribe saline on the day ward. We saw there were seven nurses who had been signed as competent to administer the saline. A PGD signed by a doctor and agreed by a pharmacist, can act as a direction to a nurse to supply and/or administer prescription-only medicines (POMs) to patients using their own assessment of patient need, without necessarily referring back to a doctor for an individual prescription
- For patients who chose to self-medicate we saw self-administration forms had been completed. Self-administration assessments had also completed by a pharmacist and nurse.

Records

- The electronic patient records were shared by doctors, nurses and other healthcare professionals. This meant all professionals involved in a patient's care could see the record. We reviewed eight sets of medical patient records and saw patients care plans included all identified care needs.
- Risk assessments had been completed on admission. These included pressure ulcer; venous thrombo-embolism (VTE) checks, nutrition and falls risk assessments. However, not all the assessments had been reviewed. Two patients who were long stay had not had their risk assessments reviewed for a month. One patient had been initially been assessed at being at high risk of developing pressure ulcers if suitable care and prophylactic interventions were not routinely carried out such as frequent re-positioning and ensuring the patient received good levels of nutrition and hydration.
- Patient allergies were recorded in records.
- Patient records showed treatment and observational actions required of the nurses had been completed. For example, we observed turns charts, and fluid balance charts. The latter had been balanced and calculated correctly.
- Records showed where specific equipment was required these had been ordered and provided appropriate to the risk. Staff told us pressure relieving mattresses would normally be provided within two hours of being requested.

- The hospital audited nursing records over a three month period from June 2016 to August 2016. On level one of the Duchess of Devonshire Wing, 41% of patients had a sample of urine tested on arrival, 26% had no documentation so say whether urinalysis had been conducted and 33% of patients were not able to provide a sample. There was evidence of a VTE assessment in 99% of audited records.
- Repeat audits of fluid balance charts during July, August and August demonstrated good overall and consistent compliance of fluid balance charts being accurately completed on the 3rd floor and Level 2 DDW, attaining 100% on each occasion. Whilst Level 2 DDW consistently achieved 100%, 3rd floor had shown the most improvement over a six month period. The audit however did not record the number of records reviewed and so interpretation of compliance with hospital policy was considered with caution by the Commission. Another audit (referenced above for Duchess of Devonshire Wing) identified that of three fluid balance charts audited, one was not correctly completed. However, it is the opinion of the Commission that such a low audit base would not provide statistically relevant findings and so again, the information and audit outcome was considered with caution.

Safeguarding

- The hospital had no reported safeguarding alerts in the reporting period July 2015 to June 2016.
- Staff had access to the hospital safeguarding policies for children and adults via the hospital intranet. Staff knew the relevant safeguarding leads.
- Staff were able to identify the potential signs of abuse and the process for raising concerns. The hospital had an identified lead for safeguarding.
- Safeguarding information and contact numbers were displayed as a reminder and easy access for staff on the wards.
- Safeguarding vulnerable adults was part of the mandatory training programme for staff. Nursing staff we spoke with on the ward told us they attended safeguarding training. Data provided by the hospital showed 91% of staff in the nursing care directorate and 92% in the medical directorate had completed safeguarding vulnerable adults.

Mandatory training

- The mandatory training programme included fire, health and safety, infection control, child protection training, safeguarding vulnerable adults, patient manual handling, falls prevention, controlled drugs, infusions and transfusions, blood transfusion workshops, diabetes, VTE, intravenous drug administration, basic life support, pain management and medical gas safety training.
- Training was provided via e-learning modules and face-to-face.
- The London Clinic (TLC) had recently introduced a learning management system to capture training records, so they were held locally and centrally. The hospital was still in the process of rolling out the system and updating this with historic data.
- Consultants and clinicians with practising privileges were not required to complete training via the hospital but assurance of mandatory training was checked by the medical advisory committee.
- The resident medical officers (RMOs) received mandatory training via their RMO agency and had access to the hospital's on-line training systems. The resident medical officers (RMOs) received advanced life support (ALS) via the RMO agency.
- Data provided by the hospital showed 86% of the nursing care directorate and 75% of the medical directorate had completed training in health and safety. Fire safety training had been complete by 90% and 83% respectively.
- We were provided with information post inspection which indicated an action plan had been put in place to address under performance against mandatory training targets in the oncology, day unit and endoscopy.

Assessing and responding to patient risk

- There was an admission policy setting out agreed criteria for admission to the hospital. All patients were admitted to the medical service under the care of a named consultant.
- There was a deteriorating patient policy to enhance patient safety by early detection of the deteriorating patient using the Early Warning Score (EWS).

- Patients' clinical observations such as pulse, oxygen levels, blood pressure and temperature were monitored in line with NICE guidance CG50 'Acutely Ill-Patients in Hospital.' A scoring system known as the early warning score (EWS) system was used to identify patients whose condition was at risk of deteriorating. The inpatient medical services assessed patients by using the (EWS).
- Staff we spoke with were clear about the processes to follow if a patient deteriorated. However, on three of the records we reviewed we saw three scores of three and one score of five had not been reviewed. The hospital's policy stated the frequency of monitoring should be increased to a minimum of one hourly. This meant nursing staff were not following the escalation process.
- A sepsis management pathway was available to support the treatment and care of patients presenting with such symptoms. The hospital had an outreach service which was available 24 hours per day. A sepsis steering group existed and had been responsible for developing a sepsis care bundle, which was aligned to national best practice standards for the management of sepsis. Twice-daily and evening handovers were attended by the outreach team, clinical fellows, RMOs and the nursing management team, where at-risk or deteriorating patients were identified and discussed. Sepsis grab boxes were available across medical wards; these contained the right medicines and equipment essential for first line investigations and treatment of sepsis.
- The practising privileges agreement for each doctor ensured there was 24 hour clinical support from the named consultant when they had patients in the hospital. This included making alternative arrangements for a named consultant to attend to patients in an emergency if they were not available.
- During out of hours patients were able to phone the inpatient oncology ward nurses for advice.
- Basic life support was part of the mandatory training programme clinical staff were required to attend. Across the hospital 63% of ward staff had completed basic life support training with an additional 30% of staff having completed immediate life support training. Overall, therefore, 93% of staff had completed at least a basic level of life support training with some members of the team having additional skills. Nursing teams based on wards were also supported by an outreach and cardiac arrest team which was made up of health professionals in receipt of advanced life support skills.

Nursing staffing

- The hospital did not use an acuity tool to determine the minimum staff levels on wards. Staffing levels on the oncology wards varied with one nurse in charge and three or four others. At the time of inspection there were five patients plus three further admissions planned. We observed enough staff on duty at the time. Staff told us oncology was always well staffed.
- The hospital had identified a skills gap in the number of nursing staff able to administer chemotherapy. To increase the number of nurses on the oncology wards the hospital were training seven nurses in the level 6/7 Foundation of Cancer Care, Chemotherapy and Care of the Dying.
- Staff advised us the use of agency staff on the oncology and day ward was high as chemotherapy specialist agency nurses were utilised to administer chemotherapy to patients. The hospital anticipated reducing their reliance on specialist agency staff when their nurses had completed their training. We saw induction checklists had been completed when chemotherapy specialist agency nurses were working on the oncology inpatient and day wards. Copies of certificates were held to demonstrate competence.
- Agency nurses underwent hospital orientation and induction. The use of bank and agency staff across the hospital between July 2015 and June 2016 was between 17% and 20%. This was higher than the average rate for independent hospitals. However, senior staff told us they always tried to book the same agency staff, as this ensured they were familiar with the service and the expected standards.
- The rate of bank and agency health care assistants was higher than the average when compared with other independent hospitals. For the period July 2015 and June 2016 the use of agency staff across the hospital was between 14% and 63%.
- We observed one handover from night to day staff and found the handover was detailed and robust. Staff printed handover guidance notes, which they updated

during the handover of information between shifts. All the patients were discussed and actions outstanding for patients were allocated. Staff were allocated to patients who then introduced themselves to the patient.

Medical staffing

- A requirement for all consultants within the hospital policy for granting practising privileges was they remained available (both by phone and, if required, in person), or arranged appropriate named cover at all times when they had inpatients in the hospital. Part of the consultant's practising privileges agreement was they should reside and work within a reasonable (maximum 60 minutes) travel time of the hospital. Most of the consultants with practising privileges were also employed by neighbouring NHS trusts; staff told us it was easy to contact them when needed.
- Clinical fellows and clinical assistants worked eight to ten hour shifts across the main hospital and within oncology during the day Monday to Friday. At weekends day time cover was provided to oncology was covered by bank staff working 10.5 hour shifts. At night the oncology inpatient wards were covered by an oncology resident medical officer (RMO) who worked 14.5 hour shifts on rotation four nights per week.
- RMO's were provided under contract with an external. The agency ensured the RMO's training was up to date. All RMO's on the oncology wards had completed advanced life support training.

Emergency awareness and training

- The hospital had a contingency plan for staff to use in the event of interruption to essential services.
- There was a member of the senior management team on duty each day who was responsible operationally for any major incident affecting the hospital. Out of hours there was an on call rota and staff were aware of whom to contact in case of a major incident.

Are medical care services effective?

Good

We rated effective as good.

Evidence-based care and treatment (medical care specific only)

- The hospital used a combination of professional guidance produced by the National Institute for Health and Care Excellence (NICE) and the Royal Colleges. For example, the ward used NICE Guideline - CG50 - covers recognising and responding to deteriorating patients.
- Clinical policies and procedures were available on the hospital's intranet and staff were aware of how to access them.
- Oncology patients were cared for using the hospital cancer pathway. Patients were supported from diagnosis by clinical nurse specialists (CNS) and were part of the multidisciplinary team.
- The hospital audit programme mirrored national programmes and included inpatient falls audit, consultant endoscopy performance (JAG) and Percutaneous endoscopic gastrostomy (PEG) outcomes. PEG is an endoscopic medical procedure in which a tube (PEG tube) is passed into a patient's stomach through the abdominal wall, most commonly to provide a means of feeding when oral intake is not adequate. However the hospital did not provide us with audit results or information to demonstrate they had made improvements in patient outcomes as a result of the audit findings.
- The hospital had an audit calendar which set out the audits to be undertaken across the hospital for 2016 / 2017. The audits included for infection control, chemotherapy turnaround times, patient health records, nutritional screening and red tray and acute pain management audit.

Pain relief (medical care specific only)

- A pain scoring system was used with patients across oncology inpatients. The scale asked patients to rate their pain level between one (no pain) and 10 (very bad pain). We saw evidence that patients were usually asked about their level of pain and this was documented alongside the routine patient observations.
- Patient pain scores were audited in July and August 2016. Action points were identified. This included a re-audit to be carried out to measure improvement.
- A random sample of inpatient records which included oncology wards in August 2016 showed pain scores

were documented regularly for 83% of patients; however, 17% of patients (6) did not have regular pain scores documented. Staff were aware of the need to improve this.

- All patients were prescribed analgesia as appropriate.
- The hospital had an established pain team which could be accessed 24 hours per day, seven days per week.
- None of the patients needed a referral to the pain service, as none had a documented pain score of more than 4/10 at the time of the inspection. Patients we spoke with told us they received appropriate pain relief.

Nutrition and hydration

- We saw the patients' nutrition and hydration needs were assessed and met. We observed patients always had drinks available within reach.
- Patient's nutritional needs were assessed using the Malnutrition Universal Screening Tool (MUST) as recommended by the British Association for Parenteral and Enteral Nutrition.
- Patients were reviewed by a dietitian if there were concerns with their weight or food intake.

Patient outcomes (medical care specific only)

- We were informed that the private insurance companies were presented with data on outcomes from consultants in endoscopy. Outcome measures reporting within the independent sector were said to be a challenge, particular as a number of the NHS bodies did not allow private sector organisations to submit data. It was anticipated that the submission of data to PHIN would improve this.
- Between July 2015 and June 2016 a total of 6,712 endoscopies were undertaken. The endoscopy service was not JAG accredited. However, the endoscopy service undertook audits to capture the performance of the department and the consultants, audits of consent forms, and PEG audits. Further, the hospital had engaged with JAG and was working on an action plan to enable the service to become JAG accredited.
- The 2015 endoscopy consent audit showed 98% of the forms were signed and dated on the day of the procedure. The London Clinic's strategy was to achieve JAG accreditation for all endoscopy services. The Joint Advisory Group (JAG) on gastrointestinal endoscopy is principally a quality improvement and service accreditation programme for gastrointestinal endoscopy.
- The hospital took part in the National Confidential Enquires into Patient Outcomes and Deaths (NCEPOD). There was one unexpected death reported during the reporting period July 2015 to June 2016.
- Between July 2015 and June 2016 there were 54 unplanned re-admissions of medical inpatients within 28 days. The number of unplanned re-admissions was not high when compared to other independent acute hospitals, and reflects the nature of treatment and care needs of oncology patients.
- Between July 2015 and June 2016 there were four unplanned transfers to other hospitals. In two of the cases transfers were requested by the patient and or their insurer. The other two transfers were due to the nature of the treatment and availability of a colorectal surgeon. The number of unplanned transfers was not high when compared to other independent acute hospitals.

Competent staff

- Throughout our inspection we observed staff were professional and competent in their interactions with colleagues, patients and their relatives and carers.
- Staff told us they participated in the appraisals process and it was useful to focus on learning objectives. The appraisal rate for endoscopy staff was at 85% at the time of the inspection, and 96% of staff on the oncology inpatient and day unit had an appraisal in 2016. The appraisal year ran from January to December.
- Nursing staff in endoscopy informed us they received specific training, which included endoscopy ultra sound. This is a scan which uses an endoscope with an ultrasound probe attached to create detailed pictures of internal organs and structures
- New staff working on the oncology inpatients ward had access to a ward facilitator who supported new staff and students whilst they were working on the ward. Nursing staff also had access to a practice development nurse who provided clinical support and development.

Good

Medical care

- Staff we spoke with were very positive about the training they were undertaking. Nurses working on the oncology wards also had access to specific training on palliative care, bereavement and loss and symptom control.
- The hospital had identified a skills gap in the number of nursing staff able to administer chemotherapy and were training seven nurses in the level 6/7 Foundation of Cancer Care, Chemotherapy and Care of the Dying.
- On the day ward 70% of the staff had undertaken a competency in chemotherapy. Senior staff told us there were two staff who had not had their competency to administer chemotherapy assessed. We saw where chemotherapy specialist agency nurses were working on the oncology inpatient and day wards; induction checklists had been completed. Copies of certificates were held to demonstrate competence.
- We saw the hospital had a specialist nurse forum which met quarterly and CNS's from endoscopy and oncology attend the meetings. Clinical supervision for CNS's was due to commence in January 2017.
- Training for oncology and endoscopy agency staff was provided the hospital's preferred agency. They ensured all health care professional staff completed skills for health statutory and mandatory training. Bank oncology and endoscopy staff had access to the hospitals learning hub.
- Staff were able to attend external conferences as part of identified individual personal and professional development.
- Nursing staff told us they felt supported by the consultants while they were on site and if they needed to contact them out of hours.
- The RMO told us they were able to access consultants if they needed advice and the agency which employed them undertook regular appraisals.
- All consultants working with the hospital had practising privileges, which required consultants to have an up to date General Medical Council (GMC) registration, evidence of indemnity insurance and revalidation certificate. These were reviewed and highlighted at Medical Advisory Committee (MAC) meetings.

Multidisciplinary working

- The hospital had a dedicated multidisciplinary team (MDT) co-ordinator and MDT assistant to co-ordinate meetings. MDT meetings were held fortnightly or monthly for the following specialities: colorectal, gynaecology, lung, breast, HPB and upper GI, urology, haematology, neuro–oncology, endocrinology and skin.
- All patients diagnosed with cancer or treated at the hospital were discussed at an MDT. The MDT meetings included discussion of inpatients and day cases. The hospital was also part of the London Cancer Network.
- In patient records we saw multidisciplinary team (MDT) working was evident. For example; the oncology ward had access to a range of allied health professionals which included physiotherapists and occupational therapists, dietitians and tissue viability nurses.
- We observed a morning hand over from night to day staff; this included an update of patient's progress and highlighting any concerns. Patients who had "Do Not Attempt Cardio Pulmonary Resuscitation" (DNACPR) forms in place were highlighted on handover.
- The oncology resident medical officer (RMO) attended the oncology inpatient ward staff handover each morning and evening.
- There was effective multidisciplinary working in the endoscopy suite. During our inspection, we saw the administrative staff, endoscopy staff and consultants worked well together to ensure the patient pathway was effective.
- Consultants and nursing staff we spoke with all described good working relationships with other hospital services.
- Pharmacists were part of the multidisciplinary team (MDT) on the ward and met patients at all stages of their treatment. They provided information to patients on their medications.
- Pharmacists and nurses were involved in counselling patients about their medicines. An on-call pharmacist was available for advice and support out of hours.

Seven-day services

- Endoscopy service was available Monday to Friday. There was an on call rota for out of hours available for emergency bleeds.

Good

Medical care

- Clinical fellows and clinical assistants worked eight to ten hour shifts across the main hospital and within oncology during the day Monday to Friday. At weekends day time cover was provided to oncology was covered by bank staff working 10.5 hour shifts. At night the oncology inpatient wards were covered by an oncology resident medical officer (RMO) who worked 14.5 hour shifts on rotation four nights per week.
- A senior nurse was available on site seven days a week as a contact point for staff, consultants and patients via bleep or telephone.
- Consultants saw their patients daily and remained available (by phone and, if required, in person). They were required to formally arrange appropriate named cover if they were unavailable, at all times when they had inpatients in the hospital.
- The pharmacy was available Monday to Friday and until 1pm on a Saturday. There was also an on call service available out of hours.

Access to information (medical care only)

- Staff had access to patient electronic records via a secure log in. Agency staff were also able to access the systems.
- Patient investigation results were accessible electronically, including blood tests and imaging reports.
- Staff had access to national guidance on ward computers which could access internet sites. They told us this was invaluable for accessing NICE guidance and other key reference documents.
- To ensure continuity of staff working on the wards had detailed hand over sheets which they could refer to.
- Staff had access to an online learning management system and hospital policies and protocols via the intranet.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards (medical care patients and staff only)

- Mental Capacity Act 2005 (MCA) and Deprivation of Liberties Safeguards (DoLS) training was not part of the mandatory training programme. However staff we spoke with informed us they had undertaken MCA and DoLS training via e-learning and were aware of the requirements of their responsibilities as set with regard to MCA and DoLS.
- In endoscopy, staff informed us that formal written consent was taken by the consultant involved when the patient was admitted for the procedure. The endoscopy service audited consent as part of its audit programme.
- Patients told us they had signed consent for their procedures. In patient records we saw evidence of consent forms signed by patients.
- Patients told us staff asked their permission before care or treatment was given and medical staff explained their treatment.

Are medical care services caring?

Good

We rated caring as good.

Compassionate care

- The hospital used the Friends and Family test (FFT) to get patients views on whether they would recommend the service to family and friends. We looked at the latest FFT scores that were available to us and during the period January 2016 to June 2016 these showed satisfaction with the service offered at TLC was between 74% and 81%. The hospital response rate for this period was between 7% and 10% which was low.
- An oncology inpatient told us staff protected their privacy and dignity, and were courteous, kind, gentle, and had the time to provide very good care. They described how night staff would come into their room and check on them, patting their hand to reassure them, asking ask if they were alright.
- We observed housekeeping staff protected patient privacy and dignity. They knocked before entering the room, introduced themselves, asked whether they could clean the room and spoke courteously with patients.
- We observed interactions between staff and patients were professional, kind and friendly. For example, we

observed staff explaining to patients what they were doing and always checking if there was anything else they needed. Staff asked patients if they wanted drinks and made sure they were comfortable.

- Patients told us all the staff were 'outstanding' and 'exceptional' this included the porters who greeted patients addressing them by name, the hotel staff who ensured patients had choice of food available to them and the nurses on oncology who were described as, 'just amazing'. One staff member described how they had gone out to buy particular items of food as the kitchen did not have items the patient wanted.
- We observed the nursing staff were not rushed when caring for a patient, staff all had friendly smiles and took time to talk to patients if they wanted to chat. One staff member explained to us how they had the time to spend with patients; they would often get to know the patients and their families as most patients' treatments were on-going.
- Patients we spoke to commented on the time taken by both nursing and medical staff talking to them and their relatives. Patients also commented they got to know the staff which gave them confidence as the staff knew their medical background and supported them during their on going treatment. One patient we spoke with informed us they attended the day ward twice a week and the staff made it "more bearable, even the kitchen staff". Another patient told us 'we are met with a smile, they know who we are'.
- Patients who had an endoscopic procedure received a telephone follow up call from nursing staff to check they were well.

Understanding and involvement of patients and those close to them

- Patients had a good understanding of their care and treatment and many had good relationships with their consultants, having been to them for a number of years.
- Patients told us they were 'very much involved in their care' and comprehensive information regarding care and treatment was provided throughout their hospital stay with staff explaining clearly the nature of tests required and the purpose of observations. They were helped to make informed decisions about their care. One patient described how their consultant had built a team of specialists around them to ensure they got the most appropriate medical care.

Emotional support

- Cancer patients had access to counselling services provided at TLC. Cancer patients could also be referred to local NHS community support teams who had links with other community based organisations such as Macmillan Cancer Support.
- Overseas patients were able to access counselling services proved by the hospital via skype.
- Staff described compassionate and reassuring ways of giving patients news about their health.
- Clinical nurse specialists were able to support patients and nurses. Nursing staff told us they found this useful especially when patients they have cared for had died.
- We observed patients and their families were treated with kindness, dignity and respect. Every patient we spoke with felt the standard of care was either 'very good', 'outstanding' or 'exceptional'.

Are medical care services responsive?

Good

We rated responsive as good.

Service planning and delivery to meet the needs of local people

- The endoscopy department was working towards Joint Advisory Group on gastrointestinal endoscopy (JAG) accreditation.
- The endoscopy service was available Monday to Friday from 8am to 8pm. There was a 24 hour provision for all queries regarding an endoscopy procedure through the matron's office and an out of hour's emergency upper GI bleeds. Between July 2015 and June 2016 there were 6,712 endoscopy procedures.
- There were 2,619 inpatient oncology admissions and 7,957 day case chemotherapy sessions between the reporting period July 2015 to June 2016.

Good

Medical care

- The hospital provided a medical oncology inpatient ward, chemotherapy day ward and endoscopy services for private patients. The dedicated cancer centre included a radiotherapy department, breast and reconstructive surgical ward, medical and haematology oncology, and a stem cell transplant unit.
- All patients' rooms were single ensuite and there were no restricted visiting times for patients. The hotel services were available 24/7 and relatives were also offered refreshments.

Access and flow

- Bed capacity was planned on a weekly basis. The ward manager communicated with the hospital admissions team to manage unscheduled overnight stays. Endoscopy had a planned number of patients due for procedures each day.
- The hospital had an admissions eligibility policy which ensured suitable patients were admitted to the ward.
- Consultants admitted medical patients' by completing a booking form and referring them through the administration team to the appropriate service. Patients admission would be planned for a mutually convenient date.
- All patients were admitted under the care of a named consultant. The consultants reviewed patients prior to commencement of each treatment and provided a 24 hour on call service as and when required.
- The pharmacy targets were to produce the chemotherapy within 60 minutes of the go-ahead in outpatients and 90 minutes in inpatients. Their recent audit showed the 90 minute target for inpatients was 52.9% in March 2016 and 100% in June 2016. The 60 minute target for outpatients was 38.3% in March 2016, and 56.8% in June 2016.
- To take home tablets (TTOs) were available from the pharmacy in a timely way on discharge of a patient.
- Patients told us they saw their consultant at least daily, and the nursing staff were always in attendance to check on their condition. In patient notes we saw daily reviews were written up by the consultants.

Meeting people's individual needs

- In endoscopy there was no specific room or space where consultants could meet with patients to discuss the outcome of their procedures. Staff told us if consultants need to meet with patients privately they would utilise offices on the department.
- The endoscopy department had 16 individual cubicles which had three solid walls and a floor length curtain which remained closed to maintain patient's privacy and ensure male and female patients recovered separately. This had been assessed as complying with the JAG advice for same sex accommodation standards for endoscopy November 2015.
- We saw patients had their individual needs assessed. We reviewed eight sets of patient records and saw their care plans included all identified care needs such being assessed by a dietitian.
- Intentional rounds were undertaken hourly or two hourly checks by nursing staff to monitor patients welfare and any change in the patient's clinical condition. Intentional rounds are a structured approach where by nurses conduct checks on patients at set times to assess and manage their fundamental care needs.
- The ward had open visiting times which meant relatives could visit their loved ones at any time. Staff told us patients families were encouraged to stay to reassure and or assist patients.
- Patients told us they had access to aromatherapy sessions which were provided through the hospital.
- Patients had single rooms providing them with privacy and comfort with ensuite facilities.
- We observed call bells were answered quickly. A patient told us call bells had been answered promptly and they felt they never had to wait to speak to a member of staff. Patients told us staff answered bells straight away.
- Inpatients were able to access the hotel services 24/7 should they need drinks or food. Patient on the day ward and in endoscopy were able to access the hotel services whilst they were on the units.
- Patients were offered the choice of cooked or cold meals three times a day, seven days per week and a range of snacks were also available. The menus were designed to include a range of special diets, healthy

eating options. A new international menu had recently been launched which introduced different dishes and menus were also available in different languages. Patients commented the food had improved and hotel services team came twice a day to book breakfast, lunch, dinner and any light snacks.

- For patients whose first language was not English, staff were able to arrange for interpreters to assist them.
- We saw leaflets were available in both English and Arabic and other languages could be made available if required.
- Staff had access to on line dementia training and the hospital had 65 staff trained as dementia friends.
- Patients who had complex needs including living with a learning disability or dementia where identified at pre assessment. Staff informed us that in these instances specific arrangement would be put in place. Examples provided included booking patient's appointments to be at the end of the list in endoscopy or making arrangements so patient's relatives could stay with them on the ward. We observed during the senior managers' morning patient safety brief, patients being admitted were identified and any arrangements that had been put in place for the patient were discussed.

Learning from complaints and concerns

- Details of complaints raised by patients showed there were 92 complaints across the hospital during the six month period March 2016 to August 2016. We saw these had been followed up and learning outcomes had been identified in most instances.
- Two complaints had been referred to the Ombudsman or Independent Healthcare Complaints Adjudication Service (ISCAS) during the reporting period July 2015 to June 2016.
- The hospital had a complaints policy. Staff we spoke with were aware of the complaints policy and how to access it. Staff told us they tried to resolve complaints and concerns at the time where ever possible. Staff informed us following a complaint made by an international patient that staff on the oncology ward had attended culture and sensitivity training.
- The hospital had a Patients Experience Manager (PEM) who patients or visitors could speak too if they had any concerns or compliments.

Are medical care services well-led?

Good

We rated well-led as good.

Leadership and culture of service

- Please see the surgery section for main findings.
- There was a clear management and operational structure at The London Clinic. The hospital management was led by the chief executive, with the matron /director of nursing, responsible for nursing, cancer services, pharmacy, clinical training, radiography, infection control and theatres. The endoscopy department manager, the oncology inpatient and day ward managers were all managed by the matron.
- There was a structure in place to provide support to staff on the oncology inpatient and day wards and endoscopy.
- Staff told us managers were supportive and approachable, they also felt they had opportunities for personal development and when they raised concerns they were listen to and their concerns addressed. Staff told us they felt respected and valued.
- Staff were very proud to work for The London Clinic; they were enthusiastic about the care and services they provided for patients. They described the hospital as a good place to work. Some of the staff we spoke with had worked at the hospital for many years and were enthusiastic about the services the hospital offered and the care provided.
- Staff we spoke with told us the senior staff were visible on the wards and the matron's office undertook daily rounds. Throughout our inspection we saw senior staff members were visible in all areas.
- Staff said there was an open and transparent culture where people were encouraged and felt comfortable about reporting incidents and where there was learning from mistakes.

Good

Medical care

Vision and strategy for this this core service

- All staff we spoke with were aware of the hospital's vision ‘to be the most trusted hospital’ and values of ‘caring, pioneering and inspiring’. Some staff were able to tell us how the values translated into their everyday practice.
- Staff we spoke with from the endoscopy department were aware they were working towards JAG accreditation.
- A lead cancer nurse had helped to develop a fully integrated cancer care pathway.
- All staff we spoke with were aware of the hospital's vision ‘to be the most trusted hospital’ and values of ‘caring, pioneering and inspiring’. Some staff were able to tell us how the values translated into their everyday practice.

Governance, risk management and quality measurement (medical care level only)

- The governance processes were the same throughout The London Clinic. We have reported about the governance processes within the well-led section of the surgery service.
- The hospital advised since the inspection a new clinical endoscopy lead had been appointed and there were plans to recruit a head of cancer.
- Separate clinical governance meetings for the endoscopy department for the department were due to commence and there were plans for a separate clinical governance meeting for cancer.
- Quality measures related to medical services, endoscopy and oncology fed into the main governance and assurance processes.
- The senior managers' morning safety brief aimed to enhance communications between all departments and staff (clinical and non-clinical).

Public and staff engagement

- Please see the surgery section for main findings.
- The hospital engaged with staff through open staff forums. Nursing staff also had access to training and development to promote retention and investment of staff.
- There were quarterly specialist nurse forums to ensure staff were kept aware of developments and updates.

Innovation, improvement and sustainability

- The London Clinic had recently introduced ‘Values Awards’ for staff who were seen to ‘over and beyond’ what was expected. Staff were nominated for the awards by their colleagues.
- The London Clinic is the only Joint Accreditation committee of ISCH and EBMT (JACIE) accredited stand-alone private unit in the country and the largest stem cell collection centre in Europe. (ISCT-International Society for Cellular Therapy, EBMT – European Society for Blood and Marrow Transplantation.)
- The hospital was the first private hospital or department in the United Kingdom to implement rectal Spacoar implants for prostate radiotherapy patients. To offer radioactive radium treatment for prostate bone metastasis and to offer radioactive Sirtex for liver metastasis.

Good

Surgery

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

Are surgery services safe?

Requires improvement

We rated safe as requires improvement.

Incidents

- Between July 2015 and June 2016, the hospital reported one never event, which was a wrong site tooth removal. Never events are serious patient safety incidents that should not happen if healthcare providers follow national guidance on how to prevent them. Each never event type has the potential to cause serious patient harm or death but neither need have happened for an incident to be a never event.
- During the period July 2015 and June 2016, the hospital reported 881 clinical incidents of which 371 occurred in surgery or inpatients. There were 171 non-clinical incidents relating to surgery or inpatients. Data showed 99.9% of incidents were low harm or no harm. This demonstrated the positive incident reporting culture we observed.
- The hospital used an electronic system for reporting incidents. Staff could describe the process for reporting incidents, and gave examples of times they had done this. All staff we spoke to had confidence in the incident reporting process.
- The hospital had effective systems to ensure staff learned from incidents to improve patient safety. Incidents were investigated by the heads of department. The quality review group (QRG) considered incidents, whilst more significant incidents were also reviewed by the clinical governance committee, such as returns to theatre. We saw evidence of QRG and CGC meeting minutes, which reflected this. Changes as results of an incident led to improvements For example, a prescribing incident had resulted in a refresh of pharmacy processes.
- Nursing staff we spoke with told us they received feedback with any learning from incidents at ward or theatre meetings. We saw copies of theatre and ward meeting minutes, which reflected this. Staff were able to give us examples of changes to practice following incident learning. An incident policy was located on the clinic's intranet and all the staff we spoke with could locate the policy.
- The hospital reported 86 patient deaths for the reporting period July 2015 to June 2016. Of the 86 deaths, one death was reported as unexpected.
- Morbidity and mortality cases were discussed within the multidisciplinary team meeting programme. Any patient deaths not discussed within the multidisciplinary meeting were referred on for discussion at the clinical governance committee meetings. Information provided by the clinic demonstrated that surgical morbidity and mortality death cases had been discussed as part of the gynaecology MDT and at the CGC meeting in October and July respectively following two patient deaths.
- All of the staff we spoke with were aware of the duty of candour under the Health and Social Care Act (Regulated Activities Regulations) 2014. Duty of candour is a regulatory duty that relates to openness and

transparency and requires providers of health and social care services to notify patients (or other relevant persons) of "certain notifiable safety incidents" and provide reasonable support to that person.

- Staff knew what duty of candour meant and gave us examples of incidents of when duty of candour would be triggered, such as drug errors. Staff could describe their responsibilities relating to duty of candour, which ensured patients and/or their families would be told when incidents happened and an apology would be given.

Clinical Quality Dashboard

- The hospital had a quality dashboard which was used for measuring, monitoring and analysing harm. The proportion of patients that experienced 'harm free' days from pressure ulcers, falls, urinary tract infections in patients with a catheter and venous thromboembolism (VTE) were measured.
- There were 26 incidents of hospital acquired VTE or pulmonary embolism (PE) during the period July 2015 and June 2016.
- Patients had VTE assessments completed on admission. VTE screening rates for the period July 2015 to June 2016 showed that between 86% and 91% of patients had an assessment on admission.
- We saw VTE prophylaxis in the form of compression stockings prescribed in patient notes
- The VTE prophylaxis and treatment policy was written in line with National Institute for Health and Care Excellence (NICE) guidelines CG92. The policy stated VTE assessment was mandatory on admission. However, the hospital was not always meeting its VTE assessment requirement of 100% of patients receiving a VTE assessment. There was an action plan in place to address this matter and there were signs of improvement in the audit score.
- We reviewed the last four VTE prophylaxis usage audits for July and November 2015 and February and May 2016. The results demonstrated that 91% in July 2015, 92% in November 2015, 97% in February 2016 and 96% in May 2016 of at patients audited had received appropriate VTE prophylaxis. This showed that progress was being made as a result of the issues identified within the audits.
- There was one case of meticillin sensitive Staphylococcus Aureus (MSSA). There were no cases of meticillin resistant Staphylococcus Aureus (MRSA) or Clostridium difficile (Cdiff) within the same reporting period.

Cleanliness, infection control and hygiene

- The environment across the surgery wards and theatres was visibly clean. We saw the use of green 'I am clean' stickers, which indicated pieces of equipment that had been cleaned and were ready for use. Space was limited within the theatre suites and equipment was stored in some corridors. We saw four damaged theatre support items with tears in their coating, which meant they could not be cleaned sufficiently. Three lead aprons were touching the floor when hung on their stand, which was an infection control risk.
- All staff we met were "bare below the elbows" to allow effective hand washing. Alcohol hand sanitiser and clinical wash hand basins were available in all clinical areas. We saw all clinical wash hand basins were compliant with the Department of Health's Health Building Note 00-09. We observed staff wash their hands and use hand gel appropriately, for example before and after patient contact. This was in line with the world health organisation's (WHO) "Five moments for hand hygiene".
- Hand hygiene audits were undertaken monthly by infection control link nurses. The hospital also undertook the World Health Organisation (WHO) five moments of hand hygiene audit every four months.
- In May 2016 it was identified there was an issue with the hand hygiene audit in theatres. This was because the audit had included anaesthetists and those already scrubbed. This significantly altered the results to show low levels of compliance. A new audit tool was introduced following discussions with the local NHS hospital. This was discussed by the Infection Control Committee on 11th May 2016 as a means of resolving the matter and presenting more accurate information.
- We observed sharps management complied with Health and Safety (Sharp Instruments in Healthcare) Regulations 2013. We saw sharps containers were used appropriately and they were dated and signed when started to be used.

- All theatre staff dressed appropriately in scrub suits and designated theatre shoes. Staff were not permitted into any clinical areas within the theatre department in outdoor clothing. We saw a sign on the internal doors within theatres reminding staff of the need to wear theatre clothes in these areas. Staff either changed clothes or wore a clean gown over their theatre clothes if they needed to visit other areas within the clinic. We observed that all staff followed this policy.
- We saw appropriate personal protective equipment (PPE), such as gloves and aprons, available in all clinical areas. We saw staff using PPE appropriately, for example, when cleaning patient rooms.
- We checked sluices on wards and in theatres and all were clean, tidy and well organised. The toilets and shower facilities we inspected appeared to be visibly clean and tidy.
- All the patient rooms we visited were visibly clean. We saw housekeeping staff cleaning throughout the day; they were discreet and thorough in their work. Rooms had daily cleaning schedules in place, and these were up to date and signed. Housekeeping services were also available at night if required on the wards.
- We observed staff were managing the different types of waste safely, using the designated bins or receptacles. There were clinical bins in patient's rooms as well as bins for used PPE.
- Cleaning equipment followed the National Reporting and Learning Service's (NRLS) national colour coding system for cleaning equipment, to ensure that equipment was not used in multiple areas, therefore reducing the risk of cross-infection.
- The provider held regular infection control committee meetings which were attended by senior management, there were standard agenda items and action points were identified and reviewed.
- Infection control training formed part of the mandatory training programme for staff. Data provided by the hospital showed that 97% of registered nurses and health care assistance (HCA) within the theatres had completed their infection control training.

Environment and equipment

- Theatre infrastructure was well maintained. There were ten theatres ranging in size. Four of the theatres including the hybrid theatre had laminar flow.
- We checked five resuscitation trolleys, three in theatres and two on the wards. All equipment and drugs were within their use-by dates. We also saw checklists for all trolleys showing evidence staff checked the trolleys daily. This provided assurances emergency equipment was safe and fit for purpose.
- We checked the anaesthetic machine in Anaesthetic Room one and saw a logbook showing evidence of daily checking. This was in line with the Association of Anaesthetists of Great Britain and Ireland (AAGBI016151) guidelines. Records showed staff changed the machine's tubing weekly to maintain its function.
- The orthopaedic instrument store room had a thermometer; the temperature was reading 24 degrees at the time of our visit. The recommended storage temperature for orthopaedic instruments is between 18 and 22 degrees. We highlighted this high temperature to the provider and we were informed that a fan had been provided to regulate the temperature.
- A list of all equipment including model, make, age and serial numbers was available from facilities department. Maintenance contracts and service level agreements were in place with external providers to service, maintain and repair equipment. Equipment maintenance contracts were checked and records showed all schedules were up-to-date.
- Theatres had a daily checklist which was a good way of ensuring all daily tasks of maintaining equipment were checked. The checklists we saw were complete.
- We visited wards one, five and six where surgical patients were placed. Each ward had individual patient en-suite rooms. A nurse station, office area and clinical rooms were situated in the middle of the corridor. There was a housekeeping cupboard where cleaning supplies were stored and kitchen area on each floor.

Medicines

- We checked controlled drugs (CDs) in the theatre recovery area, anaesthetic rooms, and on the wards. Controlled drugs are medicines liable for misuse that require special management. We saw the CD cupboards

were locked in all areas. Only authorised staff could access CDs using individual keys. We checked the CD registers in all areas and found two members of staff had signed for all controlled drugs. This was in line with national standards for medicines management. We randomly checked the stock level of two CDs on wards one, five and six, and in theatre recovery area. We saw the correct quantities in stock according to the stock list, and that all were in-date.

- The provider conducted CD audits twice yearly and we saw the previous three audits from March and October 2015 and April 2016. Each audit showed an improvement in performance and details action plans to address any concerns identified.
- There was an antibiotic prescribing policy in use. Prescribing staff had access to an application on their mobile telephone, tablet or computer providing up-to-date information and policies for the prescription of antibiotics and other medications.
- The provider undertook antibiotic prescribing audits every two months. We saw the audits for June and August 2016. Microbiological sampling was at 82% and 91% of antibiotics prescribed were considered to be appropriate. The audits were developed using NICE guidelines on antimicrobial stewardship (QS121) and (NG15 systems and processes for effective antimicrobial medicine use (and Public Health England antimicrobial prescribing and stewardship competencies 2013 guidance.
- We looked at six medication records of patients within the surgery services. We saw appropriate arrangements were in use for recording the administration of medicines. These records were clear and fully completed. Drug allergies had been clearly documented in the six sets of patient records we reviewed, and also on their drug charts.
- The provider had its own pharmacy where patient prescriptions could be dispensed. The pharmacy was staffed by qualified pharmacists and technicians who provided medicines to all patients at the clinic. The pharmacy team was available 24 hours a day, seven days a week. The pharmacists were part of the multidisciplinary team (MDT). Pharmacists visited the wards twice daily to check patient records and restock medicines.
- The provider undertook patient's medicines history audits every two months. This assessed whether inpatients had their medicines histories checked by the pharmacists within 24 hours of admission. The results were 90% compliance in June 2016 and 97.7% compliance in August 2016. The compliance target was 95%.
- We checked the drugs fridges in one of the anaesthetic rooms and on wards one, five and six. We saw that fridge temperatures in all areas we checked were within the expected ranges. We saw records, which showed staff had checked the fridge temperatures daily. All temperatures recorded were within the expected ranges, and there were no gaps on the checklist. This provided assurances the clinic stored refrigerated medicines within the recommended temperature range to maintain their function and safety.
- We saw medical gases were secured to the wall and stored safely in theatres. On all the wards we visited there was suction and piped oxygen in every patient room. We saw recordings showing staff checked the oxygen and suction daily.

Records

- We reviewed six patient records and saw evidence of clear documentation, with no loose records. Staff had signed and dated all entries, which was in-line with guidance from the General Medical Council and professional guidance for nurses. All six patients had care plans, which identified all their care needs. Care plans had been reviewed when required.
- On wards one, five and six, staff stored notes securely in lockable cupboards at the nurses' stations. This prevented unauthorised access to confidential patient data. After discharge, the provider held patient records in its secure health records office. This allowed clinic staff to easily access patient records, for example following readmission, to assist with clinical decision-making. We saw the operation notes were integrated into patients' provider records in line with best practice guidance.
- Risk assessments had been completed on admission. These included pressure ulcer; venous

thromboembolism (VTE) checks, nutrition and falls risk assessments. We reviewed these risk assessment on the online system for the six patient records we reviewed. They had all been completed.

Safeguarding

- Staff we spoke with could describe safeguarding and what types of concerns they would report and the process they would follow.
- Safeguarding policies were stored on the provider's intranet and staff we spoke with knew how to access safeguarding policies and procedures. This meant staff were aware of their roles and responsibilities and knew how to raise and escalate concerns in relation to abuse or neglect for vulnerable adults and children.
- It is the duty of healthcare organisations to ensure that all health staff have access to appropriate safeguarding training, learning opportunities, and support to facilitate their understanding of the clinical aspects of child welfare and information sharing. The Safeguarding children and young people: roles and competences for health care staff intercollegiate document 2014, sets out the requirements related to roles and competencies of staff for safeguarding vulnerable children and young people. Level 2 training was required for all non-clinical and clinical staff that had any contact with children, young people and/or parents/carers. Level 3 training was required where clinical staff work with children, young people and/or their parents/carers and who could potentially contribute to assessing, planning, intervening and evaluating the needs of a child or young person and parenting capacity where there are safeguarding/child protection concerns.
- Across the wards 91% of nursing staff and 92% of medical staff had completed child safeguarding level 2. All bleep holders and Matron's Office were level 3 trained.

Mandatory training

- There was a combination of online and face-to-face training. Staff undertook training in their work time. The provider's mandatory training programme included the following modules: safeguarding vulnerable adults and children, duty of candour, fire health and safety, infection control, moving and manual handling, basis life support (BLS) falls prevention and controlled drugs update.
- Data provided by the hospital showed 86% of the nursing care directorate and 75% of the medical directorate had completed training in health and safety. Fire safety training had been complete by 90% and 83% respectively at the time of inspection.
- We were told by the person responsible for overseeing consultant personnel files the medical staff completed mandatory training at their employing NHS trust, and they were expected to provide evidence of this. Our review of consultant files indicated some gaps in the evidence of training having been completed, which we brought to their attention. They added that where a consultant had not completed mandatory training off-site it could be arranged at the location, and such training was recorded in the electronic database.
- We were shown a new form which was in the early stages of being sent out to consultants seeking completion of training or identifying what training they needed on-site. Managers advised that any failure to meet mandatory training requirements would potentially lead to a suspension in practising privileges.
- The provider had recently introduced a learning management system to capture training records that were held locally to a central location. The provider was still in the process of rolling out the system and updating the system with historic data.

Assessing and responding to patient risk (theatres, ward care and post-operative care)

- All inpatient surgical wards used the Early Warning Score (EWS) system, which enabled nursing staff to monitor the patients' condition and alert medical staff of any potential problems. We reviewed six patient records, these were fully completed.
- There was a policy on managing the deteriorating patient. This policy was up today and within its review date. The policy was written in line with NICE guidelines.
- There was an admission policy setting out agreed criteria for admission to the clinic. The admission policy outlined patients that were not appropriate for admission to the clinic, including admission of children and infectious patients. All patients were admitted for surgery had a named consulted who was responsible for their care.

Good

Surgery

- There was a comprehensive pre-assessment service for patients coming in for elective surgery. More recently a continuous service improvement lead nurse had developed a pre admissions tool which ensured a standardised approach to pre-assessment. The pre-admissions tool was developed in line with NICE guidelines in preoperative care. There were four levels of pre-assessment. A paper based questionnaire, a telephone conversation, a face to face assessment with a nurse and finally a consultant assessment. Issues identified during the pre-assessment were notified to the relevant department and any risks were notified to the matron's office, pain team or IPC lead.
- The provider had a policy for following the World Health Organisation (WHO) safer surgery checklist. Theatres carried out monthly audits of the use of the completed WHO checklists.
- We viewed the audits for July and August 2016. There was a consistently low rate of fully completed WHO safer surgery checklists. In the two audits carried out in July, 40% and 32% of the checklist were fully completed and in the August audit 34% of the checklists were fully completed. There were actions plans on each audit to try to improve the completion rates but there was decline in compliance over the audits we viewed. The provider felt that the introduction of the national safety standards for invasive procedures (NatSIPPs) paperwork would improve the audit results. We were informed that NatSIPPs had commenced in October 2016. We were also told the documentation for recording the WHO safety checks was being redesigned to make it less complex.
- The least well completed areas were the American society of anaesthesiologists (ASA) classification grade system. The ASA grade system was a subjective assessment of a patient's overall health that is based on five classes. We noted the other area of poor compliance was in relation to instrument, needle and swab counts, and whether this was officially confirmed as correct by the scrub nurse.
- The practising privileges agreement for each doctor ensured there was 24 hour clinical support from the named consultant when they had patients in the clinic. This included making alternative arrangements for a named consultant to attend to patients in an emergency if they were not available.
- All of the staff that we spoke to were aware of the process for escalating unwell patients to the resident medical office (RMO) or other relevant clinicians.
- There was a service level agreement between the hospital and a local NHS hospital for the transfer of deteriorating patients.

Nursing and support staffing

- The theatre department staffed operating lists in accordance with The Association for Perioperative Practice (AfPP) guidelines.
- The theatres were staffed with 53.7 full-time equivalent (FTE) theatre nurses. There were 7.2% FTE theatre nurses vacancies. This meant the nursing vacancy rate for theatres was 12%. Provider wide nursing was at 175.5 FTE and HCAs staff was 28.6 FTE.
- The service filled vacant shifts using bank and agency staff. The use of bank and agency nurses in theatre departments ranged from 9% to 21% from July 2015 to June 2016. This was better than the average rate for other independent acute hospitals for which we hold this type of data during the same period, except for October to December 2015, which was higher than the average.
- There were 61.9 FTE operating department practitioners (ODPs) and healthcare assistants (HCAs) in theatres. There were 4.4 FTE posts vacant for OPDs and HCAs in theatres. This gave a vacancy rate of 7%.
- The use of bank and agency ODPs and HCAs in theatre departments ranged from 0% - 3.5% in July 2015 – June 2016. This was better than the average rate for other independent acute hospitals we hold this type of data for during this period.
- We saw evidence of one to one staffing ratio for patients with an airway in situ as per the Association for Preoperative Practice (AfPP) guidelines.

Medical staffing

- Consultants working at the clinic had been granted practising privileges. Practising privileges is a term used when doctors have been granted the right to practise in an independent hospital. This right is subject to various checks on for example; their professional qualifications, registration, appraisals, revalidation, and fitness to practice declaration.

Good

Surgery

- We reviewed five consultant files covering different specialities, including orthopaedic and colorectal surgeons. Of these files only two related to consultants who were actively working at the location. Information was required to be collected against a formal checklists, which included; their application, professional registration, appraisal, certificates and specialist register details, qualifications, appraisals, ionising radiation training, disclosure and barring service checks, and their indemnity.
- We found general medical council registration status was in the revalidation documentation in the two active files. However, there was no evidence of an independent check against this recorded. The checklists in the files examined had no initial or current CRB/DBS status recorded.
- One contract stated that admitting privileges were reviewed biennially but there was no evidence that this had actually occurred.
- We were advised consultants would be chased a maximum three times for updated information, and we saw evidence of this. Failure to produce documentation would result in suspension of their practising privileges.
- As part of their practising privileges agreement, consultants had to be available on-call 24 hours a day whenever they had an inpatient under their care in the clinic. Staff told us consultants attended promptly to review patients where there were clinical concerns.
- The provider's RMOs provided medical cover 24 hours a day, seven days a week. This ensured nurses could quickly escalate any issues concerning a deteriorating patient. The RMO also informed the patient's consultant in an emergency so that they could provide consultant-level care.

Emergency awareness and training

- The provider had an up to date major incident and business continuity plan in place. The plan set out clear roles for key personnel. Staff we spoke with showed us that they were familiar with how to access and use the guidance.
- Fire, health and safety and practical fire evacuation formed part of the provider's mandatory training programme.
- In the main theatre store FR30 the fire door was held open by a cardboard wedge. When we drew this to the attention of staff this was rectified immediately.
- The provider tested the fire alarms weekly and we heard the alarms being tested during our inspection.

Are surgery services effective?

Good

We rated effective as good.

Evidence-based care and treatment

- We reviewed policies and procedures relating to surgery. All policies we saw were up to date and within their review dates. They all referenced relevant national guidance. This included National Institute for Health and Care Excellence (NICE), Nursing and Midwifery Council and the Association for Perioperative Practice (AfPP). Staff could access policies and procedures on the provider's intranet and were able to demonstrate this for us.
- The service audited staff compliance with provider's policies in several areas and reported the results monthly. For example, we saw monthly WHO surgical safety checklist, pain score assessments and nursing records audits. We saw staff meeting minutes, which demonstrated staff received feedback on local audit results and areas for improvement. Feedback was also displayed on noticeboards in the theatre suite.
- The clinic used a combination of professional guidance produced by the National Institute for Health and Care Excellence (NICE) and the Royal Colleges. For example, the wards provided care in line with NICE Guideline - CG50 - that covers recognising and responding to deteriorating patients.
- We reviewed six patient records, which all showed evidence of regular observations, for example, pain scores, blood pressure and oxygen saturation to monitor the patient's health post-surgery. Staff had completed all six observation charts in line with NICE guideline CG50: Acutely ill patients in hospital - recognising and responding to deterioration.

- Patient notes showed pre-assessment nurses performed pre-operative tests such as electrocardiogram for patients with pre-existing heart conditions. This was in line with NICE guideline NCG45: Routine preoperative tests for elective surgery.
- There was an audit programme which set out the audits to be undertaken across the clinic in 2016/2017. The audits included five steps to safer surgery checklist, infection prevention and control, consent forms, acute pain management and surgical site marking audits. For example on the pain management audit the results of August 2016 showed that 83% of patients had their pain scores documented regularly.
- An updated sepsis pathway was in the process of being introduced. Training for the use of the revised protocol had not yet commenced. There were 167 sepsis cases during the reporting period July 2015 and June 2016, which reflected the type of patients coming into the service.

Pain relief

- There were different methods of pain relief available to patients, including patient controlled analgesia.
- Patients' records showed the level of pain was assessed regularly as part of their observation records. Pain scores were assessed using a numerical scoring system, with one demonstrating no pain to 10 demonstrating worst pain.
- The provider had undertaken audits of the documentation of pain scores, which we reviewed as part of the inspection. The audits from July and August 2016 showed that between 83% and 98% of patients were being asked about their pain levels every four hours. Actions were noted in both audits to address any concerns.
- Theatre nurses told us all patients' pain scores were reviewed prior to leaving the recovery area to ensure they were comfortable and their pain was managed.
- In the six sets of patient's notes we reviewed, pain scores were regularly monitored and pain relieving medication was given appropriately.
- Patients confirmed they were asked by staff what their pain level was and were not kept waiting for analgesia when it was required.
- There was a hospital-wide pain team who visited the wards daily. The pain team consisted of four consultants covering Monday, Wednesday, Thursday and Fridays. There were two clinical nurse specialists on the pain team who covered the wards from 8am-8pm on weekdays and one Saturday morning per month. Patients with a pain score above 4/10 would be referred to the pain team. The pain team provide on-going support to patients when they had returned home. A letter was sent to the patient's GP updating them with respect to their treatment and care. Overseas patients were provided with letters to take home to their healthcare provider.

Nutrition and hydration

- The staff followed the Royal College of Anaesthetists guidance on fasting prior to surgery. The guidance suggested patients could eat food up to six hours and drink clear fluids up to two hours before surgery. Pre-operative patients were advised prior to surgery, on fasting times. Patients having operations in the afternoon could have an early breakfast on the day of surgery. This was in line with best practice. We saw that staff asked patients to confirm the time they last ate and drank before surgery. This ensured the service complied with the Royal College of Anaesthetists guidelines
- A Malnutrition Universal Screening Tool (MUST) was used to assess patient's nutritional needs. This is a recommendation of the British Association for Parenteral and Enteral Nutrition. We saw evidence of the MUST within the six patients' notes what we reviewed.
- We were told by patients that nurses ensured they were kept well hydrated. Hot and cold drinks were provided throughout the day.
- A dietitian was available within the clinic to review patients should nursing staff be concerned about a patient's food intake.
- Patient's hydration was monitored by nursing staff using fluid balance charts. We saw evidence of this in the patient notes reviewed.

Patient outcomes

- Data provided showed there had been 23,000 inpatient and day cases attendances between July 2015 and June 2016. In the same period there had been 54 unplanned

readmissions within 28 days of discharge. However, this number was not high when compared to a group of acute independent hospitals which submitted data to the CQC.

- During the period July 2015 to June 2016 there were four unplanned transfers of patients to other hospitals. The number of unplanned transfers was not high when compared to the performance data submitted by other acute independent hospitals
- Between July 2015 and June 2016 there had been 12 cases of unplanned return to the operating theatre.
- The orthopaedic department participated in the National Joint Registry audit. The provider was in the process of developing a new application to be used to collect patient reported outcomes measures (PROMs) scores for hip and knee surgeries.
- There was a clear pathway for orthopaedic patients including a pre-assessment where patients were given information in the form of a detailed leaflet. Patients were also told about pre surgery interventions, the availability of hydrotherapy and given a tour of the wards and intensive care unit such they need to use it during their stay.
- The theatre department had a comprehensive annual audit programme to measure performance. We saw the audit schedule, which included areas such as anaesthetics and pain management.
- The hospital had a subscription with the Private Healthcare Information Network (PHIN). PHIN allows independent hospitals to share performance data in accordance with legal requirements regulated by the Competition Markets Authority. The provider submitted their 2015 data for non-NHS funded patients to third party contractor for inclusion in PHIN before the September 2016 deadline.
- In the pre-inspection submission the provider informed us 'the private sector has limited systems for monitoring longer term outcomes other than when patients return for further care. They relied on consultants to benchmark their outcomes from patients treated at The London Clinic with their practice in the NHS, where comparisons amongst institutions was said to be easier.
- The hospital provided us with a list of national audits they were participating in. This included National Confidential Enquiry into Patient Outcome Death (NCEPOD) for gastrointestinal haemorrhage and tracheostomy care. They also had a rolling programme collecting data for patient outcomes, such as colonoscopy completion rates, adenoma detection rates and quality of bowel preparation. We could not identify specific results for this hospital from the web site.
- The hospital submitted information to the National Joint Register for hip and knee surgery patients.
- The provider was in the process of developing a new application to be used to collect patient reported outcomes measures (PROMs) scores for hip and knee surgery.
- Surgical site infection rates were collected by specific consultants for orthopaedic patients, spinal and cranial surgery.

Competent staff

- During the appraisal year running from January 2016 to December 2016 over 75% of nursing staff had had their appraisal at the time of our inspection. The appraisal year was on a rolling 12 months within theatres. Completion rates were at 93% in main theatres, 97% in the minimal investigations and treatment units (MITU), and at 100% for the hospital sterilisation and disinfectant units (HSDU).
- Staff told us they had access to development opportunities; they felt well supported to develop their careers within the clinic.
- Throughout our inspection we observed staff who appeared to be competent and professional in the interactions with patients and colleagues.
- Consultants who requested practising privileges are invited to a formal interview with the matron, medical director and chief executive. Following the interview they were passed to the medical advisory committee (MAC) for approval.
- Practising privileges were reviewed on an annual basis requiring evidence of their General Medical Council (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.

- The resident Medical Officers (RMOs) underwent mandatory training as part of their induction and appraisals were provided by the agency they worked for.
- New staff, including bank and agency, had an induction pack with a signing check sheet. We checked three completed check sheets and saw they were all fully completed. Employed staff had a two week induction period. Student nurses were allocated a mentor who had undertaken the mentorship programme at City University.
- Over 10 staff had been trained as surgical first assistants on the Association for Perioperative Practice (AfPP) course.

Multidisciplinary working

- Multidisciplinary team (MDT) meetings were held weekly and included discussion of both inpatients and day cases.
- Patients had access to a number of allied health professionals. We saw evidence of this noted in the six patient reports we reviewed. There was demonstrated evidence that a range of professionals had input into patients' care. This included physiotherapy, dietitians, occupational therapists and pharmacy. Staff we spoke with reported positive multidisciplinary working relationships with colleagues.
- There was a handover at the beginning of the day and night shifts. We attended a morning handover. At this meeting the night shift staff discussed each patient, documenting any concerns or issues that had arisen and handed over their care to the day shift.
- A daily matron's meeting was held. At the meeting we attended discussions took place on bed occupancy, discharge, closure of wards, infection prevention and control, near misses and a power spike.
- There was pharmacist support on the wards and they provided information to patients on their medications.
- Our observation of practice, review of patient records and discussion with staff confirmed effective multidisciplinary team (MDT) working practices were in place.

Seven-day services

- Eight out of the 10 theatres operated a seven day a week service from 7:30am to 9pm. the remaining two theatres operated a Monday to Friday 7:30 am to 9pm service only.
- The RMO was on call 24 hours, seven day a week to cover surgical inpatient care.
- Consultant surgeons were expected to be available 24 hours a day, seven days a week if their patients required urgent review, or if they were not available they were expected to have arranged alternative consultant cover.
- An out of hour's on-call theatre team was available.
- Allied health professions worked on Saturdays and were available on Sundays should they be required.
- Surgeons and surgical staff worked alongside the radiology team during some procedures. There was one hybrid theatre, which allowed for radiological support on complex surgical interventions.
- There was an on-call pharmacist service out of hours when the clinic's pharmacy service was not available.

Access to information

- Staff could access local policies and procedures electronically through the provider's intranet. All staff we spoke with knew how to do this. Staff could access national guidance via the internet, and we saw computers available in staff areas to enable them to do this.
- Records for inpatients were paper based and stored in a locked cabinet at the nurse's station on each of the wards. As well as keeping confidential patient data safe, this ensured timely access to all the information needed for patient care. We reviewed six sets of notes for surgical patients. All six contained sufficient information to enable staff to provide appropriate patient care. This included diagnostic test results and care plans.

- The provider provided discharge letters for patients' GPs. The letters included all relevant information to allow continuity of care in the patient's community. Information included operation details, prescribed medications and wound care.
- Notice boards in staff areas held a variety of information including audit results, training dates, team meeting minutes and actions.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- We reviewed six consent forms for surgery. On all six forms, we saw consultants had documented the risks and benefits of surgery, in line with GMC guidance. In all six forms, we saw patients and consultants signed consent forms before the day of surgery. This was in line with guidance from the Royal College of Surgeons (RCS) "Good Surgical Practice 2014", which states staff should "obtain the patient's consent prior to surgery and ensure that the patient has sufficient time and information to make an informed decision". Patients and consultants then provided an additional signature on the day of surgery to confirm their consent to proceed in line with best practice guidance.
- Patients we spoke with felt that they had received sufficient information from their consultant about their surgery and its associated risks to give informed consent.
- The provider's consent policy was up to date. The consent policy detailed mental capacity; lack of capacity, the use of consent forms, informed consent and refusal of treatment, as well as advance decisions. Patients we spoke with told us that staff always asked their consent prior to commencing any treatment including taking blood pressure reading, temperatures etc. Staff also explained the treatment they were going to undertake.
- The hospital undertook monthly audits of consent forms. 15 forms were selected at random monthly and were checked for completion. We reviewed the audits for June, July, August and September 2016. Within the monthly audits the areas that had consistently low completions were anaesthetic type, patient printing their name as well as signature and date of procedure.
- Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS) training was not part of the mandatory training. Data the clinic provided to us showed that 45% of nurses and HCA's had completed MCA and DoLS training during 2016. None of the anaesthetics and recovery team members had completed the MCA or DoLS training during 2016.However, all of the staff that we asked understood their responsibilities under MCA and DoLS.

Are surgery services caring?

Good

We rated caring as good.

Compassionate care

- Inpatient survey results for September 2016 indicate that 84% of 153 inpatients rated the quality of care as excellent, with 14% as very good.
- We spoke with eight patients and three relatives during our inspection and all spoke highly of the care, compassion and respect they were shown by all the staff they encountered during their time in the clinic. Comments we received from patients and relatives included "they are so kind, nothing is too much trouble", "the food is excellent" and " All of the nurses have been very caring and always have time to chat".
- During the time we spent on the wards and in the theatre department, we observed many examples of compassion care. We saw staff introduce themselves to patients and ask patients how they would like to be addressed. We saw all grades of staff talk to patients in a polite and respectful manner.
- Staff had the time to build relationships with their patients and as a result, we saw staff conversing with patients about their interests.
- We saw staff on all wards respecting patients' privacy by knocking on the door before entering patient rooms.
- Patients told us their call bells were answered very promptly.
- There was a chaperone service for both inpatient and day surgery patients. Staff we spoke to were aware of the chaperone service and where to find the policy

- Family members were able to stay in the clinic with the patients. Beds and food were provided for them so they could be with the patient at all times.
- The housekeeping service worked to encourage patients to eat and thus would make every effort to provide whatever food the patient fancied.

Understanding and involvement of patients and those close to them

- All patients recovering from surgery on the wards we visited had named nurses to care for them. This allowed patients to build a good relationship with the staff looking after them, as well as helped with planning and agreeing care.
- In theatres, we saw staff talking to patients and reassuring them while they waited for surgery to start. We heard surgeons and anaesthetists answering patient's last minute questions before they commenced procedures and reassuring them.
- Patients we spoke to told us staff involved them and their relatives in discussions about their care and they were involved in the decision making around their care. One patient told us, "All my questions were answered and I felt assured". Another patient described their consultant's approach as "very professional and reassuring".
- Staff told us about a patient who was expected the following week for a surgical procedure; the patient was living with dementia. Arrangements had been made for the patient's daughter to accompany them during their time in the clinic. The daughter would also accompany the patient to the anaesthetic room prior to their surgery, to provide support.

Emotional support

- A patient we spoke with told us they felt very nervous before surgery. They described how their surgeon and anaesthetist made them feel at ease through their calming manner and the provision of information.
- Staff were aware of how to access chaplaincy services at the patient's request. There was an annual multi-faith service held for staff, former staff, patients' families and former patients from the clinic.
- For an additional charge, visitors could eat a meal on the ward with their relative or friend. This allowed patients to receive emotional support from family and friends while they were in clinic.

Are surgery services responsive?

Good

We rated responsive as good.

Service planning and delivery to meet the needs of local people

- The international office managed all aspects of care of international patients. This service was designed to meet the needs of the large demographic of international patients the clinic received. The clinic maintained positive working relationships with the embassies of the countries from which the majority of its overseas patients came. The international office also provided cultural information to clinical and housekeeping staff and translation services for patients.
- The clinic provided only private care; therefore the majority of services were elective. This meant admissions to the surgical inpatient wards were planned in advance with the patient, at a time and date convenient to them.
- Some patients and their families were not local to the area and facilities were available for relatives to stay with the patient if the patient wished. A folding bed could be provided and we saw that they were able to access meals and drinks when required.

Access and flow

- All patients were admitted under the care of their consultant who had practising privileges at the clinic. The consultant had to be available throughout the patient's intended stay at the clinic, or they had to arrange a colleague with admitting rights to cover an absence.
- Dates for surgery were booked around patients' and the consultant's schedule. Patients we spoke with told us they were able to choose from several dates.

Good

Surgery

- During the 12 months from July 2015 to June 2016, five procedures had been cancelled for non-clinical reasons. Of these cancellations, four (80% of) patients were offered another appointment within 28 days of a cancelled operation.
- Patients under the age of 16 were not treated at the hospital.
- Arrangements were made with inpatients to arrive at the clinic between 8am and 6pm. On arrival patients were taken directly to their rooms. There was an option available for patients to have a late planned admission; those inpatients would arrive between 6pm and 8pm.
- Discharges were managed with the patients' input. Discharge letters were sent to the patients' GP and any other relevant practitioners.
- Take home tablets were available from the pharmacy in a timely manner on discharge of a patient.
- Discharge for overseas patients' was arranged by the international office. The international office maintained contact with the patients relevant embassies pre and post discharge.
- The theatre team had an on-call rota to cover any unplanned returns to theatre outside of normal operating hours. Anaesthetists also participated in an on-call anaesthetic rota to ensure 24-hour anaesthetic cover.
- We viewed the clinic's friends and family test (FFT) information for 2015. 96.6% of patients stated that they were 'likely' or 'extremely likely' to recommend the clinic to their family and friends.
- Results from the patient satisfaction survey September 2016, demonstrated that 86.2% of patients who responded to the survey had rated the discharge process as 'excellent' or 'very good'.
- Patients told us they saw their consultant at least daily, and the nursing staff were always in attendance to check on their condition. Within patient records, we saw notes written by consultants following their consultation with their patient and with regard to daily reviews and progress.
- Bed occupancy rates ranged from 60% to 79% during the period July 2015 and June 2016.

Meeting people's individual needs

- The individual needs of patients were identified prior to surgery by the consultant responsible for their care and during the pre-assessment process.
- Translation services for the clinic were based in the international office. There were translators for numerous languages employed directly by the clinic. Translators were available from 8am until 8pm every day. Outside of these hours, or where the patient's language was not spoken by the translators, there was a telephone translation service. Staff we spoke with knew how to access the telephone translation service if it was required.
- We saw leaflets, posters and menus in Arabic and we were told other languages could be provided.
- Religious and other dietary preferences were catered for.
- Patients had single rooms that provided privacy and comfort with en-suite facilities.
- The theatre department and wards were accessible for wheelchair users. We saw additional aids to support patients with limited mobility such as shower chairs. Lifts provided accessibility between levels and the corridors and doors were wide enough to accommodate a wheelchair. This allowed wheelchair users to access services on an equal basis to others.
- We saw patients were provided with support equipment like Zimmer frames and toilet frames.
- Dementia and Learning Disability (LD) training was not part of the mandatory training. However staff we spoke with were aware of the dementia policy and the use of the "This is Me" document. During our inspection there were no inpatients living with dementia, so we did not see the use of either of these documents but staff talked us through them.
- Staff told us they would be made aware that a patient with LD was being admitted prior to their admission and would ensure they came with a carer who could help to support them.
- There were call bells in patient's rooms. We saw call bells being answered promptly by staff.

- Information booklets about the clinic were available for patients. These included room facilities, meals, care expectations, health and safety, discharge and a patient guide which included information on complaints.
- A chaperone service was in use and all staff we spoke to knew how to arrange this and where to locate the chaperone policy. There was a multi-faith room available for prayer and quiet reflection in the Devonshire building. The room was neutrally decorated and could be used by people of any faith or if they had no faith.
- Inpatients chose their meal from a menu each day, a member of the housekeeping team was available to discuss ingredients and allergies with patients and clarify any aspects of the menu. The patients we spoke with said the choice of food was very good. Housekeeping staff and health care assistants monitored if patients weren't eating or drinking and notified nursing staff.

Learning from complaints and concerns

- Information provided prior to inspection documented that 92 complaints had been raised by patients across the clinic during the six month period March 2016 to August 2016. We saw these had been followed up and that learning outcomes had been identified in most instances.
- Of the complaints received by the clinic during the period July 2015 to June 2016, two complaints were referred to the Independent Sector Healthcare Complaints Adjudication Service (ISCAS).
- We were shown a new patient leaflet, which outlined the new time lines for responding to complaints, and this was to be in use from January 2017.
- The clinic had a Patients Experience Manager (PEM) who was available for patients or visitors to speak to if they had any concerns or compliments. The PEM explained how the complaints process was about responding to patients in real time. The process had been re-designed in June 2016, so there was a five day and 20 day pathway to be followed. They aimed to deal with the majority in the five day target, but more complex matters allowed 20 days to enable detailed investigation.
- The PEM undertook a daily walk around the wards, and ascertained if there were any grumbles, with the aim of preventing these escalating.
- We were shown the complaints system, which detailed name and reference, date opened, first received, incident date, acknowledged, actioned and or holding. The name of responsible person, where the complaint happened and description of the matter, the investigator, actions and approved.
- Our review of five separate complaints indicated there was a clear processes through the investigation, and actions taken. The letter sent to individuals was not a standardised response but took time to outline all the points made and provide a detailed response, even if not upheld. We were able to see letters of apology, and evidence of flowers having been sent to complainants.
- Patients were aware of how to raise concerns and information on how to make a complaint and the process was provided as part of the patients information pack on admission. We saw 'how to make a complaint' leaflets. Within the leaflets contact details for the Parliamentary Health Services Ombudsman and the Care Quality Commission were provided.
- Staff we spoke with were aware of the complaints policy and how to access it. Staff told us they tried to resolve complaints and concerns immediately whenever possible. Staff were aware of the raising a concern at work policy.
- Complaints were discussed at the weekly quality review group meetings. We saw evidence of this in the minutes of quality review group meetings. Learning from complaints and concerns was discussed a team meetings.
- The clinic received 189 complaints during the period July 2015 and June 2016 of which 20 were relating to surgical patients. We reviewed the clinic's complaint log for May to August 2016. This showed the clinic met their target response time for one out of the two complaints relating to surgery during this period. However, we saw that the clinic apologised to patients where they did not meet the 20-day target.

Are surgery services well-led?

Good

Surgery

Good

We rated well-led as good.

Vision and strategy for this this core service

- Staff we spoke with in the surgical areas were aware of the hospital's vision, which was to be the 'Most Trusted Hospital'. They understood what the values were and how they were expected to deliver services in manner which reflected these. The values were said to be: caring, inspiring, and pioneering.
- The vision was embedded across surgical services and other clinical departments. We observed staff demonstrated the values in the way they treated and cared for patients and their families. They also referred to the values within staff handover for example, exploring and discussing how they could demonstrate the vision and values.
- The objectives for 2016 demonstrated the importance of recruiting and retaining the best staff and providing the best patient experience. The staff we observed caring for patients demonstrated a commitment to provide the best care for patients.

Governance, risk management and quality measurement (and service overall if this is the main service provided)

- There were clear governance arrangements within surgery and other clinical departments to ensure high standards of care were maintained through regular audits, reviews of incidents and complaint data and consideration of risks.
- A range of committee meetings were held at clinical and operational levels. This included three main governance committees, namely the Clinical Governance Committee, the Quality Review Group and Medical Advisory Committee, which met at regular intervals. Minutes reviewed by us indicated there were representatives from surgical services and other clinical areas at the Clinical Governance Committee and the Medical Advisory Committee meetings. We noted a range of sub-committees fed into the CGC. These included the VTE committee, the drugs and therapeutic committee, and the medicines management committee.
- The clinical governance committee (CGC) met every two months and provided clinical governance and assurance to the executive team.
- The Clinical Governance Committee discussed complaints and incidents, patient safety issues such as VTE and infection control.
- Minutes we reviewed for January, May and July 2016 confirmed the governance meetings provided a forum for reviewing various quality measures and included scrutiny and challenge related to; performance, activities, incidents, risk registers, infection prevention and control, and audits.
- The matron cascaded information from the governance committee meetings to the monthly ward managers meetings and from there information was cascaded to the wards.
- The hospital's medical advisory committee (MAC) provided the formal organisational structure through which consultants communicated. The MAC advised the hospital's executive and worked to maintain high standards and improve the quality of services. A consultant surgeon represented surgery on the MAC. The MAC met every two months.
- We reviewed MAC minutes from December 2015, and February, April and June 2016. The minutes showed discussions around continuous service improvement, clinical resources and innovation.
- There was a risk register for the hospital. Senior ward and theatre staff discussed clinical risks with us that were showing on the risk register. For all these risks, we saw action plans had been put in place and these were monitored. We saw evidence the risk register and governance issues were discussed at ward meetings.
- There were formal arrangements to ensure only consultants' with appropriate supporting information had their practising privileges approved. Where surgeons and anaesthetists were not regularly undertaking practice at the clinic their privileges were suspended, and we saw evidence of this.
- Clinical governance dashboards were in use across clinical areas. This monitored monthly performance in a

range of key areas relating to surgery and medicine, and included clinical indicators and risk management. For example, monthly return to theatre audits, patient deaths, cancelled operations and incidents.

- We saw that staff received feedback on key performance indicators at ward meetings. This meant the service addressed any deterioration in performance and highlighted positive practice.

Leadership / culture of service related to this core service

- Staff working in surgical areas told us the senior management team (SMT) were visible and approachable. The matron led the daily matron's meeting and discussed any concerns for the day with staff. The matron's office had an "open door" policy, and staff we spoke with told us they would feel confident to approach the matron with any concerns.
- There were daily meetings and mop-up sessions with deputies and senior nurses. The six senior nurses worked on rotation and had 24/7 on-site presence. Two nursing ward rounds took place daily, which allowed staff to share information and discuss any major risks or concerns.
- Discussion with staff attending a staff forum provided commentary on their perspectives of the service. We were told by staff they were encouraged to be innovative, and gave examples to us of improved services. For example, the development of the overseas department, which had in-house translators 24/7, and the provision of hotel services. Staff who spoke with us said they had autonomy and personal responsibility was encouraged. Further, managers were very accessible to discuss information and share ideas with.
- Every member of staff we met with spoke positively about their relationships with both their line manager and the senior management team. Staff told us managers were approachable and dealt with any issues in a timely fashion. An example was staff were encouraged by their line managers to undertake training for their own personal career development.
- The ward and theatre managers were knowledgeable about their areas and demonstrated good leadership skills. They were visible and staff told us mentors were provided to support new staff or temporary staff.
- The director of nursing told us "culture is important; people want to do something and make it better." They added, "It's exciting and happening" and "we try to follow through on good ideas."
- The clinical governance lead said the "culture is one of providing care, inspiration and to be pioneering. We are aiming to be the best", and "I think care is exceptional." They added, "We are good at dealing with patients from varying cultures and we have an international office, as well as a diverse nurse population."
- All of the staff that we spoke to talked about an open and non – blame culture. They said they felt able to discuss concerns and issues they were having and felt safe and protected to do so.
- A member of staff responsible for complaints told us, "It's great here, I was floored by how sensitively they (the managers) took it (complaints management), making sure the process was thorough." They added "the managers and staff pay attention."
- The culture was described to us by staff as "very positive and patient focussed." An example was given to us where the staff had taken time to invite a patient who had a range of allergies in to the hospital in advance of their admission, so they considered everything to ensure the patient was safe.
- All the staff we met were very welcoming, helpful and friendly. They said they were extremely proud to work for the clinic.
- We spoke with consultants, including the chair of the MAC. As a group they were very supportive of the management, describing them as responsive, listening and accessible in character. This was unanimously echoed at the larger multidisciplinary staff meeting we attended.

Public and staff engagement (local and service level if this is the main core service)

- The director of nursing told us the trustees had an interest in what was going on and attended meetings, such as those related to building and new developments.

Good

Surgery

- We were told by the recently appointed clinical governance lead the "patients did not necessarily want to get involved in the service," but they expected "exceptional care." They confirmed there were no patient group forums for surgery or otherwise.
- The hospital actively engaged with staff through open staff forums. They provided free refreshments for staff in their staff rooms along with access to microwave ovens, journals, nursing magazines and daily newspapers. Notice boards in staff rooms provided details of available training courses for example, laser training, manual handling and fire safety training. On the notice boards throughout theatres, information was displayed relating to representatives at various committees, clinical waste and sharps disposal and the latest theatre meeting minutes.
- There were quarterly specialist nurses forums. These forums were used to ensure that nursing staff kept up to date with service developments.
- Staff had benefits packages including healthcare, and gym membership. There was provision of accommodation locally for new starters if required for an initial three month period.

Innovation, improvement and sustainability (local and service level if this is the main core service)

- Advances in urology and the do not attempt cardiopulmonary resuscitation (DNACRP) policy were areas of service which had been focussed on in meetings recorded for the MAC for December 2015, February, April and June 2016. This showed the MAC took action to continually improve the quality of care.
- During 2016 the hospital commenced on a comprehensive redevelopment plan to modernise patient bedrooms and build new theatres. During the inspection we saw some of the newly renovated bedrooms, which had been completed to a high standard.
- A new extended pre-assessment service was launched before the commencement of our inspection. Prior to this pre-assessment was only conducted for a limited number of procedures. The new pre-assessment tool had been developed in line with NICE guidelines on preoperative care and was provided by a lead nurse. All surgical patients would have a pre-assessment prior to admission to assist with preparation prior to surgery. The pre-assessment had four levels: a paper questionnaire, telephone interview, face to face meeting and consultant assessment.
- In the hospital's continued goal to recruit the best staff, they had provided subsidised local accommodation for staff. Staff that we spoke with who used the accommodation said it made them "feel valued".
- The matron explained that there were opportunities for development for overseas staff and career progression pathways. They had established links with a local university and 100 students went through the clinic. Staff from other cancer related services external to the clinic also attended to undertake training.
- The hospital had recently started a 'Values Award' scheme. The award were present to staff that had been nominated by their colleagues and had been seen to go 'over and beyond' what was required of them.
- The corporate objectives for 2016 set out the steps taken by the hospital to ensure a sustainable service for the future. The objectives included, retainment of the best staff, attracting and valuing loyalty of consultants, developing strategic partnerships, becoming more efficient and providing the best patient experience.
- The consultants who spoke with us commented on the MD PhD programme, designed to provide first tier medical ITU and critical care cover through reciprocal support of research fellows. This was impressive as an example of a Royal College and an independent provider working together.

Good

Critical care

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

Are critical care services safe?

Good

We rated safe as good.

Incidents

- Never events are serious patient safety incidents that should not happen if healthcare providers follow national guidance on how to prevent them. Each never event type has the potential to cause serious patient harm or death but neither need have happened for an incident to be a never event. There were no never events on the unit in the reporting period.
- Serious incidents are those which cause, or have the potential to cause, serious harm to patients, staff or the public. There were no serious incidents in the reporting period. There were five moderate harm clinical incidents in the reporting period, all of which had been appropriately investigated. In addition, there had been six moderate and five no harm health and safety incidents in the reporting period.
- There was a policy recently introduced on the unit for each permanent member of nursing staff to report one incident per month. Staff told us they found this a useful way of learning from incidents and driving improvement. They said that incidents were treated as learning opportunities and were not dealt with punitively. Where staff did not have an incident to report, they told us they would report a concern, or make a suggestion to drive improvement.
- We looked at five recent incidents recorded on the electronic reporting system. The records were detailed and included investigation records, action plans and learning outcomes.
- We were told about one serious incident where a controlled drug was found to be missing. The incident was reported through the electronic reporting system. The issue was flagged to the pharmacy team. Following an investigation, it was discovered that a permanent and agency nurse had failed to sign out the controlled drug from the controlled drugs cupboard. Both nurses were asked to provide a statement reflecting on the incident.
- The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain 'notifiable safety incidents' and provide reasonable support to that person. All staff we spoke with had a good understanding of the duty of candour and where it should be applied. We saw examples of duty of candour letters and staff were able to recount incidents where the duty had been followed. The hospital monitored the use of the DoC through hospital-wide audits. There had been no incidents meeting the duty of candour criteria in the reporting period.
- Morbidity and mortality cases were discussed as part of the hospital's multidisciplinary team meeting programme. We saw the minutes of previous mortality and morbidity meetings, albeit not involving the critical care unit.

Good

Critical care

Clinical Quality Dashboard or equivalent (how does the service monitor safety and use results)

- The unit had previously completed a monthly clinical quality dashboard. The most recent dashboard, from 30 June 2016 was displayed on the old unit, which was being used as a breakout area for nursing staff. The 30 June 2016 dashboard set out the number of falls on the unit since the last review on 1 January 2016. There had been no falls in the previous 12 months; the number of pressure ulcers, of which there had been one in the previous 12 months; the number of Venous Thromboembolism, of which there had been one over the last 12 months; and the number of urine infections, of which there had been none in the last 12 months. The unit manager told us there were plans to display a dashboard within the new unit, but did not provide a timeframe for this.
- The quality dashboard also set out infection prevention and control statistics, including instances of MRSA bacteraemia over a period of 911 days and Clostridium Difficille (CDiff) over the same period. There were no such instances during the period. The dashboard also included the result of the most recent hand hygiene compliance audit, on 3 May 2016, at which a score of 85% compliance had been achieved. This was the hospital wide standard, meaning that no further action was taken. It also set out the number of compliments versus the number of complaints, and the number of medication related incidents since the last review on 27 May 2016.
- The clinical quality dashboard was available to all staff on the intranet. However, the results were not displayed publically on the unit.

Cleanliness, infection prevention and control and hygiene

- The hospitals housekeeping staff provided day to day cleaning of the department. They had supporting guidance and directives as to the standards required. The unit was visibly clean throughout our inspection.
- We observed the use of dated 'I am clean' stickers on equipment throughout the unit. These were up to date.
- Sharps disposal bins were appropriately signed, dated and sealed.
- There were clinical waste bins in each of the patients' rooms as well as bins for used Personal Protective Equipment (PPE).
- The sluice was visibly clean and clutter free.
- There was an infection prevention and control (IPC) link nurse for the service who worked with the hospital-wide IPC team. The role was to drive improvement in IPC within the unit through training, advice and audits. The IPC link nurse told us that the new unit was easier to keep clean.
- The IPC team carried out a monthly hand hygiene audit. There was also a World Health Organisation (WHO) 'five moments of hand hygiene' audit held three times a year. At the most recent five moments of hand hygiene audit, in June 2016, the unit scored an 85% compliance rate. This met with the hospital's own target.
- The hospital followed the National Reporting and Learning Service's (NRLS) national colour coding system for cleaning equipment. This meant separate items of equipment were used for cleaning the different areas of the unit, thereby minimising the risk of cross contamination.
- There were handwashing stations with sinks, soap and hand sanitising gel throughout the unit, and in each of the patients' rooms. Each of the stations had instructions on effective handwashing techniques. We observed staff and visitors using the stations.
- All of the staff we observed adhered to the 'bare below the elbow' protocol, which enabled them to wash their hands and wrists in accordance with best practice.
- There was no instances of CCU acquired MRSA, MSSA or C. Difficile in the reporting period. There were two instances of CCU acquired E. Coli in the period January to March 2016 and one in the period April to June 2016.
- There were no incidents of hospital-acquired blood infections on the unit in the reporting period.
- There were four rooms for respiratory isolation. These rooms had air-lock entry chambers, to ensure the pressure inside was maintained. There were pressure monitors outside each of the rooms which would alert staff if the pressure within the room was outside of normal range. These rooms had en-suite facilities.

- We observed a number of patients in respiratory isolation rooms. There were signs indicating that these patients were subject to isolation.
- On entering patient's rooms, staff used PPE, including disposable aprons. Advanced PPE was used when entering the rooms of patients in respiratory isolation, including full length, sleeved disposable aprons, surgical caps and masks and gloves.

Environment and equipment

- The service had moved into a new unit on the week of our inspection. The new unit had been designed by architects and designers working directly with the lead consultant and other staff to ensure that it was the best possible environment. The lead consultant told us that during the design process, life sized models of the unit had been built in the available space, to fully test their suitability, with actual nursing and other staff carrying out exercises in them.
- The rooms accommodated either Level 2 or Level 3 critical care patients, depending on acuity. Level 2 patients are defined in the Guidelines for the Provision of Intensive Care Services by the Faculty of Intensive Care Medicine as: Patients requiring more detailed observation or intervention including support for a single failing organ system or post-operative care and those 'stepping down' from higher levels of care; whilst Level 3 patients are defined as: Patients requiring advanced respiratory support alone, or basic respiratory support together with support of at least two organ systems.
- The unit was designed along three corridors, with the nurses' station and the reception desk located centrally, to allow ease of access to all areas of the unit. In addition, there was a computer desk situated outside each of the patient's rooms, to allow nurses to complete administrative tasks, whilst maintain observation of the patients.
- Five of the rooms (including the four isolation rooms) had en-suite facilities. For patients with restricted mobility, there was a ceiling hoist by which they could be lifted to the en-suite toilet, or to the commode.
- The four isolation rooms in the unit were positioned together at the end of a corridor, to allow staff to monitor these patients more closely and, further to ensure they were kept fully isolated from other patients when being transferred to and from the unit. The isolation rooms had their own sluice and store cupboard.
- On day one of the inspection, we learnt that there was only one commode available for those rooms that did not have en-suite facilities and this was being cleaned elsewhere in the hospital. The staff took immediate action and the following day, the unit manager informed us that a further seven commodes had been ordered and delivered to the unit, and were now available.
- All of the equipment had been newly acquired for the new unit. The hospital had introduced a database of assets to hold details of service and maintenance contracts and service records and to create capital replacement plans for equipment. Previously, department managers had been responsible for the renewal or replacement of equipment on their units.
- Resuscitation equipment for use in an emergency was checked daily. We saw equipment was documented as checked and ready for use. We reviewed documentation which indicated that resuscitation trolleys were checked and logged on a daily basis. Resuscitation trolleys were secured with breakable, coded tags. There was a hospital wide equipment team who could be contacted to repair and maintain equipment. Maintenance was also carried out by the equipment suppliers.

Medicines

- There was a designated pharmacist who visited the unit to ensure there was oversight of medicines prescribing and optimisation.
- Patient's allergies were clearly documented in their notes and on prescription charts.
- There was an antibiotic prescribing policy in place across the hospital. Prescribing staff had access to an application on their mobile telephone, tablet or computer providing up-to-date information and policies for the prescription of antibiotics and other medications.
- Medications were kept in a central medication store in the unit. This was kept locked, and was only accessible by electronic pass. During our inspection we discovered that the housekeeping staff, had access to the

medication store via their electronic passes. We raised this as a concern with the critical care manager. The following day, the housekeeping staff still had access to the medication store. We raised the issue again and confirmed that housekeeping staff no longer had access to the medication store. We were told that, following this incident a policy was being developed to allow for the store to be cleaned.

- There was a locked controlled drugs cupboard within the medication store. The keys to the cupboard were held by the nurse in charge.
- Controlled drugs were always administered and signed for by qualified staff. Agency nurses were required to administer controlled drugs only in the presence of a permanent member of staff. We saw completed records for the administration of controlled drugs, with both signatures present. There was also an up-to-date signature record for each permanent member of staff. These were stored in an unlocked draw in the nurses' break out room, which was accessible only by electronic pass.
- There were fridges in the medication store for medicines which needed to be kept at a specific temperature. The fridge temperatures had been checked and recorded daily by nursing staff and were in range for the period which the fridge had been in use.
- There was an airway trolley in the unit. This included equipment for intubation of difficult airways. The trolley was secured with dated tabs and had been checked and signed for by nursing staff on a weekly basis.
- In addition to the medications held in the store room, patients' individual supplies of prescribed medications were held in locked cabinets in their rooms.
- We saw an unlocked medication and equipment trolley in the corridor, which we discovered contained the drug lidocaine. We raised this concern with the unit consultant. We were told that staff used the trolley for convenience, but that a storage space had not been assigned for it following the move to the new unit. Following our raising the concern, the trolley was immediately relocated to the main medication cupboard, and information shared with all the staff. The following day, the trolley remained locked in the cupboard.

Records

- Critical care assessment proformas were used to assess the level of care required by each patient throughout their stay on the unit.
- Patient records were readily available, and updated through a secure online system to which all clinical staff had access. Agency staff also had access to the online record system. All of the staff we spoke with, including agency staff said that records were readily available and there were no issues in accessing them. We observed staff locking computer screens before leaving them.
- We were told that there was no formal audit process for notes within the unit. There were, however, audits of a random selection of five patients' nursing notes from across each of the in-patient departments of the hospital, including the critical care unit. These were carried out in June, July and August 2016 and were found to be compliant with the Hospital's expectation.
- We checked a number of patient's records. They were satisfactorily completed and signed. With consent sought and documented where appropriate.

Safeguarding

- Safeguarding and child protection formed part of the mandatory training requirement for all staff. 79% of staff in the critical care unit had completed adult safeguarding courses.
- All of the staff we spoke with had a good understanding of safeguarding and when and how to make a referral. Within the team structure there was a 'safeguarding team', whose non-clinical focus was on issues of safeguarding. Staff told us that this meant they were always working with someone with safeguarding expertise. There were posters in staff areas providing contact details for the hospital's safeguarding lead.
- Staff were aware of issues relating to female genital mutilation (FGM) and child sexual exploitation (CSE).

Mandatory training

- Prior to our inspection, the hospital management team provided us with the mandatory training records for the unit. Mandatory training included fire safety; safeguarding vulnerable adults; and health, safety and welfare. Data provided by the hospital showed 86% of

the nursing care directorate and 75% of the medical directorate had completed training in health and safety. Fire safety training had been complete by 90% and 83% respectively.

- Data provided by the hospital showed 91% of staff in the nursing care directorate and 92% in the medical directorate had completed safeguarding vulnerable adults.
- During our inspection, the management team on the unit were unable to access mandatory training records and were unclear as to which staff had undertaken which training. They told us this was being addressed and that it was the role of the new clinical educator to improve training compliance, access and information across the unit. The clinical educator was responsible for ensuring nursing staff on the unit had had their appraisals.
- There was a filing system in the office in which staff were expected to place certificates of any training they had undertaken in a drawer marked with their name. However, not all of the drawers contained certificates.
- 21 staff members had completed an Intensive Life Support course, whilst 11 had completed an Advanced Life Support course.

Assessing and responding to patient risk

- There was a policy on the management of deteriorating patients in place across the hospital. This had been developed by a consultant, a doctor and the critical care outreach sister.
- There was a critical care outreach team. The team visited critically unwell patients throughout the hospital daily, seven days a week, to monitor whether they required admission to the unit and also visited patients who had been stepped down from the unit to wards, to ensure that their recovery was continuing.
- Staff we spoke with demonstrated a clear understanding of escalation procedures for deteriorating patients and their responsibilities for doing so.
- The unit used an early warning score system to assess patient risk. We saw completed early warning score records for patient on the observation chart kept in each patient's room. Nurses recorded observations on the EWS score card, which allowed them to calculate the risk of deterioration and refer the patients to the clinical fellow on duty for assessment and treatment.
- The physiotherapists completed a rehabilitation dashboard for each patient, to measure their recovery. This included a delirium score. We saw completed delirium scorecards for patients.
- In addition, the rehabilitation dashboard included questions to determine whether the patient required referral to the Speech and Language Therapy team; a Chelsea Critical Care Physical Assessment Tool (CPAx); an anxiety and a mood score.
- Staff completed fluid balance charts, to ensure patients remained hydrated.
- The unit had recently introduced a revised "sepsis 6" pathway, to manage patients with sepsis. The standard observation chart included an assessment of sepsis risk. On the back of the chart there was a flow-chart setting out the current sepsis pathway. This stated that if a nurse considered their patient to be septic, they should ensure that a clinical fellow and a member of the hospital-wide sepsis outreach team were present within 30 minutes and immediately commence the Sepsis 6 pathway.
- We were informed the staffing numbers in ICU allowed for them to respond to emergency calls from other areas. On receipt of an urgent call, the senior nurse attended to support with the emergency situation.

Nursing staffing

- Nurse staffing levels met the standards set out in accordance with intensive care society guidelines; level 3 patients received 1:1 care and high dependency patients received 1:2 care.
- Each patient on the unit had one to one nursing care, with one nurse allocated solely to that patient for their shift.
- The established nurse staffing was; 5.5 whole time equivalent (WTE) Band 7 nurses; 10 WTE Band 6 nurses, with three vacancies; 40 WTE Band 5 nurses with a vacancy rate of 30 unfilled roles.
- The 75% vacancy rate was based on a new model of nursing for the new Intensive Care Unit (ICU). In the

former ICU staffing was based on 1:2 nurse to patient ratio for level 2 and 1:1 for level 3 patients. When the new unit opened it was thought a nurse to patient ratio would need to maintain 1:1 consistently. However, following detailed practice sessions they concluded that a 5:3 ratio was more appropriate, to ensure availability of runners and meal relief. The practice educator, ward manager and shift lead were not included in the daily numbers.

- The vacancy rate was based on a 5:3 nursing ratio running at full capacity, however, the unit had an average occupancy of six out of 13 beds. There was a plan for phased recruitment, as bringing in too many new members of staff to such a unit at the same time would not have been safe. Further, using regular bank and agency staff, who were well known to the hospital was safe and efficient.
- The agency nursing staff were in the main regular attendees and had a good awareness and understanding of the requirements of the unit and hospital. The unit manager told us that all agency staff underwent an induction to the unit. This was confirmed by the agency staff we spoke with. The manager said that wherever possible, they also used the same agency staff members, to ensure continuity of care.
- The unit manager told us that the vacant nursing posts were currently being advertised. They said that there was a difficulty in recruiting nurses in the area with the relevant skills and experience. Prior to employment on the unit, nurses were required to have at least one year's experience working on a critical care unit in the UK.
- Managers and staff we spoke with said that despite heavy reliance on agency nurses, the unit was never short staffed. The unit sourced nursing staff from one agency and tried to use the same individuals where possible. We were told that there was a good working relationship with the agency and agency staff, allowing the unit to obtain additional staff or cancel agency bookings at short notice. We observed the ward clerk contacting the agency with one day's notice to cancel a booking.
- At the time of the inspection, there were additional nurses on the unit. We were told that this was part of the action plan to mitigate against risks arising from the move to the new unit and had been the case since the move to the new unit.
- In addition to the staff on the unit, there was a critical care outreach team. The team acted as a link between the unit and the rest of the Hospital. Further, the team visited critically unwell patients throughout the Hospital to monitor whether they required admission to the unit and also visited patients who had been stepped down from the unit to wards, to ensure that their recovery was continuing. The outreach team visited relevant patients daily, seven days a week. Outreach team members that we spoke with told us that they felt part of the wider critical care team. They were involved in the monthly team days.
- We attended a morning handover. The handover was informative and well managed. Nurses were able to challenge the views of colleagues and managers.

Medical staffing

- Medical staffing levels met the standards set out in the Core Standards for Intensive Care Units of the Faculty of Intensive Care Medicine.
- The unit had a lead consultant, who along with four other consultants worked for the hospital via practising privileges. The lead consultant worked in line with the Core Standards for Intensive Care Units of the Faculty of Intensive Care Medicine.
- The lead consultant ensured each consultant took a turn to be on-call. Twice daily ward rounds were undertaken by the on-call consultant. All consultants lived within 30 minutes of the hospital, which enabled them to return to the unit should the need arise.
- In addition, there was a registered medical officer (RMO) on duty 24/7. All of the RMOs on the unit were clinical fellows, undertaking research at a local university. Their supervision was managed through the universities. The clinical fellows worked 24 hour shifts, remaining on site throughout. Their supervision was managed through the universities. The clinical fellows worked 24 hour shifts, remaining on site throughout. Their roster was planned so that they did not work nights on two consecutive shifts. RMOs attended handovers at 8am with the senior nurse on shift. In addition, they attended

the daily briefings in ICU with the senior nurse on duty and outreach team at 10.30am and 10.30pm. The senior nurse on duty was aware of which RMOs were on shift. There were six RMOs connected to the unit.

- The RMOs we spoke with said that they had a good working relationship with the consultants practising on the unit.

Emergency awareness and training

- There was a hospital wide business continuity plan, which identified the primary risks such as fire, or an emergency situation in the surrounding area.
- We saw the unit's fire evacuation standard operating procedure. This was clear, detailed and up-to-date.
- Staff told us that they had taken part in fire evacuation drills including the use of safety skipads and blankets for immobile patients. They were confident of the process of evacuation and their role in it.
- The hospital had backup generators in case of a power outage.

Are critical care services effective?

Good

We rated effective as good.

Evidence-based care and treatment

- We reviewed a sample of trust policies and found appropriate reference to relevant National Institute for Health and Care Excellence (NICE) and Royal College and Intensive Care Society and Association of Anaesthetist guidelines.
- At the time of our inspection, the critical care outreach team were developing a newly revised hospital-wide sepsis pathway. This involved the introduction of sepsis boxes, containing information, equipment and medication for treating patients suffering from sepsis. We saw prototypes of the boxes. The new pathway was due to be launched shortly after our inspection.
- We had sight of hospital-wide audits from the reporting period. We were not provided with records of localised audits. However, the hospital-wide audits did highlight where there were concerns in specific areas of the hospital. The controlled drug audit for April 2016 indicated that there were some crossings out in the controlled drug book, otherwise the unit performed well. The audit indicated that the pharmacist would provide the unit with an action plan to address the highlighted concerns. However, we were not provided with a copy of this action plan.
- The unit scored 90% in the hospital-wide five steps to hand hygiene audit in February 2016 and 85% in June 2016. The hospital's expected compliance was 85% and as such, no further action was required.
- There were hospital-wide audits of missed medication doses and pharmacist interventions; however, this was not broken down into specific units.
- In September 2016, the unit had introduced discussion of the results of audits as a standing agenda item at the monthly team days. In addition, there was a monthly quality forum at which senior staff discussed the outcome of audits.
- Following our inspection, we were provided with an audit plan for 2017, this included audits of safeguarding compliance, records quality, equipment, VTE, infection prevention and control, compliance with the sepsis 6 pathway and use of Early Warning Scores (EWS). Each of the audits had been assigned to be carried out by one of the 6 teams based on the unit.
- Physiotherapists on the unit completed an Intensive Care Physiotherapy Short Clinical Assessment Form on the patient's admission to ICU; prior to discharge from ICU and on the ward. This included both an assessment of both physical and non-physical symptoms and was based on the NICE clinical guideline 83- Rehabilitation after critical illness.

Pain relief

- The unit applied the Royal College of Anaesthetics' Core Standards for Pain Management in the UK.
- There was a hospital-wide pain team, who visited the unit daily. All of the staff we spoke with were aware of the pain team and said that they had a good working relationship with them.
- One of the patients we spoke with told us that their pain had been managed effectively throughout their time on the unit. They said that pain relief medication was administered in a timely manner when requested.

- Patient notes that we looked at indicated that pain management was regularly reviewed and was individualised to meet individual patient's needs. Pain relief was administered to patients by their named nurse. Where the pain relief medication was a Controlled Drug, this was appropriately signed for by two registered nurses.
- The efficacy of pain relief was monitored by the hospital wide pain team and the RMOs and adjusted in consultation with the patient's named consultant. We saw evidence of changes to pain relief having been documented. Further, patients had 'step up' pain medication prescribed for them to administer by the RMOs in accordance with guidelines set down in the notes by their consultant.

Nutrition and hydration

- Staff used a nutritional assessment tool to monitor patients' needs on the unit.
- Patients with sufficient mobility had access to water within easy reach. Patients with restricted mobility were assisted in eating by their named nurses.
- Dietitians visited the unit on a regular basis to monitor patients and were involved in both the admission and discharge processes; in developing nutrition plans for patients for their stay on the unit and on their return to the ward.

Patient outcomes

- The unit submitted information to the Intensive Care National Audit and Research Centre (ICNARC). We saw the ICNARC Quarterly Quality Report for the 1 April 2015 to 31 March 2016. The unit was performing above average in all of the areas assessed by ICNARC. The ICNARC audits allowed the unit to benchmark against comparable providers nationally. The unit scored within the expected range for a unit of its size in the ICNARC data for the period April 2015 to March 2016. For example the unit scored 1.05 for risk adjusted acute hospital mortality (ratio of observed to expected) for the same period; out of a range of 0.3- 2.0.
- The hospital carried out DNACPR) audits. There was 100% compliance with DNACPR policies.
- The unit had a 2% readmission rate to CCU within 48 hours of discharge, placing it within the modal range for comparable units.
- There were monthly audit meetings for link nurses to learn from audit results. Information and learning was then fed back to staff on the unit at the team days.
- In the period January to June 2016 there were 11 patients requiring resuscitation. The Hospital kept a record of all resuscitation attempts and the Hospital's named resuscitation officer carried out a RCA of the incident. We had sight of one of the RCAs, which included recommendations for future improvements to the process and action plans to avoid any identified risks in future.

Competent staff

- The unit met the skill mix requirements and staff to patient ratios outlined in the Guidelines for the Provision of Intensive Care Services. The guidelines state that a minimum of 50% of registered nursing staff will be in possession of a post registration award in Critical Care Nursing, whereas 100% of permanent nursing staff on the unit were in possession of such an award. The hospital ensured that agency nursing staff also had critical care training.
- A clinical nurse educator was appointed at the beginning of November 2016 and was responsible for co-ordinating education and training and ensuring continued professional development of staff.
- The RMOs all had previous experience working on critical care units and had the skills and expertise to care for critically unwell patients. We saw evidence of their previous work experience and training.
- Consultants' practising privileges were the responsibility of the hospital's clinical governance lead and were reviewed at medical advisory committee (MAC) meetings. The clinical governance lead was also responsible for arranging yearly refresher training for consultants.
- We were told that staff were all up to date with their appraisals. However, a number of staff we spoke with could not recall when they had had their last appraisal. We were not provided with evidence of staff appraisals, as neither the unit manager nor the clinical educator had access to this information.

Multidisciplinary working

- Physiotherapists were present on the unit, and played an active part in consultant ward rounds.

- The unit had a good working relationship with other wards and departments at the hospital. Patients admitted directly from surgery were brought from the recovery area. We spoke to staff in the recovery area, who described a positive working relationship with the critical care unit. There were clear lines of communication between the unit and the recovery team to ensure that staff on both units were kept informed about potential delays and issues.
- There was a clear process for transfer to other wards within the hospital. We spoke with a patient who was due to be discharged back to the ward that day, but remained on the unit due to low blood pressure. This was being managed by the RMO, and the patient was under continual assessment for return to the ward. Staff on the receiving ward were kept notified throughout.
- Throughout our inspection, physiotherapists and dietitians were present on the unit. We observed them taking part in the senior consultant's ward round, and engaging with patients, their families and other staff.
- Physiotherapists and dietitians were part of the multidisciplinary team (MDT). MDT meetings were held weekly, at which patient's care plans were discussed.
- We spoke with a physiotherapist who said that they felt part of the team and that their work was supported by other staff on the unit.

Seven Day Working

- Consultants were available seven days a week and lived within half an hour of the hospital. There was an on-call rota and a buddying system for consultants to ensure 24 hour cover.
- Physiotherapists, dietitians and other allied health professionals routinely worked on Saturdays, and nursing staff told us that they were available on Sundays if required.

Access to information

- There were clear lines of communication between staff in theatre recovery and the unit.
- All clinical staff had access to patients' records through the secure online record keeping system. Agency staff also had access to the system where necessary. All of the staff we spoke with said that they had never faced any issues in accessing patients' records.
- Discharge forms were completed for patients transferred to the ward, detailing the treatment and medication they had received on the unit.
- Internal policies and external guidelines were accessible through the hospital's intranet. On the unit's shared drive, the relevant policies had been compiled into a searchable document by the clinical educator. Staff we spoke with confirmed that information easily accessible on the system.
- Learning from incidents and policy updates were shared at monthly team meetings and via team-wide emails. The minutes of team meetings were added to a printed folder and signed by all staff as read, the folder was then stored in the unit manager's office for future reference. We reviewed this folder and saw that the minutes had been signed by staff.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards (medical care patients and staff only)

- Due to unavailability of complete training records within the unit at the time of our inspection, there was no evidence that staff had completed Mental Capacity Act (MCA) or Deprivation of Liberty Safeguards (DoLS) training. However, all of the staff we spoke with had a clear understanding of the principles of the MCA 2005 and DoLS.
- We observed one of the RMOs obtaining verbal consent before carrying out an examination of a patient and before taking blood from the patient.
- We reviewed three signed consent forms. These were appropriately completed.
- We also observed a translator assisting a consultant in explaining treatment options and expected outcomes to a patient whose first language was not English.
- At the time of the inspection, there was a patient on the unit with a do not attempt cardio-pulmonary resuscitation 'DNACPR' form in place. We had sight of the DNACPR form. The form had been appropriately completed and signed, including evidence of the discussion between the patient, the consultant and the patient's family.
- There was an up-to-date consent policy, which detailed all aspects related to the process to be followed.

Good

Critical care

- Delirium assessment was part of the Intensive Care Physiotherapy Short Clinical Assessment form. We reviewed a number of completed forms, and saw that they had been properly completed.

Are critical care services caring?

Good

We rated caring as good.

Compassionate care

- We spoke with three patients who were overwhelmingly positive about the care they received from staff.
- We observed positive, caring interactions between staff and patients and their families.
- One of the patients we spoke with described the staff as going 'above and beyond' to care for her. They told us that, following surgery, they had been afraid and that the nurse assigned to care for them in the unit had made them feel safe and reassured.
- We observed a consultant in conversation with a patient's son. The consultant appeared to know the patient and spoke with him with care, compassion and interest.

Understanding and involvement of patients and those close to them

- Staff told us that discussions with patients regarding organ donation were handled sensitively and leaflets were available.
- Patients and their family members told us that they were kept informed about their care and were provided with sufficient information to make informed decision about their care. In addition, they said that they had been kept informed about the cost of care through sensitive discussions.

Emotional support

- There were counsellors based in the hospital who could be called on to provide counselling services to both patients and their families.
- We also observed medical and nursing staff offering emotional support to an upset patient.
- Nursing staff told us that the one to one named nurse policy meant that they could form effective relationships with patients under their care, and they could offer appropriate emotional support where necessary.
- The unit was undertaking a project with the Helen Hamlyn Centre at the Royal College of Art, whereby the hospital funded arts students who were working to develop a tablet-based application to allow for greater personalisation of care, and emotional support for patients.
- The unit had established a good relationship with local religious organisations. Multi-faith chaplaincy services were provided. Staff we spoke with were aware of how to access a chaplain on a patient's behalf.
- There was a yearly multi-faith service held annually for staff, former staff, patients' families and former patients from the hospital. Staff told us that this was an effective way to provide on-going support for patients who had been seriously ill on the unit.

Are critical care services responsive?

Good

We rated responsive as good.

Service planning and delivery to meet the needs of local people

- The majority of patients cared for on the CCU were self-funded patients from overseas. The unit 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. Throughout the reporting period, the majority of patients had been medical patients. The majority of the patients on the unit were elderly.
- Through the international office, the hospital maintained positive working relationships with the embassies of the countries which the majority of its

overseas patients came from. We visited the international office, which in addition to liaising with foreign embassies, also provided translation services to patients and cultural information to clinical staff.

- There were arrangements in place for family members to stay at the hospital. In addition, family members could purchase food from the on-site restaurant, or from the patient menu.
- There were televisions in each of the rooms, showing programmes in English and multiple languages.

Access and flow

- There were 4,026 critical care bed days available in the hospital during the reporting period (Jul 15 to Jun 16). Out of all critical care bed days available 1,154 bed days were used for level 2 care, giving an occupancy rate of 32%. Out of all critical care bed days available 798 bed days were used for level 3 care, giving an occupancy rate of 20%. As such, there was an overall occupancy rate of 52% during the reporting period.
- The unit's Operational Policy stated that in order to meet admission criteria for the unit, the "patient must be cardiovascular stable with a patent airway adequately ventilated; there must also be adequate intravenous access and the patient must be adequately sedated where appropriate." The policy was made available to staff in other units, and was accessible through the intranet. Theatre staff that we spoke with were aware of the inclusion and exclusion criteria for critical care.
- In addition, The London Clinic Transfer Policy stated that: "A patient who requires continuous nursing care at level 2 or 3 and patients who are being ventilated or have compromised respiratory ability, should also have medical staff in attendance. In such cases, if a second porter is required to aid with transfer of these critically ill patients the nurse in charge must state the reason".
- During the reporting period, there had been no patients refused admission to the unit.
- At the time of our inspection, the unit was not operating at full capacity. This was because it was a new unit, and the decision had been taken to allow staff to get used to the unit before all rooms became fully operational.
- We were told that patients were admitted to the unit within four hours of the decision to admit. We were told that there were rarely delays in getting patients onto the unit and that as a result, surgery lists were not delayed by a lack of critical care beds. The unit did not, however, audit the time between the decision to admit the patient and the actual admission.
- Generally, patients were discharged from the unit to one of the wards within the hospital. Following discharge, the critical care outreach team visited the patients in the wards to monitor their recovery. Discharge summaries were completed by consultants and made available to the staff on the receiving ward via the electronic records system.
- We were told that delayed discharges were very uncommon. However, during the reporting period there had been a complaint from a patient whose discharge was delayed from 10:30 until 19:00. The unit did not audit discharge times or keep a record of delayed discharges.
- Overseas patients' discharges were arranged by the international office. We observed the arrangements for booking a flight for a patient requiring medical support on the flight. The international office maintained contact with the relevant embassies throughout the patients' time at the hospital and following their discharge.

Meeting people's individual needs

- Rooms in the new unit were soundproofed for patient's increased comfort. All of the rooms had glass walls facing the corridor, allowing for staff to observe patients as they passed through the unit, and for patients to enjoy natural light. Patients could control the tint of the windows for their privacy, and could alter the lighting in the room to suit their mood.
- Translation services were based in the international office. There were translators for numerous languages employed directly by the hospital. Translators were available from 8am until 8pm every day, including weekends. Outside of these hours, or where the patient's language was not spoken by the translators, there was a telephone translation service.
- We spoke with a translator, who told us that they felt a valued member of the team. They told us that they were involved in all communications with patients, including admission and discharge.

Good

Critical care

- Dementia and Learning Disability (LD) training was not part of the mandatory training. However staff we spoke with were aware of the dementia policy and the use of the "This is Me" document. During our inspection there were no inpatients living with dementia or LD.
- Staff told us they would be made aware that a patient with LD was being admitted prior to their admission and would ensure that an appropriate care package was developed.
- We saw leaflets in both English and Arabic. All signs in the unit, however, were in English.
- Information was accessible throughout the unit in the form of posters and leaflets. Leaflets could also be obtained in different languages through an online translation system.
- All patients had access to a menu from which food could be ordered 24 hours a day and prepared within half an hour.
- Food was available for patients' families from the patient's 24 hour menu, as well as from the on-site café in another part of the Hospital. There was no accommodation for patient's families within the unit. However, there was accommodation available to patients' families elsewhere in the hospital. Further, the international office could assist in arranging hotel accommodation for overseas patients' families.

Learning from complaints and concerns

- We saw 'how to make a complaint' leaflets in the unit. The leaflet made reference to and provided contacts for the Parliamentary Health Services Ombudsman and the Care Quality Commission.
- There was a hospital-wide patient experience manager who undertook daily rounds across the hospital, including the critical care unit, They were available to facilitate visits to patients, for advice and to provide resolutions on weekdays.
- There was a clear process for escalation and investigation of complaints and concerns. Patients could report a complaint to a staff member. This was then raised as a concern on the online incident reporting system. This would then be escalated to the unit manager and other relevant parties for investigation. Complaints were managed in line with the hospital-wide complaints policy.
- In addition, all patient complaints were discussed daily at the hospital-wide matron's handover, which was attended by senior staff from the unit. This ensured that complaints were being progressed in a timely manner, that appropriate resources were allocated for investigating and resolving complaints and that actions arising from complaints were being taken. There was also a weekly hospital-wide quality review group which discussed and implement any themes, trends, learning and any changes that needed to take place.
- There was one complaint in the reviewing period. This related to a delay in discharging a self-pay patient from the unit from 08:30 to 18:00 due to how busy staff were across the Hospital. The complaint was fully investigated within the established timeframe and the patient received a written apology and a discount off their overall fee for their treatment.
- Following our inspection, the hospital provided us with examples of learning from concerns raised by patients and family members on the unit, such as the introduction of a new visitor policy in August 2016 to allow patients "quiet time". We were told that this had reduced the number of concerns with reference to noise and disturbances within the unit.
- Learning from complaints and concerns was shared at team meetings, and at the monthly team days. We saw examples of this in the minutes of team meetings.

Are critical care services well-led?

Good

We rated well-led as good.

Vision and strategy for this this core service

- The unit shared its vision with that of the Hospital, to be the most trusted hospital.
- In addition, there was a documented strategy to coincide with the opening of the new unit for the period of 2016 to 2019.

Good

Critical care

Governance, risk management and quality measurement (medical care level only)

- The service governance processes were the same throughout the hospital. We have reported about the governance processes under surgery service within this report.
- There was a critical care service monthly governance meeting. We saw the minutes for these meetings. They were attended by a multidisciplinary team, including the unit manager, the clinical educator, members of the pain and outreach teams a dietitian, nutritionist, and nursing staff from the unit. The meeting reviewed incidents reported through the online reporting system as a standing agenda item.
- There was a local risk register for the unit. This was maintained by the unit manager. Each of the risks identified had an action plan against it with timescales for implementation. At the time of our inspection, one of the key risks identified on the register was the shortage of permanent nurse staffing. The action plan for this risk included a recruitment drive, the adverts were due to be placed in November 2016, following our visit, in line with the time frame stated on the register.
- There was also a specific risk register relating to risks arising from the move from the old into the new unit in November 2016.
- The unit had links to the Medical Advisory Committee (MAC). The lead consultant for intensive medicine was also the chair of the MAC. The move to the new unit and the challenges this would present had been discussed at MAC meetings.
- We saw the minutes of the MAC meeting, at which the challenges of ensuring service continuity following the move to the new unit had been discussed.
- Another aspect of general risk management oversight was the daily 10.30am meeting was held in the ICU. This was attended by the ICU senior staff, ICU fellow/RMO, the emergency bleep team members for that day (red team and yellow team) and the Senior Nurse. They discussed all patients who were seriously ill, those ready to leave the ICU environment, those with active DNACPR and any concerns from those on the emergency bleep team for the day may have. This was facilitated by the Senior Nurse on duty for the Hospital.

Leadership and culture of service

- The unit was managed by the ICU manager who reported directly to the matron/director of nursing.
- The critical care manager had responsibility for the day to day running of the unit. He was, in turn, managed by the matron of the hospital. The critical care manager had recently appointed a clinical educator to ensure that all staff on the unit had the relevant skills and expertise to carry out their role safely and to resolve the issues around mandatory training. The clinical educator was new in post at the time of our inspection. The post of deputy unit manager was vacant at the time of our inspection. There was also a ward co-ordinator and two critical care assistant posts, one of which was also vacant at the time of our inspection.
- Throughout our inspection, senior staff members were visible on the unit. Junior staff that we spoke with confirmed that this was the case at other times.
- The local leadership demonstrated experience and knowledge of managing a critical care unit. They had a clear vision for the future of the unit, which was intrinsically linked to the move to a new physical environment. As such, at the time of our inspection, many of the leadership and cultural innovations, for example the introduction of team days and the new clinical educator role, were in the planning or early stages, and consequently there was little evidence to demonstrate what impact they had had to date.
- There were two monthly staff days on the unit, which all of the permanent members of nursing staff were rostered to attend. Each of these days was led by one of the six nursing teams, and focussed on that team's area of expertise. We saw the programmes for previous staff days. These included internal and external guest speakers and a chance for staff to raise issues with the leadership team.
- Staff were overwhelmingly positive about the local leadership of the service. They told us that they had been initially reluctant to engage with the new system of monthly staff days that the unit manager had introduced, but all said that they had come to see the value of the days. They found them an essential part of their learning and development and of the culture of the team.

- Staff said that the local leadership was supportive and approachable.
- Staff described an integrated and supportive multidisciplinary team across the unit. One of the staff members we spoke with described the camaraderie on the unit, describing it as “a lovely place to work”.
- We were told that the unit always sought to use the same agency staff wherever possible, to ensure continuity of care. The agency staff that we spoke with confirmed that this was the case and said that they enjoyed working on the unit, where they were made to feel part of the team.
- There was an audit nurse attached to the unit, responsible for carrying out the various local and hospital-wide audits, and feeding back to the local leadership team and the hospital’s clinical governance team.

Public and staff engagement

- Staff were enthusiastic about their role on the unit, and the team they were a part of. They told us they felt engaged in decisions that were made regarding the day to day running of the unit.
- A number of staff we spoke with said that they had been consulted at various stages of the design and building process for the new unit. They felt that their views had been listened to. The lead consultant told us that during the design and building of the new unit, mock-ups of the rooms had been created, and staff were invited to participate in simulations of work, before giving feedback as to the impact of the various physical environments on their practice.
- We were told staff were given the opportunity to attend an annual multi-faith memorial service at a local chapel, alongside former patients, their families and members of the wider community.
- We saw leaflets in communal areas on the unit inviting patients and family members to provide feedback on their experience on the unit. In addition, we were told that the hospital-wide patient experience manager undertook

Innovation, improvement and sustainability

- The unit manager had introduced an innovative new team structure. The permanent nursing staff were divided into six teams, in addition to the critical care outreach team. Each team had an area of focus: data, equipment, infection prevention and control, quality, safeguarding and safety. Staff within these teams had these subjects as the focus of their non-clinical work and each team took it in turns to host the monthly team day. Staff said that this meant they knew who to ask for advice about different areas of practice. All of the staff we spoke with praised the new to team structure. Some said that they had been initially reluctant to engage with it, but that they could now see the merits of the system.

Outstanding ☆

End of life care

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

Are end of life care services safe?

Good ●

We rated safe as good.

- There was an open culture of learning. Staff were candid when things went wrong and the staff were able to describe scenarios where they had learnt following an incident.
- Clinical environments were clean and well maintained. Medical equipment was accessible and maintained.
- Patients were risk assessed in line with national standards. Action was taken where patients were identified as being at risk; for example, development of venous-thrombo emboli (VTE).
- There were sufficient numbers of staff to meet the individual needs of patients.

Incidents

- There were no incidents reported by the Palliative and Supportive Care Team (PSCT). We were assured any incidents appearing on the hospital's datix system in the future would be fed through to the EoLC steering group.
- There was evidence that incidents were considered by the EoLC steering group to determine any themes or trends which required addressing.
- Staff were aware of their responsibilities in regards to the reporting of incidents. Staff could describe the types of issues which constituted an incident. Staff were conversant with the need to report near miss and no harm incidents. This ensured that there were no missed opportunities to learn from when things may have gone wrong or not as intended.

Mandatory Training

- All four nursing staff working within the SPCT had completed fire and health and safety mandatory training and where necessary, future updates had been planned and booked. Three of the four nursing staff had completed information governance training; data was missing for one member of staff.
- The management of end of life care patients had been included as part of the hospitals mandatory training programme. At the time of the inspection, approximately 200 staff had received training in regards to the individualised care plans. Non clinical staff also received training to help raise awareness of managing end of life care patients, relatives and each other.

Safeguarding

- The PSCT had all completed the required safeguarding training. Staff we spoke with all had a sound understanding of their responsibility in relation to safeguarding adults.
- At the time of the inspection there had been no safeguarding concerns reported for EoLC patients at the hospital.

Cleanliness, infection control and hygiene

- We observed PSCT staff comply with hand hygiene requirements; staff used personal protective equipment appropriately.
- Clear guidance was available for staff to follow to reduce the risk of infection when providing end of life care or caring for people after death.

End of life care

Environment and equipment

- Six syringe drivers were available at the hospital and staff we spoke with were aware of how to access and use them. These were serviced and maintained in line with medical devices guidance.
- The hospital did not have in-house mortuary services and so this was not considered as part of the inspection.

Medicines

- We witnessed few EoLC prescribed medications due to the low numbers of patients receiving end of life care at the time of inspection. However those we did review were in line with the National Institute for Health and Care Excellence (NICE) CG140 'opioids in palliative care' and NICE QS13 'end of life are for adults'. The individualised end of life care plan included evidence based algorithms to support the prescribing of appropriate anticipatory medicines.
- An audit of end of life care provision conducted by the clinical lead in August 2016 identified that in ten of eleven cases, anticipatory, as required medicines had been prescribed.
- Controlled drugs (CD) were securely stored within a locked environment. We saw records of checking both the use of CD and stock levels daily.
- There was no palliative pharmacist at the hospital; however the PSCT could access the services of the oncology pharmacist on the Duchess of Devonshire wing.

Records

- We inspected patient records on various wards where EoLC patients may be found. Such records were up to date, well completed and readily available.
- The hospital had a Do Not Attempt Cardio Pulmonary Resuscitation (DNACPR) guideline. Staff we spoke with were aware of the guideline and knew how to access it. An audit of 11 records identified that in 90% of cases, a DNACPR form was included in the notes. Where there was no DNACPR form for the eleventh patient, there was evidence of the decision having been made that the patient was not for resuscitation, which was recorded in the medical notes. Whilst we acknowledge the good practice of having the decision recorded in the medical notes, the lack of a formal DNACPR form, which are used as visual reminders to staff of a patients resuscitation status, could have led to a patient being inappropriately resuscitated.
- Of the 10 DNACPR forms present, 80% had been fully completed. A record of discussion with the patient, regarding DNACPR had been carried out in 55% of cases. For the remaining case notes audited, there was a recorded rationale as to why a discussion regarding DNACPR had not been had with the patient. There was evidence that discussions regarding DNACPR had taken place with relatives of the patient in 90% of cases. The audit had acknowledged that the depth of detail of discussions regarding DNACPR was variable. Outcomes and agreed actions resulting from the audit were considered by the end of life care steering group and had been disseminated across the London Clinic.

Assessing and responding to patient risk

- For patients where the progression of their illness was clear, the amount of intervention was reduced to a minimum. Care was based on ensuring the person remained as comfortable as possible, at all times. Proactive, anticipatory care plans were put in place to ensure that non specialist staff were aware of the best way to manage symptoms that were likely to present as part of the disease progression. The individualised end of life care plan had been designed around NICE guideline 31 – Care of dying adults in the last days of life.
- The identification of deteriorating/dying patients was a particular area of interest and education on the Haematology Unit which was to be commended. In conversation with staff on the unit we were impressed with their ability, knowledge and skills around identifying the deteriorating patient and their confidence in conveying this to the medical teams who were often not based at the hospital.
- The clinical lead and nurse specialists had introduced symptom assessment tools to help support non-specialist staff to effectively and safely manage the dying patient. The Support Team Assessment Schedule (STAS) was a validated tool for use the in the palliative care population. Its use was to assess individual patient needs and individual responses to interventions in order

that the effectiveness of care could be measured and symptoms better controlled. The tool could also help identify where additional staff may be required if a patient's clinical needs become more acute or intensive.
- The clinical lead conducted an audit of 11 randomly selected records in August 2016 and mapped the outcomes against the most commonly experienced problems experienced by patients using the London Clinic service. The audit provided some evidence that patient's symptoms improved with input from the specialist team. The audit acknowledged that further work was required to ensure that staff routinely completed the STAS score. However, we acknowledged that the introduction of STAS had been relatively new at the London Clinic. A concise action plan and learning from the initial audit had been shared with the wider team to drive improvements.

Nursing staff

- The PSCT consisted of the palliative medicine consultant, a lead clinical nurse specialist (CNS) and three additional CNS's responsible for symptom management, supportive care and complex discharge respectively. There was also a palliative care service administrator. The team worked five days a week (Monday to Friday) and were available to provide face to face support between 8.30am to 6pm. The consultant worked at the hospital three days a week, and was available out of hours via telephone.
- The PSCT described itself as an advisory service for inpatients at the London Clinic, and those attending the hospital for day case treatments and procedures. All of the members were employed directly by the hospital.
- The PSCT worked in conjunction with the patient's named consultant and their team, and did not take over the care of patients.

Medical staffing

- Patients were admitted for medical care under the responsibility of the designated consultant.
- Consultants working at the clinic had been granted practising privileges. Practising privileges is a term used when doctors have been granted the right to practise in an independent hospital. This right is subject to various checks on for example; their professional qualifications, registration, appraisals, revalidation, and fitness to practice declaration.
- As part of their practising privileges agreement, consultants had to be available on-call 24 hours a day whenever they had an inpatient under their care in the clinic. Staff told us consultants attended promptly to review patients where there were clinical concerns.
- We witnessed EoLC patients being discussed in detail at ward level multi-disciplinary team (MDT) meetings with inputs from the resident medical officer (RMO), physiotherapy, pharmacy, a nutrition nurse and the PSCT.
- Resident medical officers (RMOs) provided medical cover 24 hours a day, seven days a week. This ensured nurses could always quickly escalate any issues concerning a deteriorating patient. The RMO also informed the patient's consultant in an emergency so that they could provide consultant-level care.
- We witnessed a morning handover on an oncology ward attended by the charge nurse, staff nurse and the RMO. All of the current patients were discussed and the three new admissions. An update on their overnight condition was given along with their national early warning score (NEWS). The NEWS is an observational guide used by medical staff to quickly determine the degree of illness of a patient. We also heard blood results, nutritional and falls risk and fluid balance being discussed.

Major incident awareness and training

- The PSCT had a business continuity plan in place, dated November 2016. The main component of the plan was aimed at setting minimum staffing levels required to operate an effective service to patients. Where staffing levels fell below minimum standards, there was detail within the plan as to what action should be taken to mitigate any risks to the service.

Are end of life care services effective?

Outstanding ☆

We rated effective as outstanding.

- Treatment was planned and delivered in line with national and international standards.
- Staff adopted a holistic, patient-centred approach to planning individual care.
- Staff were engaged in developing protocols for measuring quality; for benchmarking services and for assessing the effectiveness of quality.

End of life care

- Staff were highly competent and knowledgeable.
- Staff worked collaboratively to ensure care was joined-up and consistent.

Evidence-based care and treatment

- The London Clinic had replaced the Liverpool Care Pathway (LCP) with an individualised care plan (ICP). The ICP was based on national best practice guidance and afforded staff a structured way of undertaking a holistic assessment of individual needs in regards to planning end of life care treatment.
- We saw evidence of algorithms for symptom management for pain, secretions, agitation, breathlessness and nausea/vomiting. These were in accordance with the National Institute for Health and Care Excellence (NICE) guidelines NG31, QS13 and CG140. The individualised care plan incorporated national best practice guidance. Anticipatory medicines were prescribed in line with national standards.
- Within the intensive care unit (ICU) we saw evidence of an IPC being used in conjunction with an end of life care plan. There was good evidence of daily discussion with the patient's family about the patients' EoLC management. It was evidenced from the IPC and nursing care plans and also from observing the excellent patient care for this patient on ICU that this was being carried out. Mouth care, eye care and pressure area care particularly were excellent. Management of symptoms such as pain and agitation were witnessed as being very well managed**.** The patient also had a properly completed do not attempt cardiac pulmonary resuscitation (DNACPR) in place, which had been discussed with the family.
- We saw evidence of IPCs reviewed by a consultant when there had been a change of condition for the patient.
- Staff were conversant with NICE Quality standard for end of life care for adults, Quality statement 6: Holistic support – spiritual and religious. This states that, "People approaching the end of life are offered spiritual and religious support appropriate to their needs and preferences". It suggests that there should be evidence of availability of local chaplaincy services. Staff were able to describe the various religious services available including but not limited to Christian, Catholic, Muslim and Jewish denominations. The individualised care plan included a section to demonstrate that people's spiritual needs had been assessed.
- An EoLC resource folder had been developed and was available and used on all wards. The information was current, relevant and in line with the 'Leadership Alliance for the Care of Dying People (LACDP) five new priorities for care' introduced in 2014 to replace the Liverpool care pathway. Ward based staff were able to direct the inspection team to the resource folder and were conversant with its contents suggesting the folders were frequently used. Ward based staff reported the resource folder to be a valuable tool when caring for end of life care patients.
- The new Priorities for Care meant that the possibility that a person may die within the coming days and hours was recognised and communicated clearly, decisions about care were made in accordance with the person's needs and wishes, and these were reviewed and revised regularly by doctors and nurses.
  - Sensitive communication took place between staff and the person who was dying and those important to them.
  - The dying person, and those identified as important to them, were involved in decisions about treatment and care.
  - The people important to the dying person were listened to and their needs were respected.
  - Care was tailored to the individual and delivered with compassion – with an individual care plan in place.
- Ward information about 'last office's' procedures was in line with the hospital's policy. We also saw details for funeral directors to be contacted as appropriate. Current information and contact details was important as the hospital did not have a mortuary facility.

Nutrition and hydration

- We saw evidence of a nutritional risk assessment tool being used as part of the IPC form completion. The individualised care plan prompted staff to facilitate discussions with patients and their relatives to explore personal preferences around nutrition and hydration at the end of life.

End of life care

- Staff were sensitive to the individual needs of patients. We observed that where a patient was nearing the end of their life and was nil by mouth, nursing staff used oral sponges to maintain good oral hygiene.
- There were processes in place to ensure that patients were referred to a dietician at an early stage. Staff were able to describe the referral process if a patient was identified as being at risk of malnutrition or where treatments were likely to result in nausea or vomiting leading to weight loss as an example.

Pain relief

- Effective pain control was considered by staff as integral to the delivery of effective end of life care. We saw anticipatory EOLC medications prescribed appropriately in line with NICE guidance NG31.
- Care of the dying guidelines included guidance on prescription of anticipatory pain relief for patients at the end of life. The resident medical officer that we spoke to could direct us to the guidance and explained how they consulted with the SPCT to ensure people had access to analgesia when they needed it.
- Nursing staff were able to describe the tools available to them to assist in assessing pain levels amongst patients who were disorientated or in an altered state of consciousness. Nursing staff directed the inspection team to the end of life care resource folder which included non-verbal pain assessment tools. A review of a patient record who was receiving end of life care demonstrated that pain levels had been assessed frequently, with evidence of escalation of analgesia as required.

Patient outcomes

- The clinical team were actively engaged in activities to monitor and improve the overall quality of end of life care and palliative care services at the London Clinic. The clinical lead was working with national organisations and local services including hospices as a means of seeking opportunities to benchmark the quality of services being provided at The London Clinic.
- At the time of the inspection, the hospital was not participating in the national care of the dying audit programme. This had been acknowledged as an area for improvement. We saw evidence of enquiries having been made by the clinical lead with the national audit director to determine whether the London Clinic could participate in the audit moving forwards.
- As an interim measure, the clinical lead had adapted the national audit and had conducted a small internal audit to determine the services effectiveness of providing palliative and end of life care.
- The audit concluded that: “In general, the quality of care as measured by this audit is high. There was documentary evidence of recognition of death, and of inclusion of the dying person where possible, and of those close to them, in discussions about end of life care. DNACPR forms were generally completed correctly and fully, with evidence of discussion with both the multidisciplinary team and with the dying person and those close to them. Assessments of comfort were undertaken, and appropriate end of life care medication was made available. Referral to the palliative and supportive care team was routinely undertaken, from all clinical areas except ICU. However, there was no indication that the quality of end of life care on ICU was lacking, and this may reflect the expertise of ICU staff in symptom control and care of the dying person, especially when related to withdrawal of life-sustaining treatment, for their population of patients.”
- We found that whilst the internal audit had demonstrated there were improvements to be made in regards to the referral processes from staff working in the ICU, action had been taken to address this. Our assessment of the quality of end of life care being provided on the ICU was good. Staff were conversant with the individualised care plan, were able to speak about and identify members of the PSCT, and were providing care in line with national best practice standards. The ICU had appointed a link nurse to work more closely with the PSCT and to raise wider awareness of the work of the team.
- The hospital had a system in place which ensured there was a timely way of identifying people in need of end of life care services. This included a system which ensured patients were referred to the PSCT when active treatment was no longer a viable option and therefore palliation services were needed.
- During 2015-2016, of the 72 deaths which occurred at the London Clinic, 47 patients had received input and support from the PSCT. The PSCT team received a total of 270 referrals during the previous year. All patients with a diagnosis of cancer had received support from the team.

- The lead PSCT consultant and specialist nurses had reviewed the characteristics for the remaining patients who had not received direct input from the team. This included patients who had received treatment in ICU where such treatment was subsequently withdrawn. The team had worked more closely with the ICU to raise awareness of the service (we have detailed above the wider work undertaken in regards to ICU).

Competent Staff

- We saw a resource folder at the nurses station which contained contact details for the palliative care team. These resource folders were evident on all the wards we visited and staff were able to show it to us when asked. Folders contained information about syringe drivers, how to access one, types available in the hospital and how to return the driver after use. The folders also contained guidance about symptom management, pain control, analgesia algorithms, pain assessment tools and protocols for caring for deceased patients.
- Training in the use of the Mckinley T34 syringe driver was e-learning based. The module was very interactive and easy to understand. All of the staff on the transplant unit had undertaken the training and this was confirmed by inspection of the register. In addition 'hands on' training with an actual syringe driver was available on request.
- The nursing staff working within the PSCT were well qualified, competent staff. PSCT staff had completed level two and three advanced communication skills training and had a wealth of clinical experience in a range of areas including symptom management as an example. All the cancer site specific and EoLC clinical nurse specialists (12 in total) had attained level two psychological supportive care training.
- Staff appraisal and supervision was conducted regularly and staff had access to further training. One junior member of the nursing staff we spoke with had undertaken training in the previous 18 months on ECG monitoring, bladder scans and individual plan of care documentation relevant to her role. She had been supported and encouraged to learn not just about EoLC generally but the specifics and particular difficulties patients may face on the haematology ward she worked on.
- The clinical nurse specialists reported that they had not routinely received any formal clinical supervision. However, this had been acknowledged and was scheduled to commence from January 2017.

Multidisciplinary working

- We witnessed an oncology MDT meeting where all the patients on the ward were discussed and all of the professionals present were able to contribute. We saw excellent emphasis on risk assessments regarding falls and nutrition, the discharge needs of relevant patients was discussed and pharmacy had input regarding control of chemotherapy adverse effects.
- Staff knew the palliative care team members and the consultant by name and staff we spoke with told us they were visible and responsive when called to see a potential end of life care patient or a patient requiring symptom management.
- The medical staff we spoke with were able to talk confidently and with knowledge about identifying deteriorating patients and when to involve the palliative care team. They appeared confident to challenge medical colleagues about such patients as they had daily interaction with them.
- Junior staff we spoke with felt they would be listened to by senior staff if they raised patient concerns and were able to contact the palliative care team independently should the need arise.
- We witnessed consultants and nursing staff working together, recognising when treatments were working as expected and when moving the patient to palliative and /or EoLC would be beneficial.
- If required, the discharge of patients home to die was facilitated by the palliative care team and the international team if required. There was also liaison with other appropriate community based services.
- The PSCT could make arrangements for a patient to be discharged to die at home if that was their wish. We were told of an instance of a patient who was transferred to their home by means of an independent ambulance service within hours of the request and died four hours later at home.

- Staff had started to use a complex discharge check list/ care plan for complex palliative discharges. There was also a 'needle and syringe home kit' to be used for anticipatory medications at home.

Seven-day services

- The PSCT did not provide a seven day face to face service, although the palliative medicine consultant provided out of hours telephone cover once the need had been triaged by the Matron's office, RMO or the senior nurse on duty. In addition the RMO's and hospital medical staff were able to refer to the patient's end of life care plan and anticipatory medications were supplied as required.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Staff demonstrated a good understanding of the Mental Capacity Act and the associated best practice guidance. Staff could describe the actions required for assessing and documenting the mental capacity of patients, specifically as they neared the end of their life. Staff recognised and were conversant with the concept of "Fleeting capacity" and could describe situations when this had occurred and the action they had taken.
- The hospital had a Do Not Attempt Cardio Pulmonary Resuscitation (DNACPR) guideline. Staff we spoke with were aware of the guideline and knew how to access it. An audit of 11 records identified that in 90% of cases, a DNACPR form was included in the notes. Where there was no DNACPR form for the eleventh patient, there was evidence of the decision having been made that the patient was not for resuscitation, which was recorded in the medical notes. Whilst we acknowledge the good practice of having the decision recorded in the medical notes, the lack of a formal DNACPR form, which are used as visual reminders to staff of a patients resuscitation status, could have led to a patient being inappropriately resuscitated.
- Of the 10 DNACPR forms present, 80% had been fully completed. A record of discussion with the patient, regarding DNACPR had been carried out in 55% of cases. For the remaining case notes audited, there was a recorded rationale as to why a discussion regarding DNACPR had not been had with the patient. There was evidence that discussions regarding DNACPR had taken place with relatives of the patient in 90% of cases. The audit had acknowledged that the depth of detail of discussions regarding DNACPR was variable. Outcomes and agreed actions resulting from the audit were considered by the end of life care steering group and had been disseminated across the London Clinic.

Are end of life care services caring?

Outstanding ☆

We rated caring as outstanding.

- Feedback from people who used the service and those close to them was continually positive about the way staff treated people. People felt that staff went the extra mile to provide care which exceeded their expectations.
- There was a strong, visible person-centred culture. Staff were highly motivated and inspired to offer care that was kind and promoted people's dignity. Relationships between people who use the service, those close to them and staff was strong, caring and supportive.
- Staff recognised and respected the totality of people's needs. They always took people's personal, cultural, social and religious needs into account.

Compassionate care

- Throughout the inspection, staff demonstrated a very strong commitment to providing holistic, person-centred care. The individualised care plan was designed in such a way that early, transparent and open discussion with patients and those close to them, in terms of planning their end of life care was a key priority.
- Staff were able to describe the long term strategy for end of life care services. This included people being conversant with the vision of end of life care services at The London Clinic which was "To provide the highest quality of end of life care to those accessing its services, whatever their diagnosis, irrespective of their ability to pay".
- Staff described scenarios whereby they went the extra mile to exceed the needs of patients and those close to them, at the end of their life. Staff provided examples of where the London Clinic had supported individuals to have their pets stay with them in the lead up to their death if this had been expressed as a personal wish of individuals.

End of life care

- Staff spoke with compassion and respect when describing individual scenarios of where they had been involved in providing end of life care. Nursing staff, members of the PSCT and non-clinical staff were eloquent in their descriptions of the care they provided to individuals.
- During the inspection we observed ICU staff caring for a patient who was nearing the end of their life. The care provided was on a one to one basis, as is often usual in ICU. Nevertheless the basic nursing care including mouth care, pressure area care and eye care and the way they spoke to the patient who was unresponsive was of an exceptional quality. The nursing staff spoke gently to the patient, describing the procedures they were about to carry out despite the patient being unresponsive. The communication between the ICU Consultant and nursing staff was excellent in conveying the management of the patient who had complex needs but who now also required EoLC.
- A patient's wife told us "the staff have time for you and are kind and compassionate. We have had excellent supportive care from the supportive care nurse which has helped us to cope".
- As part of the hospital's bereavement services a condolence card was sent to the patient's relative, followed by a telephone contact some weeks later to determine whether any additional support could be provided and to follow-up on any questions or queries individuals had following the death of their loved one.
- Staff reported the clinic was focused not only on the needs of patients but also of those recently bereaved. The clinical team was able to describe the importance of recognising the impact of a person's death which was often long-lasting. The team was developing services which would enable them to identify people who were particularly in need of bereavement support; providing bereavement support here appropriate and to strengthen the existing systems for providing support locally; this was especially important for international patients who had died at the London Clinic.
- Bereavement counselling was available free of charge at the hospital for bereaved relatives. Further, complementary therapy services were provided for all patients and from the patients we spoke with, was received extremely well.
- The hospital had a 'care for the dying' leaflet available for relatives and each of the EoLC resource folders, available on each ward and unit, contained a practical guide of what to do after death for bereaved families.

Understanding and involvement of patients and those close to them

- Family members were able to stay with the patient and 'open visiting' was encouraged, therefore empowering relatives to leave the hospital as and when they felt it necessary. A 'compassionate care bed' was available from the matron's office to allow family members to stay with the patient. A 'compassionate care bed' is the availability of a private room with all facilities such as shower and bath facilities as well as meals and refreshments which are extended to family members to enable them to remain with the patient at end of life. We were told this was a guaranteed facility and was always available and offered where appropriate. This was free of charge and could be arranged through the Matrons Office.

Emotional support

- A counsellor was available for both patients and their families. In addition staff were also able to access up to three sessions with a counsellor if required. A patient told us the psychological care and support provided by the ward staff and her counsellor had seen her through the most difficult time of her life.
- Religious support was available from local religious leaders 24 hours per day.
- The PSCT supported patients who wished to do so to make memory boxes. We were told of staff typing letters for patients and arranging weddings for those patients at the end of life. The hospital makes no charge for such services.
- The hospital held a memorial service in November each year for those patients who had died at the hospital. Invitations were sent to those who had lost loved ones in the previous three years, although we were told many people returned annually. The London Clinic had facilitated an annual memorial for the preceding nine years and considered this to be an important element of the bereavement process. Hospital staff involved in caring for those patients and relatives were also invited to attend. The service has been adapted to include more relevant music, prayers (from different faiths) or

poems that meant something personal to families and loved ones. The lead support nurse was the families' contact for the service arrangements and gave the address last year. The hospital reported over 150 people attended in 2016.

Are end of life care services responsive?

Good

We rated responsive as good.

- Services were planned and delivered in a way that met the needs of patients. The importance of flexibility, choice and continuity of care was reflected in the services provided.
- Facilities and premises were appropriate for the services being delivered.
- People could access the right care at the right time. Access to care was managed to take account of people's needs, including those with urgent needs.

Service planning and delivery to meet the needs of local people

- The services of the PSCT were available free of charge to both inpatients and day case patients.
- The hospital had an EoLC link nurse in the ICU and other wards. The role of the link nurses who had received training from the PSCT was to provide a reliable link to the PSCT and EoLC services available and disseminate their training and knowledge to other unit or ward staff members.
- The hospital did not take part in the national NHS post-chemotherapy deaths audit. However, it conducted its own (time from first chemo to death) to ensure patients did not receive chemotherapy when it would not be beneficial.

Meeting people's individual needs

- Patients and relatives could access the hospital's Chaplaincy service for the multiple faith groups via the Matron's office.
- The hospital had two lymphedema therapists trained in the Vodder method of manual lymph drainage available to patients, including EoLC patients.
- Translation services were easily accessible throughout the hospital via the in-house interpreting service. For example a patient required an MRI scan and couldn't speak English. An interpreter went with the patient to explain the MRI checklist and what would be happening.
- Care of deceased patients appeared to be good and in line with what the palliative care team told us. The patient remained in the unit or ward until relatives had left and then undertakers were contacted in line with the families' wishes. Arrangements were in place for the repatriation of foreign nationals when requested via contact with the Embassy concerned and the hospital's own international team.

Access and Flow

- Of the 72 expected deaths at the hospital over the last year the PSCT saw 47 EoLC patients and all of the cancer patients.
- The total number of referrals to the PSCT was 270, with an average of 10 new referrals a month.
- No audit to determine the percentage of those EoLC patients who died in their preferred location had been carried out. This had been recognised by the clinical team as something to develop and was part of the EoLC strategy for 2016-2019.
- The provider however had conducted an audit in August 2016 which identified that the preferred place of death for the patient had been recorded in medical notes in four out of eleven cases. The audit result was caveated in 6 cases including "patient unconscious in the time leading up to death, patient was being actively treated until very close to death". The audit acknowledged that if was not possible to evaluate whether discussions could have taken place earlier in the course of the patient's illness, in order that appropriate plans could have been put in place.

Learning from complaints

- There had been no reported EoLC complaints in the year leading to our inspection.
- The team reported that their intention was to provide a gold standard service and to address any concerns or queries patients or their relatives may have had in an expedient way. This was echoed by two patients we spoke with who reported that the team had dealt with their queries quickly and effectively.

Outstanding ☆

End of life care

Are end of life care services well-led?

Outstanding ☆

We rated well-led as outstanding.

- Leaders had an inspiring shared purpose, strove to deliver and motivate staff to succeed.
- The strategy and supporting objectives were stretching, challenging and innovative while remaining achievable.
- A systematic approach was taken to working with other organisations to improve care outcomes.
- Governance and performance management arrangements were proactively reviewed and reflected best practice.

Leadership of the Service

- Leadership of the palliative and specialist end of life care team was comprehensive. The service was led by a consultant who was employed on a substantive basis to drive forward the end of life care strategy. Individuals within the team had clear roles and responsibilities and through our discussions with the team, all team members were aligned to enhancing the overall quality of the service.
- Staff we spoke with reported end of life care had greatly improved across the hospital since the substantive appointment of the consultant in palliative medicine. They told us that symptom management, care planning, discussions with patients and families around advanced care planning and preferred place of death had all improved significantly.
- Staff from across the hospital reported the PSCT were highly visible and were engaged in promoting high quality, effective and timely end of life care or palliative care services.

Vision and Strategy for this service

- The London Clinic's vision is to be 'the most trusted hospital'. This applies as much to the provision of end of life care as it does to all other aspects of its role. The hospital's vision for end of life care is: To provide the highest quality end of life care to those accessing its services, whatever their diagnosis, irrespective of their ability to pay.
- In addition to the overall service vision and strategy the hospital produced a continuous service update document declaring 'The Clinic has invested in the provision of clinical palliative care, through an innovative, free-at-the-point-of-use, service to people affected by life-limiting or potentially life-limiting illnesses. In line with our aim to provide the very best services, further improvements are required to strengthen the governance, data and support structure for end of life care, to bring the service in line with those of the best performing NHS and voluntary sector end of life care services'. At the time of our inspection all of the stated intentions had been completed with the exception of the development of data collection which was ongoing.
- The mission statement for the PSCT is "The PSCT will work to reduce distress caused by a life-limiting, or potentially life-limiting, diagnosis through the provision of specialist symptom management and emotional/ psychological support, to support patients in attaining the best quality of life possible, and to enable patients to die in comfort, with dignity, and in the place of their choice. The PSCT will work constructively and inclusively with other clinical teams, focused around the needs of the patient and those close to him or her, in order to achieve this".
- It was apparent that end of life care was not the sole responsibility of the specialist team but was multi-disciplinary in application. Clinical and non-clinical staff members alike were able to describe their role and individual responsibilities in meeting the needs of individuals who were receiving end of life care.

Governance, risk management and quality measurement

- The PSCT report to the Director of Nursing/Matron and was managed by the lead cancer nurse. We noted the Director of Nursing/Matron attended the MAC, clinical governance and ward managers meetings.
- The hospital introduced in July 2016 a standard operating procedure document for the PSCT which set out clearly and in some detail the description, role, governance structure and the day to day operations of the team. The document was based on NICE guidance and quality standards and GMC guidance related to end of life care.

End of life care

- The London Clinic had an effective risk register in place. There was not a separate EoLC risk register but at the time of our inspection there were no specific EoLC risks identified.
- EoLC quality and development findings were disseminated to the clinic's quality management group by the palliative medicine consultant and the specialist palliative care team (PSCT) line manager.
- There was an action plan in place to recruit another clinical nurse specialist (CNS) to cover PSCT sickness and absence. If palliative medicine consultant cover was required in the absence of the hospital's PSCT consultant it would be provided on a short term basis. This was chargeable to the patient except in exceptional circumstances. However the hospital was transparent about this and the patient/family would be given the relevant information.
- The EoLC steering group was formed in April 2016. At the time of our inspection the group led by the EoLC consultant had met twice and we were able to review the minutes of those meetings.
- In August 2016, with a view to the hospital's future participation in the 'End of Life Care Audit: Dying in Hospital' and to evaluate the level of care provided by the hospital, the EoLC consultant conducted an audit of 12 randomly selected patients who had died as inpatients as expected between January and July 2016, across all clinical areas. The results of the audit were positive and helped to drive the roll-out of the end of life care plan across all clinical areas.
- A similar audit is to be conducted quarterly going forward. 'End of Life Care Audit: Dying in Hospital' is a national clinical audit commissioned by the Healthcare Quality Improvement Partnership (HQIP) and run by the Royal College of Physicians, with additional funding provided by Marie Curie to assist with the dissemination and usage of audit results for quality improvement purposes. It has been designed to ensure that the priorities for care of the dying person outlined in the document 'One Chance to Get it Right' are monitored at a national level.

Culture within the service

- From staff and patients we spoke with it was clear the PSCT were visible and responsive and highly regarded.

Public and staff engagement

- A small patient satisfaction survey about the PSCT involving 10 patients and all reported being very satisfied or satisfied.

Innovation, continuous improvement and sustainability

- The PSCT had taken action to introduce evidence based guidance across the whole of the London Clinic. Following an audit of the trial, there was a widely accepted consensus that the ICP was to be rolled out across the whole hospital. Staff were complimentary of the PSCT team who were seen as ambassadors for ensuring high quality end of life care was provided to all patients requiring the service.
- The hospital arranged an annual memorial service for family and friends who had lost loved ones at the hospital. It had evolved and grown over the years to include more relevant music, prayers (from different faiths) or poems that meant something personal to families and loved ones.

Good

Outpatients and diagnostic imaging

Safe	Good
Effective	
Caring	Good
Responsive	Outstanding
Well-led	Good

Are outpatients and diagnostic imaging services safe?

Good

We rated safe as good.

- There was a process for reporting incidents. Staff were able to describe incidents where learning had occurred as a result.
- There were reliable systems, processes and practices in place to protect patients from avoidable harm and abuse.
- Patient areas were visibly clean and tidy and staff complied with infection prevention practices.
- Staffing levels and skill mix was planned, implemented and reviewed to keep people safe at all times.
- Risks to people who used services was assessed, monitored and managed on a day-to-day basis.

Incidents

- There was a system for reporting and recording significant events. In the 12 months prior to our inspection there had been no reported never events for the outpatient or diagnostic imaging department. Never Events are a type of serious incident that are wholly preventable, where guidance or safety recommendations that provide strong systemic protective barriers are available at a national level, and should have been implemented by all healthcare providers.
- Between July 2015 and June 2016, there had been 452 clinical incidents within outpatient and diagnostic services. 39 incidents involving ionising radiation, six of these were reportable to the care quality commission (CQC). The provider monitored and analysed incidents through its clinical governance dashboard. Incidents were categorised according to whether they were high, moderate or low risk, falls or medication errors.
- Between July 2015 and June 2016, there had been 143 non-clinical incidents within outpatient and diagnostic services, which is higher than the rate of other independent acute hospitals. Staff told us they were encouraged to report all incidents. Managers followed up all incidents and 'near misses' recorded by staff. These were investigated locally and then monitored through the quality review group and the relevant expert advisory group. This helped the hospital to identify themes and trends and implement any actions required.
- In radiology and diagnostics lessons learnt were shared through different routes including discussion at speciality meeting held quarterly. Minutes from these meetings were sent to all radiologists via e-mail and a hard copy was available in the department.
- We saw evidence that when things went wrong with care and treatment, patients were informed of the incident, received reasonable support, truthful information, a written apology and were told about any actions to improve processes to prevent the same thing happening again.
- Staff were aware of actions they should take when a 'reportable patient safety incident' occurred and assured us they were open and transparent. They were aware of the duty of candour. The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain 'notifiable safety incidents' and provide reasonable support to that person.

- Staff we spoke with were clear what duty of candour meant for them in their role. Managers accurately explained what responsibilities they had under duty of candour.
- We reviewed safety records, incident reports, patient safety alerts and minutes of meetings where these were discussed. We saw evidence that lessons learnt were shared and action was taken to improve safety in the practice. Information on how many incidents met the duty of candour threshold was unavailable.

Cleanliness, infection control and hygiene

- Nursing staff in the clinical area were wearing appropriate uniforms which complied with the hospital's "bare below the elbow" policy to allow for appropriate hand washing and prevent infections.
- The infection prevention control (IPC) link nurse supported the IPC specialist by acting as a resource and role model to staff. This was a well-established role that aimed to promote local and hospital wide awareness of infection control. Link nurses provided quarterly study days, updated staff and shared information via regular emails. They took responsibility for monitoring the clinics policy on hand washing and for training staff.
- We saw regular hand hygiene audits from the imaging department which confirmed staff were compliant with legislation.
- Nursing staff told us they had completed mandatory training in infection prevention and control training and training records confirmed this.
- The hospital maintained standards of cleanliness and hygiene and we observed the hospital to be clean and tidy and checks were in place to monitor cleanliness. All outpatients and diagnostic imaging waiting areas and clinical rooms were visibly clean and tidy. Staff had cleaning schedules for all clinical areas and records were consistently completed to show that areas had been cleaned. Spillage and cleaning products were available to staff.
- Personal protective equipment, such as aprons and gloves was available and hand-washing facilities were available in each clinical room. Staff across the outpatient services were observed to be using personal protective equipment appropriately. And in line with: Health and Safety Executive (2013) Personal protective equipment (PPE): A brief guide. INDG174 (Rev2). London: HSE.
- We observed that hand sanitisers were easily accessible to staff and patients and others visiting the hospital. They were routinely placed near an exit or entrance to the area, encouraging people to sanitise their hands. Hand gel was available in all clinical areas clear information visible on their correct use to minimise infection risks.
- There were appropriate systems for the segregation and correct disposal of waste materials such as x- ray solutions and sharp items. Sharps box audits were completed quarterly and a log kept of any incidents, for example box flaps not being sealed. Sharps containers for the safe disposal of used needles were available in each clinical area. These were dated and were not overfilled. This was in accordance with the Health and Safety (Sharp Instruments in Healthcare) Regulations 2013
- Domestic, clinical and hazardous waste and materials were managed in line with current legislation and guidance.

Environment and equipment

- Equipment we looked at was visibly clean and stored appropriately. All clean equipment had "I am clean" stickers or notes attached.
- Curtains in use within the consulting and treatment rooms were disposable and found to be in date and examination couches were wipe able, and could be easily cleaned between each patient.
- The hospital's electrical maintenance team were responsible for annual safety testing. The equipment we looked at all had an up to date safety test and appeared in good condition.
- The provider had an appointed radiation protection supervisor (RPS) and a radiation protection adviser (RPA) in accordance with the Ionising Radiation (Medical Exposure) Regulations 2000 (IRMER) regulations. As a result the hospital had an independent annual audit of the imaging services.
- A list of all equipment including model, make, age and serial numbers, was available in the department.

Maintenance contracts and service level agreements were in place with external providers to service, maintain and repair equipment. Equipment maintenance contracts were checked and records showed all schedules were up-to-date. The annual radiation protection audit (RPA) dated February 2016 commented that" radiology equipment was maintained to a very high standard", with a "comprehensive preventative maintenance programme and regular servicing". This ensured they met the health and safety executive guidance note PM77 on the recommended standards for diagnostic x-ray imaging systems.

- The provider had protocols to ensure safe operation of visible and invisible beams generated by lasers and radiation equipment.
- Resuscitation equipment was available throughout outpatients and radiology and had been checked on a daily basis.

Medicines

- We saw evidence clinical staff managed prescribed medications safely. In outpatients, radiology medicines were securely stored in locked cupboards. Lockable fridges were used, with daily temperature checks on these. The department followed the appropriate guidance on the safe handling and storage of medication.
- Medication training was provided by the hospital and competency frameworks were used to ensure staff were compliant with hospital policy.
- Emergency medication and emergency equipment was available on resuscitation trolleys. These were recorded as being checked daily and emergency drugs were checked and in date.
- The hospital had its own pharmacy where patient prescriptions could be dispensed. The pharmacy was staffed by qualified pharmacists and technicians who provided medicines to all patients at the hospital. The pharmacy team was available 24 hours a day, seven days a week.
- The radiology department used patient group directions (PGD's) for contrast media and bowel preparation (examination of the large bowel). PGD is a legal mechanism that allows named registered healthcare professionals to supply and/or administer medicines to groups of patients that fit the criteria laid out in the PGD. They are written instructions for the supply or administration of medicines to groups of patients. We found these were all in date, signed off and competency assessments had been completed for radiographers to demonstrate their understanding.

Records

- Clinical records were a combination of electronic and paper records. Many consultants held their own patient records off site to bring to the hospital. The hospital rented out consulting rooms to consultants who were the data controller for patient information. There were the individual or the legal person who controls and is responsible for the keeping and use of personal information on computer or in structured manual files. The clinic did not keep outpatients records for patients where the consultant was their own data controller with the exception of haematology service. This was because of the requirement to track stem cell treatments. However consultants were required to provide pre-assessment clinical information alongside a booking form when booking patients for admission to the hospital.
- Consultants and their secretaries used their own systems. The hospital told us it was not possible to have a direct link between these and the hospital systems.
- Consultants were responsible for ensuring patient's records were available for appointments.
- Medical records for each inpatient admission and appointment were scanned into a digital store (Medsafe) shortly after discharge to ensure they were accessible for future appointments or admissions. Paper records were then securely destroyed before there was any possibility of them being removed from the premises. This ensured a record was kept of all the patients care and treatment at the clinic.
- Patient care records generated in outpatients such as wound care and treatment information were kept within the department and were easily accessible. Once finished with, these were scanned into the electronic record and securely destroyed.
- Electronic records were available only to authorised people. Computers and computer systems used by hospital staff were password protected.

Good

Outpatients and diagnostic imaging

Safeguarding

- It is the duty of healthcare organisations to ensure all health staff have access to appropriate safeguarding training, learning opportunities, and support to facilitate their understanding of the clinical aspects of child welfare and information sharing. The Safeguarding children and young people: roles and competences for health care staff intercollegiate document 2014, sets out the requirements related to roles and competencies of staff for safeguarding vulnerable children and young people. Level 2 training is required for all non-clinical and clinical staff who have any contact with children, young people and/or parents/carers. Level 3 training is required where clinical staff work with children, young people and/or their parents/carers and who could potentially contribute to assessing, planning, intervening and evaluating the needs of a child or young person and parenting capacity where there are safeguarding/child protection concerns.
- Mandatory training records were held locally within departments. We reviewed the latest available training information for outpatients and radiology and diagnostics and saw the majority of staff were up to date with safeguarding adults and safeguarding children training. However it was unclear from the training record what level training staff had undertaken as this was not recorded.
- Managers told us they were in the process of inputting all local team training records into an integrated training records system. (LMS). This had identified that 88% of staff were up to date with safeguarding adults training. Plans were in place to ensure all staff completed safeguarding adults training by December 2016.
- Staff were aware of their roles and responsibilities in relation to safeguarding and could describe what types of concerns they would report and the process they would follow. They knew how and where to access safeguarding policies and procedures, and were aware of their roles and responsibilities to raise and escalate concerns in relation to abuse or neglect for vulnerable adults and children.
- Information about how to report safeguarding concerns and safeguarding adult's information was available in outpatient clinics.

Mandatory training

- The clinic provided mandatory training using a combination of electronic learning packages and face-to-face learning. Staff completed their training during their work time. Mandatory training included health and safety, infection prevention and control and fire safety. Mandatory training rates were variable, 79% of CT/MRI staff, 96% of nuclear medicine staff, 72% of breast imaging staff and 100% of nursing staff had completed their mandatory training.
- Over 90% of radiology and diagnostic and outpatient's staff had completed basic life support (BLS) training. Staff we spoke with told us they received regular training.
- Consultants with practising privileges completed mandatory training at their employing NHS trust. There were assurance systems to check training was up-to-date. Managers advised that any failure to meet mandatory training requirements would potentially lead to a suspension in practising privileges.

Assessing and responding to patient risk

- There were systems to prioritise urgent and routine new referrals and send appointments as required to patients.
- The Ionising Radiation (Medical Exposure) Regulation (IR (ME) R 2000) require doses arising from medical exposures to be kept as low as reasonably practicable. To comply with this legislation patient dose data had been collected and analysed for examinations performed with a view to establishing Local Diagnostic Reference Levels (LDRLs) and comparing against National Diagnostic Reference Levels (NDRLs). We reviewed the patient dosimetry report for 2016, which did not identify any issues or concerns.
- Appropriate signage for the radiology department was in use with clear radiation warning lights and yellow warning symbols easily visible.
- Processes were established within outpatients to manage patients who deteriorated or became unwell within the department. There was an emergency response team within the clinic who could be summoned rapidly.
- A transfer protocol was in use in the event the clinic could not safely provide care or treatment for a rapidly

deteriorating or acutely unwell patient. This could involve a transfer to a nearby intensive care unit or an accident and emergency department. The deputy matron audited all transfers for safe practice.

Nursing and Radiology staffing

- All staff confirmed there were sufficient nursing staff to deliver care safely within outpatients and no shifts had been unsafely staffed .We saw staff rotas which confirmed this.
- Between July 2015 and June 2016, the rate of outpatient nurse turnover was above the average of other independent acute hospitals. The clinic was aware and stated that "turnover is high and is a priority for us". They had developed and were implementing an action plan to address this. Staff told us some staff had left as they had moved away but many staff had been working at the clinic a long time and were happy.
- Between July 2015 and June 2016, the rates of use of bank and agency nurses working in outpatient departments were similar to or lower than the average of other independent acute hospitals.
- The rate of sickness for nurses working in outpatient departments was similar to or better than the average of other independent acute providers. The rate of sickness for outpatient health care assistants was better than the average of other independent acute providers in the same period.
- The imaging department at The London Clinic had over 60 full-time staff who provided a full diagnostic imaging service.
- There were arrangements for planning and monitoring the number of staff and skill mix of staff to meet patient's needs. There was a rota system in use for all the different staffing groups to ensure enough staff were on duty.

Medical staffing

- Consultant files reviewed by inspectors. Of the five files only two related to active consultants. Information was required to be collected against a formal checklists, which included; their application, professional registration, appraisal, certificates and specialist register details, qualifications, appraisals, ionising radiation training, disclosure and barring service checks, and their indemnity.
- We found general medical council registration status was in the revalidation documentation in the two active files. However, there was no evidence of an independent check against this recorded. The checklists in the files examined had no initial or current CRB/DBS status recorded.
- Consultants covered their own OPD clinics on a sessional arrangement, many having set days and times for consultations.
- The hospital had two Resident Medical Officer (RMO) on site 24 hours a day, seven days a week to support the clinical team in the event of emergencies or with patients requiring additional medical support.
- The individual specialties arranged medical cover for their clinics where required. This was managed by individual clinicians, who agreed the structure of the clinics and patient numbers.

Emergency awareness and training

- The clinic had a comprehensive business continuity plan for major incidents such as power failure or building damage. The plan included emergency contact numbers for staff and business continuity plans ensured the delivery of the service was maintained.
- All staff had access to annual fire training and nursing staff explained the evacuation procedure for outpatient's clinics.
- Managers in outpatients assured us all nursing staff were up to date with annual fire training and training data we saw confirmed this.

Are outpatients and diagnostic imaging services effective?

We do not currently rate the effectiveness of outpatient's services.

- Staff were competent and supported to provide a good quality service to patients.
- Care was consistently provided in line with national standards.
- There was a local audit programme to help assess the clinical effectiveness of services being provided.

Good

Outpatients and diagnostic imaging

Evidence-based care and treatment

- Patients' needs were assessed and care was delivered in line with relevant and current evidence based guidance and standards, including National Institute for Health and Care Excellence (NICE) best practice guidelines. For example, protocols were followed with regard to national guidance for radiology examinations such as orthopaedic x-rays.
- Staff were kept up to date with changes in practice. They had access to guidelines from NICE and used this information to deliver care and treatment, which met patient's needs. For example, staff received National Patient Safety Alerts and alerts from the Medicines and Healthcare products Regulatory Authority. This meant they had accurate and up to date information confirming that best practice guidance was being used to improve care and treatment and patient's outcomes.
- Policies were regularly reviewed to ensure they were aligned to best practice guidance.
- There was access to specialist investigations such as magnetic resonance imaging (MRI) or a computerised tomography (CT) scan. MRI is a type of scan that uses strong magnetic fields and radio waves to produce detailed images of the inside of the body whilst a CT scan uses X-rays and a computer to create detailed images of the inside of the body.
- Interventional radiologists and specialist radiology nurses were able to undertake a comprehensive range of procedures under sedation, local or general anaesthetic. For example, routinely undertaken diagnostic and therapeutic procedures included: arteriography and angioplasty and blood vessel embolisation and stenting. The department had full facilities for digital subtraction angiography and a 2-bedded recovery unit.
- Radiation guidelines, local rules and national diagnostic reference levels (DRLs) were available for staff to access. There was an assigned radiology protection adviser and a radiology protection supervisor for the hospital.
- We saw the world health organisation (WHO) checklist was completed before ultrasound guided injections. These are injections used to ease pain and reduce swelling and inflammation in soft tissues, such as tendons, tennis elbow or plantar fasciitis.
- The Ionising Radiation (Medical Exposure) Regulation (IR (MER) (2000) required doses arising from medical exposures to be kept as low as reasonably practicable. To comply with this legislation patient dose data had been collected and analysed for examinations and this information was reviewed in monthly quality meetings. The hospital had standard operating procedures available, For example, for MRS safety screening.
- A radiation safety survey had been completed in 2016 to ensure compliance with the Ionising Radiations Regulations 1999 (IRR99) and the Ionising Radiation (Medical Exposures) Regulations 2000 (IRMER). Staff we spoke with showed good awareness of radiation protection requirements. However, staff told us practitioners and operators not directly employed by the clinic were not provided with safety equipment such as a dosimeter (this registers exposure to radiation levels).The radiology department were not monitoring radiation exposure levels for consultants with practising privileges working at the clinic as they expected individuals to provide their own safety equipment. This meant they were not monitoring exposure levels for all individuals working in the department. We saw evidence through audits that radiation exposure was monitored for employees of the clinic.

Pain relief

- Pain relief could be prescribed within the outpatient's department and then dispensed by the pharmacy department.
- Doctors could refer patients requiring additional pain management to the pain management consultant. The outpatients department did not provide specific pain management clinics.

Patient outcomes

- The hospital did not gather data related to patients outcomes, nor participate in local and national audits which would allow them to benchmark patient's clinical outcomes for the outpatients department.
- In radiology and diagnostic imaging staff were actively encouraged to feed ideas in for local audits. Staff were enthusiastic and keen to identify any areas that could improve the patient journey and effectiveness and quality of the service for their patients.
- The hospital did not participate in imaging accreditation schemes or improving quality in physiological services

scheme. The Imaging Services Accreditation Scheme (ISAS) is a patient-focused assessment and accreditation programme designed to help diagnostic imaging services ensure their patients consistently receive high quality services, delivered by competent staff in safe environments.

Competent staff

- Consultants working at the hospital had been granted practising privileges. Practising privileges is a term used when doctors have been granted the right to practise in an independent hospital. This right is subject to various checks on for example; their professional qualifications, registration, appraisals, revalidation, and fitness to practice declaration.
- Staff had access to appropriate training to meet their learning needs and to cover the scope of their work.
- The corporate induction programme for all newly appointed staff covered a range of topics including organisational expectations and the hospital vision and culture. Mandatory training topics included safeguarding, infection prevention and control, fire safety, health and safety and confidentiality.
- Managers told us all members of staff received an induction prior to starting work in the hospital, which covered the hospitals mandatory training requirements. Nursing staff told us they had a comprehensive induction.
- In outpatients and radiology and diagnostics we saw evidence of a competency and induction folder for new and agency staff. TAs a result new and agency staff could integrate safely and efficiently into the workforce.
- The learning needs of staff were identified through a system of appraisals, meetings and reviews of practice development needs.
- Between January 2016 and December 2016, more than 75% of outpatient nurses and health care assistants had had their appraisal completed in the current appraisal year. The hospital had arrangements to ensure all staff had received an appraisal by the end of the year.
- The hospital had robust processes to ensure all new clinical and nursing staff had verified references and training and skills competency were checked on recruitment.
- Managers told us there was good availability of training opportunities and staff were actively encouraged to develop their skills and learning.
- The clinic IPC link nurses arranged an annual work programme with monthly sessions and audits for staff. This included regular refresher training on for example environmental cleanliness and care of peripheral lines. Monthly infection control audit information was shared with all link nurses and then disseminated via local outpatient department meetings.
- There were annual programmes of study days available for staff. Staff were able to attend external conferences as part of identified individual personal and professional development.
- The hospital had a “leadership academy encouraging training through e-learning and a “virtual college”. Staff gave us examples where they had been supported and actively encouraged to improve their leadership skills and knowledge to enable them to take on additional responsibilities.

Multidisciplinary working

- The clinic employed a dedicated MDT co-ordinator and assistant to co-ordinate meetings. Meetings were held either fortnightly or monthly for specialities including, colorectal, gynaecology and urology. All MDTs had a radiologist and pathologist and the relevant speciality clinicians present.
- Patients diagnosed with cancer or primarily treated at the clinic were discussed at MDT meetings and patient outcomes from external NHS or other providers MDTs included in the clinics medical records. The clinic had all the relevant information they needed to provide the appropriate health care and treatment for the patient.
- Information held on the hospitals own patient record system needed to plan and deliver care and treatment was available to relevant staff in a timely and accessible way. This included care and risk assessments, care plans, medical records and investigation and test results.
- The hospital staff shared relevant information with other services in a timely way, for example when referring patients to other services.

Good

Outpatients and diagnostic imaging

- There was a strong multidisciplinary team (MDT) approach across all of the areas we visited. We observed good collaborative working and communication amongst all staff in and outside the department. Staff reported they worked well as a team.

Seven-day services

- The outpatients department was open five days a week, Monday to Friday 8am to 7pm and Saturday 9am-1pm. Outpatients opening hours were flexible and dependent on individual consultant's availability.
- The phlebotomy service was based at Devonshire place and also provided a service to the rest of the clinic. It was open Monday to Friday, 8am to 7pm and Saturday 9am to 1pm. Patients attending colposcopy, respiratory and cardiac testing clinics all had pre booked appointments.
- A radiologist-supported 24-hour emergency CT, MRI, ultrasound, interventional radiology and X-ray service was available for all inpatients. Clinic consultants had remote access to IT reporting systems so they could immediately review the images and issue a report.
- Radiology and diagnostics services were available seven days a week, 8am to 10pm. An on call service was available after 10 pm. There was access to specialist investigations such as MRI and CT scans or to a radiologist to interpret scans out of hours. Plain film and CT services were available out of hours for emergencies for in- patients and theatres.
- An on-site pharmacy service was available for outpatients 24 hours a day seven days a week.
- On-call clinicians were available seven days a week to support clinical decision making.

Access to information

- Staff generally had the information they needed to deliver effective care and treatment to people who used services. For example, access to policies, procedures and professional guidance.
- Staff could access scans and imaging reports using secure electronic systems such as the picture archiving and communication system, the radiology information system.
- Consultants were responsible for the outpatient records for their private patients and clinic information and patient notes were accessible to relevant staff
- Consultants holding practicing privileges with the hospital were required to be registered as independent data controllers with the Information Commissioner's Office.
- We saw letters regarding the outcome of an appointment were sent to a GP and other health professionals when appropriate and patients were sent a copy of the correspondence.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Staff confirmed the importance of patients being fully informed when they were asked to give consent for care and treatment. We observed patients were given the opportunity to ask questions and agree with proposed treatment options.
- We observed radiographers following the hospital policy on consent to ensure that patient consent was gained for each scan or procedure. We compared the practice we saw with the Society and College of Radiographers' recommendations and saw the department's practice was in line with professional guidance.
- Staff told us they rarely saw patients who may lack capacity to make an informed decision and discussed treatment options during the consultation. Where written consent was required, this would often be obtained in the outpatient clinic. Patients told us they had been asked for consent before their procedures. We viewed three records that confirmed this.
- It was unclear whether endocrinology and diabetes and radiology and diagnostics staff had completed MCA training, as this information was not recorded on the training record. All OPD nursing staff were up to date with Mental Capacity Act 2005 and Deprivation of liberty training (DoLS).
- Consultants told us they were aware of their responsibilities and the hospital processes for ensuring appropriate consent before undertaking any treatment.

Are outpatients and diagnostic imaging services caring?

Good

Outpatients and diagnostic imaging

Good

We rated caring as good.

Feedback from people who used the service and those close to them was positive about the way staff treat people.

People were treated with dignity, respect and kindness during all interactions with staff and relationships with staff was positive. People felt supported and said staff cared about them.

Compassionate care

- The hospital identified patients who may be in need of extra support. For example: patients receiving end of life care, those at risk of developing a long-term condition and those requiring additional support due to a physical disability.
- We observed care provided by nursing, medical and other clinical staff. Throughout the outpatient and diagnostic imaging departments, all staff were helpful and professional, putting patients and their relatives at ease.
- All outpatients departments had suitable rooms for private consultations. Patients were admitted into individual rooms so they could discuss their procedure or treatment privately.
- Curtains were provided in consulting rooms to maintain patients' privacy and dignity during examinations, investigations and treatments.
- We noted consultation and treatment room doors were closed during consultations; conversations taking place in these rooms could not be overheard.
- Patients said most staff were helpful, professional, polite and kind. One relative gave an example about her relative where the consultant had "put them at ease, was empathetic and treated them with respect". They felt the nurses also treated their relative with "great dignity".
- Nursing and administrative staff assisted patients promptly and were friendly, supportive and discreet when patients needed support. For example, one patient was taken into a separate room so they could have a private conversation with the nurse before seeing the consultant.
- We saw reception staff greeting patients in a friendly and welcoming manner and explaining details regarding appointments and payments in a quiet professional way
- Patients could request a chaperone to accompany them during their consultation and information on how to access this service was displayed in consultation rooms. Chaperones were available for male and female patients if required.

Understanding and involvement of patients and those close to them

- Staff introduced themselves and we observed consultants introduce themselves and shake patient's hands when they were called in for their appointment slot.
- Patients told us they felt involved in decision making about the care and treatment they received. They said they felt listened to and supported by staff and had sufficient time during consultations to make an informed decision about the choice of treatment available to them.

Emotional support

- Patient information leaflets and notices were available in the patient waiting area which told patients how to access a number of support groups and organisations.
- Throughout our visit we observed staff giving reassurance to patients both over the telephone and in person.
- Written information was available to direct carers to the various avenues of support available to them.

Are outpatients and diagnostic imaging services responsive?

Outstanding ☆

We rated responsive as outstanding because:

- Clinics and services were designed to meet the needs of patients. Services were designed to be flexible and permitted patient choice. Clinic appointments were

organised in such a way that sufficient time was afforded to patients to raise questions, to speak with nurse specialists or other health professionals and to allow for patients to explore treatment options.

- Clinics were well equipped and designed to meet individual needs. Consulting areas were accessible with due regard given to the Disability Discrimination Act. Individuals with complex needs were supported and their needs were consistently met. Concierge staff welcomed patients across the various hospital buildings and assisted those patients with mobility issues or other disabilities.
- Clinical areas were sufficiently signposted. Provision had been made to support visually impaired patients who were attending clinics.
- Patients had access to one-stop multidisciplinary clinics allowing for rapid consultation, assessment, diagnosis and treatment.
- Significant support was provided to patients with life limiting conditions. Provision was made to support patients with out-patient based complimentary therapies.

Service planning and delivery to meet the needs of local people

- Outpatients and radiology and diagnostic services were located in different buildings dependent on the speciality. For example, the eye care service was located at 119 Harley Street. Consulting and treatment rooms were provided by the clinic and led by nursing staff from the clinic.
- Number 5 Devonshire Place had clinical rooms on all floors. Consulting and treatment rooms were available and these included, laser, dressing and plaster rooms and consultants and secretaries offices. Consultants at Devonshire place paid an annual payment to the hospital to have a consulting room available.
- The clinic also provided three “consulting houses”. These were facilitated by the clinic who provided administration staff to welcome patients.
- The consultant nurse led outpatient diabetic and endocrine service was based at 5 Devonshire Place. The unit provided a one stop patient service, including phlebotomy and counselling with access to an extended MDT via referral. One nurse had undergone additional training in “breaking bad news” and another nurse was booked on the next available course. The service had access via individual referral to specialist services including a podiatrist, psychologist, psychiatrist, vascular consultant and dietitian.
- There were a range of outpatient clinics offered including, orthopaedics, cardiology, neurology and diabetes and endocrinology.
- Outpatient appointment times across the individual buildings and consulting houses were flexible and staff accommodated patient’s wishes for the time of their appointments as much as possible. Radiology and diagnostics staff rota covered a 24 hour period ensuring staff were available when required. Patients could access services in the evening and at weekends if required.
- Patient’s appointment times we dependent on individual consultants working pattern and organised and arranged by their own practice management systems. One patient told us appointments were “convenient and information was good”.
- The clinic was easily accessible via public transport.

Access and flow

- On arrival, patients reported to the main reception where they would then be directed to the outpatients or diagnostic imaging departments. The relevant receptionist at the front of department would then book them in via an online system and direct them to the waiting area or clinic room and we observed patients easily finding their way to their destination. There was sufficient space and flexibility for the number of patients being treated at the time of inspection.
- Same day and next day appointments were available when required.
- Waiting times for appointments were variable. Most patients were seen within 15 minutes; however, nursing staff told us patients could wait longer when clinics were busy. We observed nursing staff kept patients updated on waiting times.
- Staff aimed to ensure patients appointments and any investigations could be accessed on the same day. This meant patients did not have to return unnecessarily. We observed one patients appointment times being rearranged to accommodate additional appointments to specialists required on the same day.

Good

Outpatients and diagnostic imaging

Meeting people's individual needs

- Patient appointments were scheduled to allow time for nursing assessment and consultation. For example, patients had a 30 minute appointment booked.
- Complimentary therapies, for example, reflexology, aromatherapy, reiki and acupuncture were offered to patients diagnosed with cancer alongside other treatments such as surgery, chemotherapy and radiotherapy.
- There was a dedicated cancer centre located at the "Duchess of Devonshire wing". This had been purpose build and provided a comfortable and calm environment for patients.
- Patient leaflets were available in the outpatient reception area covering a range of conditions and treatment options. Nursing staff told us they were not available in large print or other languages. There was no information to advise patients where they could obtain such information.
- Staff in radiology aimed to accommodate patient attendance on the same day to avoid the potential inconvenience caused by a repeat visit.
- The hospital could be accessed by those who had a physical disability as there was a lift available to all floors, and a ramp at the front entrance of the hospital. Staff could arrange porter assistance for patients travelling alone or who may need more help.
- The hospital offered proactive, personalised care to meet the needs of adults and children that attended the hospital.
- Carers, relatives and anyone else the patient requested were encouraged to attend appointments and stay with patients at all times.
- The hospital website gave clear information on what patients could expect when using outpatients and radiology and diagnostic services.
- Staff told us translation services were available for patients who did not have English as a first language and they were used occasionally.
- Signage throughout the hospital was clear and easy to follow.

Learning from complaints and concerns

- The hospital had a system for handling complaints and concerns. Its complaints policy was in line with recognised guidance and contractual obligations for independent hospitals in England and there were designated staff who handled all complaints in the hospital.
- Department specific complaints were discussed within teams. Complaint themes were also discussed with department managers at hospital leadership team meetings. Managers and staff told us feedback on any trends or themes about complaints would be provided if it was relevant to each department.

Are outpatients and diagnostic imaging services well-led?

Good

We rated well-led as good.

- There was a cohesive and open leadership team who were geared towards promoting high quality service provision.
- Governance processes were, in the main, sufficiently robust to provide an oversight of quality and clinical effectiveness. Some improvements were required to ensure all components of governance including audit was routinely reviewed to enable sufficient assurance to be provided to the executive team.
- The service was transparent when things went wrong. There was a positive reporting culture amongst the workforce. Lessons were learnt and action was taken when incidents or areas of concern had been identified.
- There was a clear vision and strategy which was known by staff across the organisation.

Leadership and culture of service

- The hospital management was led by the chief executive, with the matron /director of nursing, responsible for nursing, cancer services, pharmacy, clinical training, radiography, infection control and theatres.
- Radiology and nursing services reported to the matron/ director of nursing. Staff told us local leadership within outpatients and radiology and diagnostic services were

good. Managers were approachable, supportive and staff were proud of their service. Staff felt involved and were keen to improve systems and processes to ensure patients received the best care.

- Staff and managers at all levels said managers and senior managers were visible and accessible. Consultants spoke positively about the hospital's care and safety within outpatients and radiology and diagnostics.
- Staff commented on the proactive and responsive management style of leadership. Issues and concerns were promptly followed up and resolved and clinicians were involved and consulted about changes. Feedback was sought and responded to when considering changes or developments to services.
- There were clear lines of management responsibility and accountability within the outpatient's and diagnostic imaging departments.
- Throughout the inspection, all staff were welcoming and willing to speak with us Staff in outpatients and radiology and diagnostics departments spoke positively about the service they provided for patients. They were proud of their customer service and the way they worked as a team.

Vision and strategy for this this core service

- The hospital had a clear vision to deliver high quality care and promote good outcomes for patients. This was to be the "most trusted hospital". The hospital had five objectives that included, recruiting and retaining the "best staff", "provide the best patient experience" and being "efficient" in everything.
- There were strategy and supporting business plans that staff were aware of, which reflected the vision and values, and these were regularly monitored.

Governance, risk management and quality measurement

- A governance framework supported the delivery of the strategy and good quality care. For example, there were robust infection control processes led by a dedicated team of link nurses. Regular audits were undertaken to ensure all staff followed hand hygiene procedures. However, there was scope to improve the governance framework further by ensuring documentation and audit processes were routinely reviewed. For example, in radiology and diagnostics audit procedures were not effective enough in ensuring an appropriate system was in place to ensure practitioners and operators were adequately trained. The list of "operators" who had completed the relevant training for specific radiology and diagnostic treatment was incomplete. Schedule 2 regulation 4 of IR (ME) R… states "the employer must maintain documented and up to date training records for …operators to undertake operator's tasks and an "up to date list of practitioners should be maintained".
- There were structures to maintain clinical governance and risk management. For example, a monthly medical advisory committee (MAC), quarterly radiation safety committee (RSC) and risk governance meetings. The RSC monitored safety with representatives from radiology and diagnostic departments. The committee monitored and reviewed safety including reviewing audit information, radiation protection training, dosimetry service, radiation incidents and datix reporting. It updated staff on new legislation and guidance and reported on equipment surveys, for example, laser audits in OPD and theatres. Managers and clinicians discussed risks and clinical governance committee members included representatives from the executive board and consultants with privileges.
- The annual radiation protection audit completed in February 2016 reported that a "few minor improvements needed" to ensure they were fully compliant. We saw the action plan from the audit identified appropriate action had been promptly taken.
- As part of the hospitals IT Strategy there was a plan to transition to a single patient record. This work was in progress, with a timeframe of November/December 2016 where quality improvement and strategic options would be reviewed via the IT steering group. Currently inpatient records were kept as "episodes of care" and scanned into their IT system "Meditech".Other patient information for example pathology results and diagnostic images were kept on different systems within individual departments in the hospital.
- Outpatient's staff met monthly with matron to discuss and share relevant information about the services. Information from this meeting was disseminated to team via the team brief. Staff were asked to read and sign to ensure they were kept up to date.

Good

Outpatients and diagnostic imaging

- Weekly quality review meetings took place where they reviewed all patient complaints, compliments and incidents. Departmental meetings took place quarterly and there was good evidence of communications from junior to board staff and the other way around.

Public and staff engagement

- The hospital public and staff engagement processes have been reported on under the surgery service within this report.

Innovation, improvement and sustainability

- Staff who spoke with us in a staff forum told us there was a preparedness to invest in quality initiatives which did not (directly) generate revenue, for example, palliative Radium Rx. This was used for palliative treatment of cancer patients and anti-cancer treatments such as radiotherapy and chemotherapy.
- We were told of developments which had resulted in improvements, such as on-line radiotherapy imaging, one-stop shop for endocrinology diagnostics, and 72-hour results turnaround.

Outstanding practice and areas for improvement

Outstanding practice

- The new Intensive Care Unit has been designed and modelled in a manner which followed an holistic approach, with the aim to promote wellness and create a physical surrounding that as well as functionally efficient, is psychologically supportive.
- The annual multi-faith memorial service was recognised for its contribution to the end of life services and the broader approach of the hospital to its patients, their families and the staff.
- The hospital has membership of the British Critical Care Network to share best practice. A number of ICU nurses will be presenting at the 2017 BCCN conference for Intensive Care Nurses, which is acknowledged as a positive achievement for a small unit.
- The Falls Prevention group chaired by a senior Physiotherapist has reduced the falls within the hospital to 2.05% compared to the National Audit of Inpatient Falls 6.63% average.
- Daily Operational Handovers are attended by the whole operational team leads, including catering, housekeeping, IT, Estates as well as senior nursing staff and run by matron's office. These meetings provide an opportunity to review of all operational issues for the day including pain, falls risks, safeguarding and DNACPR. The opportunity to give feedback on operational issues which may impact on patient care is part of this.
- The hospital was proactive and supportive of staff obtaining additional qualifications.

Areas for improvement

Action the provider SHOULD take to improve

- Undertake audits of the completion of early warning score (EWS) and assess staff compliance with the required actions when a deterioration is noted.
- The radiology and diagnostics practitioner and "operator" list should be up to date and lists the appropriate individual practitioner and operator competencies.
- Improve overall compliance with the WHO Surgical Safety checklist.
- Ensure that all consultants with practising privileges have relevant DBS checks completed and recorded in their personnel files.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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