ASI London G Limited

OneWelbeck Lung Health

Inspection report

1 Welbeck Street
London
W1G 0AR
Tel:

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

Ratings

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

Summary of findings

Overall summary

This was the first time we had inspected this service. We rated it as good because:

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

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Outpatients	Good	This was the first time we had inspected this service. We rated it as good because: • The service had enough staff to care for patients and keep them safe. Staff had training in key skills, understood how to protect patients from abuse, and managed safety well. The service controlled infection risk well. Staff assessed risks to patients, acted on them and kept good care records. The service managed safety incidents well and learned lessons from them. • Staff provided good care and treatment, gave patients enough to eat and drink, and gave them pain relief when they needed it. Managers monitored the effectiveness of the service and made sure staff were competent. Staff worked well together for the benefit of patients, supported them to make decisions about their care, and had access to good information. • Staff treated patients with compassion and kindness, respected their privacy and dignity and took account of their individual needs. They provided emotional support to patients, families and carers. • The service planned care to meet the needs of their patients, took account of patients' individual needs, and made it easy for people to give feedback. People could access the service when they needed it and did not have to wait too long for treatment. • Leaders ran services well using reliable information systems and supported staff to develop their skills. Staff were involved in developing the service's vision and values. Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. Staff were clear about their roles and accountabilities. Staff were committed to improving services.

Summary of findings

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Summary of this inspection

Background to OneWelbeck Lung Health

OneWelbeck Lung Health is an independent health care provider offering outpatient services to patients. They are managed by a provider called ASI London G Limited and work within a wider hospital setting under an umbrella corporation, which provides other elements of care for the patient's pathway. The service has been registered with CQC since 2019 and had a registered manager in post at the time of the inspection and had not previously been inspected by CQC

The service had two pulmonary function testing rooms, one exercise laboratory and one spyromatrory. The service only provided care to adults. The service accepted referrals from independent doctors and accepted self-paying patients and those who had private medical insurance.

How we carried out this inspection

Our inspection was unannounced, and we used our comprehensive inspection methodology.

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

Our findings

Overview of ratings

Our ratings for this location are:

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

Good

Outpatients

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

Are Outpatients safe?

Good

Mandatory training

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

Staff received and kept up to date with their mandatory training. Staff spoke positively about training opportunities. Mandatory training was predominantly completed online but there was a hand hygiene module which was completed in a face-to-face setting. Staff had clinical competencies checked as part of their inductions and onboarding.

The mandatory training was comprehensive and met the needs of patients and staff. Staff were able to request additional or new training to ensure they could meet patient needs. At the time of our inspection, 97% of staff were up to date with mandatory training. All clinical staff completed intermediate life support training and the clinical nurse specialist working in the service completed advanced life support training.

Clinical staff completed training on recognising and responding to patients with dementia. Staff were trained to adapt communication and assessment approaches to ensure people understood their options and received the right care.

The centre director monitored mandatory training and alerted staff when they needed to update their training. Staff spoke of their opportunities to train and develop within the service.

Safeguarding

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

Staff received training specific for their role on how to recognise and report abuse. Staff who worked for a separate organisation who provided care through practicing privileges maintained the same standard of training as employed staff.

Staff could give examples of how to protect patients from harassment and discrimination, including those with protected characteristics under the Equality Act. Staff at all levels understood their responsibilities, such as staff who manned the reception desk and were able to observe patients waiting for an appointment.

Staff knew how to identify adults at risk of, or suffering, significant harm and worked with other agencies to protect them. Where staff identified that a safeguarding referral needed to be made, they would escalate to the centre director who would make a formal referral to the Local Authority Safeguarding Team.

The centre director told us that there was a policy change in safeguarding which now meant there was a requirement for senior staff to have safeguarding adults' level 4 training. The centre director had recently completed their safeguarding adults level 4 training session. The deputy centre director had completed safeguarding adults' level 3 training online, which expired on 24 December 2024.

Cleanliness, infection control and hygiene

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

The service performed well for cleanliness. The service had a contract with a cleaning company, which included the cleaning of reception and waiting areas; consulting rooms and offices; washroom and changing facilities. Waste management was also handled by the same contractor and clinical waste was collected from the service's clinical waste store at the end of each day.

Staff working in the service checked consultation rooms each morning to ensure that cleaning by the external cleaning company had taken place. Staff working in the service were responsible for bagging and disposing of linen before clinics started. Curtains got changed every six months but could be changed sooner if they became soiled.

Clinical areas were visibly clean and had suitable furnishings which were clean and well-maintained. We reviewed infection control protocols and assurance frameworks introduced as part of the service's response to Covid-19, which showed overall compliance. Handwashing and sanitising facilities were available for staff and visitors and there was signage to support good hand hygiene.

Cleaning records were up-to-date and demonstrated that all areas were cleaned regularly. The service completed cleaning checklists. There were regular audits such as hand hygiene observations, internal cleaning, infection control and sharps handling and disposal, which showed the service consistently performed to a high standard. The internal cleaning checklist audit undertaken on 13 July 2022 showed 100% compliance. Cleaning log checklists included photos taken of areas covered in the audit.

Staff followed infection control principles including the use of personal protective equipment (PPE). The service provided staff with personal protective PPE such as gloves and masks. We observed staff wearing PPE as they interacted with patients and as they moved around the service. Staff were bare below the elbows enabling effective hand hygiene, as recommended by the Department of Health.

Physiologists received hand hygiene training, with handwashing techniques observed and audited annually. Their certificates were uploaded to RADAR, the service's risk and compliance management system.

Environment and equipment

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

Good

Outpatients

The service had enough suitable equipment to help them to safely care for patients. Staff had enough space for consultations and exercise tests to be carried out safely. There were two lung consultation rooms; one exercise laboratory, two lung function testing rooms, and one spirometry.

Machinery was calibrated daily and there were service level agreements (SLAs) with companies for maintenance and repair. Gas cylinders were secured to the wall and re-ordered as necessary. The service had a contract for this with a reputable provider of industrial and specialist gases.

Consultation rooms were fitted with call bells. The nature of the service meant it would be rare a patient was left alone and needed to use the call bell. However, the system was maintained as a best practice safety measure.

The design of the environment followed national guidance. Staff demonstrated how they had access to evacuation routes and emergency equipment. There was a fire evacuation procedure and staff were informed of this procedure during their induction. The service had recently got a ski-pad mat for the event of an evacuation seen and staff had recently received training on it. There was a wheelchair available for less mobile patients.

All staff completed training in fire safety and knew how to respond in the event of a fire. The service had fire safety equipment which was checked regularly. All equipment was portable appliance testing (PAT) tested and was next due in September. The service kept an online spreadsheet to keep a record of due dates. The centre director told us and we confirmed that there were 15 air changes per hour for one of the lung function testing rooms as per recommended guidelines.

The service had a 'i-STAT Verification' standard operating procedure (SOP).

The calibration verification was performed to confirm that the calibration of an instrument or test system had remained stable throughout the reportable range.

There was a resuscitation trolley that was used by the service and two other OneWelbeck services co-located with OneWelbeck Lung Health. The service had an SLA with OneWelbeck Heart Health to use the resuscitation trolley. Expiry dates for the contents within the resuscitation trolley were all within date and we saw evidence of daily checking.

OneWelbeck Health Partners, the corporate entity to OneWelbeck Lung Health were looking to standardise all its resuscitation trolleys across all services within the building, in line with resuscitation council guidelines.

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

Assessing and responding to patient risk

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

All patients were screened upon admission to ensure safe patient care whilst at the service. The service's 'patient selection policy' provided a list of criteria to be met for them to be considered suitable to attend the service. Prior to admission, all patients underwent a pre-assessment and any issues identified would be escalated to a clinician. This was regularly reviewed in line with best practice and National Institute for Health and Care Excellence (NICE) guidance.

Good

Outpatients

A venous thromboembolism (VTE) assessment was conducted for all patients undergoing an invasive procedure.

All forms and risk assessments relating to patient admission, were discussed and reviewed at the service's quarterly Quality Assurance Performance Improvement (QAPI) Meeting.

Staff completed risk assessments for each patient, which included Covid-19 risk assessments. We saw a 'Guidance for Centre Directors and staff on Covid-19 Testing and Isolation', which outlined staff's responsibility with regards to testing for Covid-19. The guidance document stated that staff were required to test for Covid-19 twice weekly. Patients were asked to sign a consent form which recgonised the risk of contracting Covid-19 within a 'hospital' setting. Patients were screened on arrival to ensure they or no one in their household were experiencing symptoms of Covid-19. The service was managing the risk of Covid-19 amongst its staff by increasing the use of PPE and room ventilation, and ensuring that staff were lateral flow testing weekly.

There was an 'escalation of significant findings' SOP for those patients undertaking an exercise-induced bronchial provocation test.

The service's deteriorating policy set out a clear pathway for escalating concerns where a patient had a deteriorating NEWS, or a member of staff identified that a patient's condition was unstable. This included recognising the signs and symptoms of sepsis.

Staff responded promptly to any sudden deterioration in a patient's health. The service had a deteriorating patient's policy and had a transfer agreement with a local hospital. We were shown evidence of an incident form being completed, which resulted in a patient fainting whilst on an exercise bike. The incident form detailed that the emergency alarm was pulled and whilst the patient regained consciousness quite quickly, they were subject to ongoing monitoring before they were allowed to go home.

A professor who had worked in the service from its inception, told us that they felt the service had good SOPs and processes in place to manage deteriorating patients, of which there are very few. They told us that physicians would be made aware of a deteriorating patient but would not actively be involved unless needed. We were able to confirm this.

The service carried out deteriorating patient simulation drills. The themes from a recent drill where the aim was to evaluate the team's response to a deteriorating patient scenario with a health care assistant and no doctor cover included: good early recognition of symptoms; early calls for help; emergency equipment was obtained and high flow oxygen was attached quickly; and patients was laid on the floor and legs lifted for fluid return circulation.

Staffing

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

The service had enough staff to keep patients safe. Staffing included healthcare assistants (HCAs), physiologists, nurses, consultants, management and administrators. The number of clinical staff working in the service was based upon both capacity planning and based on risk assessment. The service were data driven with regards to their clinical staffing. The centre director told us that any staffing changes that had been implemented had not impacted service provision to date.

Good

Outpatients

Assessments of applications for practicing privileges were carried out by the management team. The service monitored compliance with the practicing privileges policy.

At the time of our inspection, OneWelbeck Lung Health employed one clinical cardiac physiologist as a locum. The service also employed one bank employee.

In the period 1 July 2021 to 30 June 2022, there had been a 12-month retention rate for the service of 53%. In the period 1 July 2021 to June 2022, there had been a 12-month turnover rate for the service of 47%. Two leavers went on to new posts within OneWelbeck. In the period 1 July 2021 to 30 June 2022, there had been a 4% sickness rate within the service. There was currently one 0.5 FTE Health care assistant vacancy.

Outside of business hours, recorded voicemails directed patients to their local accident and emergency department in the event of a medical emergency.

Records

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

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

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

Medicines

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

Staff followed systems and processes to prescribe and administer medicines safely. The service used a patient specific directive and worked to an 'Administering Medicines' policy. The centre director told us that there were some tests that patients couldn't self-refer themselves for because the test required the use of medicines. These tests would also not be able to be booked in by the administration team without a medicines referral from a clinician first. We saw evidence of a patient who had been nebulized, with the drug being prescribed by a referring physician. There was no requirement to counter check with a colleague or sign as administered, as completion of the test indicated that it had been given.

Staff reviewed each patient's medicines regularly and provided advice to patients and carers about their medicines. Only clinicians were able to make referrals and give advice to patients about medicines.

Staff completed medicines records accurately and kept them up to date. Patients who had been given a medicine had this recorded in their notes, which included the: batch number, strength, expiry date, drug dose and drug route.

Staff stored and managed all medicines and prescribing documents safely. All referrals for medicines were stored electronically on patient's files. Medicines keys were held by appropriate staff members. The service had implemented a red amber green (RAG) system to make sure that medicines didn't expire, and this system was described to be working well. We were provided with a medicines log, which showed that the eight medicines used in the service were all in date.

The service did not keep analgesia in stock. The service was looking to phase out medicines which didn't get used, and this was to reduce unnecessary stock levels.

A medicine storage and security audit which was completed on 26 July 2022 showed 100% compliance.

The centre director told us that the service only procured medicines from accredited suppliers and only certain members of staff could order medicines, which would then be approved by the centre director. All medicines would get signed into the service's department to say they had been received. The centre director told us the system to manage medicines could only be used by members of staff on an approved list to do so. Following this, medicines would then get taken to a medicines medical grade cabinet.

The service had a Teams Group with the other OneWelbeck services within the building, which would notify the service if there had been any deliveries made in error to other floors.

The service only used medicines approved for use.

Staff learned from safety alerts and incidents to improve practice. Medicines incidents were logged on RADAR (a compliance and risk management system), which also allowed for the creation of an accompanying action plan. Medicines and Healthcare products Regulatory Agency (MHRA) alerts were also logged. The centre director told us that any medicine that the service used would be disposed of if it had been recalled.

The service had a pharmacy advisor who worked with the service and who would notify them of any medicine recalls. The centre director told us the pharmacy advisor was always available for advice and guidance. The pharmacy advisor sat on all the service's clinical operational forums and provided updates specific to medicines management. The service had plans to employ a pharmacist within the organisation.

Medicines management training was completed by all clinical staff working at OneWelbeck Lung Health and at the time of inspection, all staff were 100% complaint

The service ensured people's behaviour was not controlled by excessive and inappropriate use of medicines. The service did not have a controlled drugs license and stated they would only be giving out medicines prescribed or advised by consultants, so the service was not worried about an abuse of that process.

Incidents

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

Staff knew what incidents to report and how to report them. They used a system called RADAR to record all incidents.

Staff raised concerns and reported incidents and near misses in line with the service's policy. We saw evidence of where staff had reported incidents.

Good

Outpatients

The service had not recorded any serious incidents, nor never events or hospital transfers, and they hadn't yet had to notify CQC of any of these occurrences. The service recognised they were a low risk service but understood and reinforced amongst their staff the importance of reporting incidents when they arose. Incidents were discussed at Quality Assurance Performance Improvement (QAPI) meetings and at weekly team briefs.

The centre director told us that in the event of an incident related to the patient's care or a formal complaint, a case review would be conducted by a consultant not involved in the case.

Staff received feedback from the investigation of incidents. Debriefs occurred following an incident and learning was shared amongst staff in a weekly email circular that was sent out by the centre director. All incidents documented on RADAR included feedback. Lessons learnt from incidents were also discussed at team meetings and operational forum meetings.

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

Are Outpatients effective?

Good

Evidence-based care and treatment

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

Staff followed up-to-date policies to plan and deliver high quality care according to best practice and national guidance. Policies were written based on best practice and amended as needed. All policies were subject to a regular review schedule which was overseen by the Quality Assurance Performance Improvement (QAPI) Committee. Policies were reviewed in the event of a change in guidance, which could result in the change of a standard operating procedure, in line with new guidance and local risk assessment. The service was following Association of Respiratory Physiologists (ARTP) guidelines and the centre director would cascade any updates or changes in the guidelines down to staff.

The service provided a range of tests and day-case procedures which met best practice guidelines for investigation of respiratory issues according to NICE guidance.

Welbeck Health Partners, the corporate entity to the service, employed subject matter experts to aid in the development of policies to ensure that they were following best and current practice. All staff had access to policies within RADAR, the service's compliance and risk management system.

New policies were shared with staff through the 'notice' function within RADAR, which required a read receipt to be acknowledged by the staff member.

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

Pain relief

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

Staff assessed patients' pain using a recognised tool and gave pain relief in line with individual needs and best practice. Assessment of pain was completed in line with the service's pain management policy. Pain was assessed using a numeric scale. The corporate entity to the service had commissioned an external subject matter expert to complete a review of pain management for patients. The centre director told us that the report was currently in draft form and the policy was now under review.

Patient outcomes

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

Managers and staff carried out a comprehensive programme of repeated audits to check improvement over time.

Managers used information from the audits to improve care and treatment. Audit results were shared and were available on RADAR and all audit results were discussed at QAPI. If staff failed in an audit, they would receive additional education from management in relation to that audit.

There were 10 audits that the service undertook in August 2022 that showed 100% compliance.

The service was not participating in any national audits.

Competent staff

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

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

The centre director was able to maintain a record of consultant compliance and was able to review when items from their practicing privileges requirements became overdue. The consultant practicing privileges record showed 100% compliance.

Managers gave all new staff a full induction tailored to their role before they started work.

The one bank employee working in the service was recruited and employed in line with the same model used for permanent staff members, which included: a right to work check; statutory mandatory training; Enhanced DBS; references; induction program and probationary period; and an appraisal schedule.

Locum staff were recruited via approved agencies. Documentation collected from the agency on appointment included: statutory mandatory training, Enhanced DBS (Disclosure and Baring Service); and references. Clinical competency assessments were also performed on appointment.

We were told by the centre director that membership to the Association of Respiratory Physiologists (ARTP) was voluntary as it was not a registered profession.

The centre director was registered with the Registration Council for Clinical Physiologists (RCCP), which was a bit more regulated than ARTP but membership with this organisation was also voluntary.

Managers made sure staff attended team meetings or had access to full notes when they could not attend. The service hosted 'all staff' meetings which featured educational content to promote staff development and knowledge.

Managers identified any training needs their staff had and gave them the time and opportunity to develop their skills and knowledge. Staff training needs were identified though one-to-one monthly meetings and clinical competency assessments. Clinical supervision contracts were in place and formed part of the one-to-one process for clinical staff. Clinical competency assessments were reviewed at annual appraisals. Annual appraisals were an opportunity to discuss continuous professional development plans.

Staff had the opportunity to discuss training needs with their line manager and were supported to develop their skills and knowledge. All staff were subject to a probationary period where managers could identify needs for development and celebrate progress and outstanding practice. Appraisals occurred annually, which served as an opportunity to provide support and highlight opportunities for development and staff progression and development. We spoke with a physiologist who told us that they had just their appraisal done by the centre director, with the aims and objectives being set for the year. They also stated that they had received good training since starting in post and felt that they were at least a year ahead of where they would be if they had remained in the NHS.

Managers and team leaders conducted monthly 1:1 meetings, which enabled staff and managers to discuss areas for development as well as providing time for staff to feel supported and acknowledged.

Managers made sure staff received any specialist training for their role. The service had a continual professional development budget which encouraged staff to attend conferences and undertake professional examinations.

Managers identified poor staff performance promptly and supported staff to improve. Staff performance was managed on a continual basis through probation review meetings, annual appraisals, 1:1 meetings and clinical supervision. Poor performance would result in an extension of the probationary period. Probation and appraisal meetings served as opportunities to discuss poor performance. The service managed performance improvement by providing additional training e.g. customer engagement program and clinical competencies.

We were told by a physiologist that there would be some HCAs would soon be undertaking a spirometry course to ease the pressure on physiologists, with the plan that HCAs would be mentored by physiologists.

Multidisciplinary working

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

Good

Outpatients

We were told by a physiologist that the service worked with the OneWelbeck Heart Health team and CT team when required, with there being a drive to work more closely with the heart health team. Staff stated that there was easy access to other services if needed.

The bookings team had close working relationships with the clinicians and their assistants to ensure patients were booked in at the correct time for follow-ups or further testing if necessary, in order to minimise any delays or cancellations.

Seven-day services

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

The service offered extended opening times of 8am to 8pm to allow availability of appointments, making the service more accessible for patients who worked or couldn't access the service during core hours.

Health promotion

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

The service had relevant information promoting healthy lifestyles and support in patient areas. Lung Health leaflets were available for patients to take on arrival or departure from the service. The service was now offering continuous positive airway pressure (CPAP) service. This is a form of treatment used to keep airways stented open while asleep.

One patient we spoke with told us that they were encouraged by a consultant's breathing techniques and holistic approach to care.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

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

Staff understood how and when to assess whether a patient had the capacity to make decisions about their care. These assessments were led by the consultant in charge of the patients care but could be requested by any member of the team who had concerns.

Staff gained consent from patients for their care and treatment in line with legislation and guidance and made sure patients consented to treatment based on all the information available. Patients told us they would have conversations at length with consultants about their treatment options.

When patients could not give consent, staff would flag to the consultant for an appropriate care plan. The service showed us a flow chart where if it was felt a patient wasn't able to consent then they would consider options such as: a best interest assessment, to identify if the patient had a power of attorney, or a specific medical power of attorney, and the results of those enquiries would determine if the service would have to explain to the patient that they would be unable to provide treatment. We were shown a 'mental capacity assessment and best interest flowchart – what is the decision and when does it need to be made' flowchart.

The service also told us they would make reasonable adjustments for patients to be able to consent such as allowing more time or giving patients extended appointment times.

Good

Outpatients

The service did not provide a dedicated mental health service but we were told by leaders that the service undertook table top exercises and scenarios to staff to see how they would deal with a patient who couldn't consent to a treatment decision because of living with a learning disability.

The centre director told us that there were times when a patient did not want to consent, which was mainly to do with having to take a medicine for their test which potentially would have side effects. The service would document it in the report and let the consultant know.

The service understood that whilst its client group were very low risk, they couldn't disregard the fact that they may receive patients who were living with a mental health issue.

The centre director and deputy centre director were trained mental health first aiders and the administration team leader was a mental health responder.

We spoke to a patient who told us that they were given a cooling off period for procedures and consent. This confirmed the service's information that such cooling off periods were provided.

The service also provided chaperones where a patient wanted to request one.

Are Outpatients caring?

Good

Compassionate care

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

Staff were discreet and responsive when caring for patients. Staff took time to interact with patients and those close to them in a respectful and considerate way. We observed several very positive interactions between staff and patients which demonstrated kindness and patience.

Patients said staff treated them well and with kindness. We observed patients being collected and called in with a warm greeting by their clinicians from the reception waiting area.

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

Staff understood and respected the individual needs of each patient and showed understanding and a non-judgmental attitude when caring for or discussing patients. Patients visiting the service were elective.

Two patients that we spoke with told us that they would recommend the service to friends and family. One of those patients told us that they had found out about the service through one of the consultants. Patients described consultants as putting them at ease, treating them well and the risks and benefits of certain procedures being explained.

Good

Outpatients

Emotional support

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

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

Staff described how they approached difficult conversations with patients, such as by ensuring they were in a private environment and offering time and space for questions.

Staff understood the emotional and social impact that a person's care, treatment or condition had on their wellbeing and on those close to them. The provider's mission statement was focused on a commitment to care and improving people's lives.

Understanding and involvement of patients and those close to them

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

Staff talked with patients, families and carers in a way they could understand, using communication aids where necessary. We observed staff adapt communication to ensure patients better understood. This included changing tone, volume and complexity of speech.

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

Staff supported patients to make informed decisions about their care. Patients all described being given the opportunity to ask questions about treatments and some told us they actively sought out the consultants at the service, due to their reputations.

Patients who were paying for their own treatment were given information about the costs before the treatment started. Those who were accessing treatment using their private medical insurance were reminded by the bookings team to have their approval codes.

Are Outpatients responsive?

Good

Service delivery to meet the needs of local people

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

Good

Outpatients

Managers planned and organised services, so they met the changing needs of the local population. Patient care was escalated appropriately where needed. This was often done based on clinical need or often simply due to the geographical location of a patient's home. The service ensured both these groups of patients accessed timely care. At times where the service had periods where multiple respiratory consultants were practicing, the scheduling team blocked key resources (namely pulmonary function testing) to allow a same day service.

The central London location meant that the service was accessible via public transport from most of the UK. The service had brokered preferential rates with hotels to allow patients to stay overnight the night before, for those patients requiring a day-case procedure if it was an early morning start.

The service minimised the number of times patients needed to attend the hospital, by ensuring patients had access to the required staff and tests on one occasion. The service ensured flexibility in scheduling appointments which allowed a patient to choose their preferred date and in most cases access diagnostic testing on the day of their consultation. This was underpinned by the service's electronic care records system, which allowed electronic audit trailed referral during consultations via bespoke outcome forms.

Facilities and premises were appropriate for the services being delivered. The facility was purpose built and designed to be step free. It aided the flow of patients through their care journey as services were positioned relevant to the stage of treatment they were in.

The service in some cases was able to procure equipment and considered the necessity to be able to remotely send ambulatory equipment to patients. This enabled patients to avoid unnecessary trips to the clinic to simply pick up or drop off equipment. Postage paid envelopes were supplied with ambulatory equipment to aid patients returning these items.

Managers monitored and acted to minimise missed appointments. The service offered extended opening times of 8am to 8pm, to allow availability of appointment early morning and in the evening, making the service more accessible for patients who relied on the assistance of relatives/carers.

Meeting people's individual needs

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

Waiting areas were bright, airy and well ventilated with comfortable seating. Staff facilitated private areas to wait on request. Waiting areas were equipped with fresh drinking water, tea, coffee and snacks.

The service was located on level three of a seven story building. The main entrance was accessible via an electronic, disabled friendly door with all floors being serviced with elevator access. The service was on one level with step free access and accessible toilets positioned at the front and back of the floor.

Patients could be supported with a hearing loop upon check-in and throughout their journey within the centre. The service had an agreement with language line which provided patients with access to translation services.

Monitors never faced patients and monitors were on an arm if staff needed to show the patient something.

Good

Outpatients

With multiple specialties working within the building, patients were supported with inter-referrals between different departments. All staff and consultants had access to the OneWelbeck directory app which detailed which consultants within different specialties were available at any given time.

We were told that patients could always be assisted by an advocate if they desired and on the day of our inspection, we saw relatives acting as advocates for patients. There was 95% compliance in the completion of the training module chaperone health and care level 2 amongst clerical and clinical staff.

We were told that newspapers and magazines were no longer provided in the reception area because of Covid-19.

Access and flow

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

Managers monitored waiting times and made sure patients could access services when needed and received treatment within agreed timeframes and national targets. There were no waiting times for patients in the service. The service aimed for lung consultations and follow up tests to be completed all in one day. The service did not want its private paying patients having to wait.

Managers monitored waiting times and made sure patients could access emergency services when needed and received treatment within agreed timeframes and national targets.

The service confirmed they were not yet having to turn patients away, but were looking at its current room utilisation for better efficiency. The service used an electronic tool to look at the room utilisation of resources to ensure the service allowed enough latent capacity to serve the needs of their patients in a timely way. Room utilisation was discussed at Quality Assurance Performance Improvement (QAPI) meetings, where data and figures would be analysed. The centre director told us that it was part of their job to look at business development and was always looking to match what the patients needed and wanted.

Managers worked to keep the number of cancelled appointments to a minimum. The service looked at cancellations at their QAPI meetings and looked at whether cancelled appointments had been rescheduled. Pre-test letters were sent to patients which some patients didn't always adhere to, and this would result in some appointments needing to be cancelled. We were told cancellations over the Covid-19 pandemic were quite high, but the service had since managed to get cancellation rates down. The service had looked at cancellation data at the beginning of the year and had instigated an action plan to address why those cancellations were occurring.

Managers and staff worked to make sure patients did not stay longer than they needed to.

The service did not have an inpatient facility. The service recognised that patients wanted choice and because it was a private healthcare facility, they did not like to have patients waiting.

Consultants always worked to time and if consultants were running late, consultants would keep patients informed. Although patients would remain in the service for extended periods of time if they chose to have their follow-up tests on the same day, this was seen as a more suitable alternative than having patients attend the service on one day for an episode of care, and then have to return on another day for a follow-up. Patients were however, given opportunities to attend follow-up appointments on another day if this was more suitable.

Good

Outpatients

The service told us they gave adequate times for their tests so they could ensure a seamless patient journey. The appointments team took account of staff breaks and lunches and other diary commitments when making bookings.

The professor working in the service told us that they were most proud of the service's recent move to change of histopathology provider, to enable direct communication including clinicians and faster processing of specimens. This had been done to prevent delays to treatment.

Learning from complaints and concerns

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

Patients, relatives and carers knew how to complain or raise concerns and told us they would be comfortable to do so, if they had concerns. The service displayed information about how to raise a concern in the waiting area.

The service clearly displayed information about how to raise a concern in patient areas. We saw patient feedback forms in the waiting area but we were also told that the service had an app that all its patients were subscribed to, and the app could prompt patients to complete a feedback form following their episode of care in the service.

Staff could give examples of how they used patient feedback to improve daily practice. The service also told us that they would invite patients to tell the service why they would never visit the service again. The service told us that all patients who stated that they would never visit the service again would be contacted as part of service's quality assurance process.

Staff understood the policy on complaints and knew how to handle them. Complaints and concerns could be logged by anybody working in the service. The centre director took ownership of complaints. We were told complaints followed: investigation, root cause analysis, and action planning. We were told that all staff were actively encouraged to take complaints seriously. All complaints were logged on the service's IT system.

Managers shared feedback from complaints with staff and learning was used to improve the service. We saw evidence of a weekly circular which was sent to all staff on a Monday from the centre director about complaints that occurred the previous week, and included actions and lessons learnt.

Managers investigated complaints and identified themes. We were told there were no general themes to complaints but there had been several complaints of patients being left in the 'subway' (a separate waiting area in the service) following their consultation before the administration staff would book the patients in for their subsequent diagnostic tests. The service told us they had since talked to consultants to make sure they were liaising with administration staff, so they know patients were waiting to be seen.

We were told the customer feedback from quarter one was that the greeting that patients received when they arrived at the service was a bit frosty. To address this, the administration team leader devised a customer engagement programme for staff which looked at how customer facing staff addressed patients, which included areas such as giving eye contact, saying good morning etc. The service was keen to ensure there was a basic standard of patient experience that patients received.

Are Outpatients well-led?

Good

Outpatients

Good

Leadership

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

OneWelbeck Lung Health was run by a top layer of management which formed the OneWelbeck Lung Health Operating Board, which included: a medical director, a quality assurance performance improvement (QAPI) chair, a commercial director, a divisional director and a further two directors. Underneath that layer of management was a centre director and then a deputy centre director. Below that middle layer of management were the administration teams overseen by an administration team leader, the physiology team, the HCA team and clinical nurse specialist, all of whom would report to the deputy centre director.

The centre director told us that there had been many opportunities for staff to progress their careers within the organisation. We were given examples of where the current administration team leader, who had been working within the service since its inception had previously worked as a receptionist and then an administrator in the service. The now divisional director who previously was the centre director of the service and had also been working within the service since its inception.

Staff from all disciplines said that leaders were visible and were happy working in the service. The administration team leader told us how they felt that they had been "nurtured and given lots of trust and opportunities they wouldn't have been given elsewhere". We were told by both the centre director and divisional director that staff in line management roles did not work from home but maintained a presence in the OneWelbeck Lung Health offices. The centre director also maintained that they and the divisional director maintained an open-door policy, and nothing was too taboo for staff to come and speak to them about.

Vision and Strategy

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

OneWelbeck Lung Health's vision was to be the largest respiratory service in London, known for quality, reliability and ease of access for patients and also be: the top lung testing centre in the U.K., with efficient and thoughtful diagnostic pathways; have diverse sub-specialties, including sleep, chronic obstructive pulmonary disease (COPD), lung cancer screening; and MDTs for full spectrum conditions, not just malignancy.

To enable this, OneWelbeck Lung Health at a local level would endeavour to: have the largest private consortium of leading respiratory physicians; be an industry leading diagnostics provider; and provide chronic disease management support and insights.

The corporate strategy for the service was to enable key growth, which included having more doctors coming in to work for the service who could also generate new patients.

Good

Outpatients

The mission statement for OneWelbeck Lung Health was: “The decisions I make and work I do make me proud of the work I do at OneWelbeck”. The mission statement was underpinned by the following values: caring, respect, being committed, unification, being patient centred, empathic, and being quality focused. We were told that the values were created in concert with staff working in the service, as the leaders wanted staff to be able to define what it was they wanted out of working for the service. From the values, staff were able to generate the slogan for the mission statement.

Culture

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

The culture at OneWelbeck Lung Health, was one that was positive and was demonstrated in the examples that we were given by staff working in all disciplines. Leaders told us they had an open-door policy for staff to be able to approach them about any matters concerning them.

The administrator team leader told us the culture of the service was “a positive one and one where we are encouraged to ask for help. It’s a healthy environment and we all know who to go to if we need help”.

We heard several members of staff refer to making the transition to working at the service as a “leap of faith”.

Governance

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

The service worked in a building alongside other healthcare services, under an umbrella corporate brand. Patients were able to move smoothly between the services, depending on their healthcare needs and staff were clear about their roles and responsibilities as separate legal entities.

The service held and participated in numerous meetings, with and without the other services in the building. Each meeting had defined terms of reference and expected attendance lists. Staff were all clear about what was expected of them at each meeting and how the different meetings worked together, when required.

There was a Quality Assurance and Performance Improvement (QAPI) committee that met quarterly. The centre director attended this and discussed multiple areas of quality including updates to policies, incidents, improvement projects and audit results. This meeting fed into the Joint Venture (Operating) Board.

There was a Medical Executive Committee that was responsible for the management of the clinicians working for the service. The medical executive committee reviewed any applications for practicing privileges, and requests to introduce a new technology or technique and any concerns that had been raised about clinicians. The committee was chaired by the medical director. This meeting also fed into the Joint Venture (Operating) Board.

The Joint Venture Operating Board Meeting took place quarterly, and was attended by the medical director, QAPI chair, commercial director, chief clinical officer, finance representative, and divisional director. The function of this meeting was to look at responsibility for the planning, direction, control and management of the centre. It was also responsible for the activity, integrity, and strategy of the centre and had a statutory duty of quality to ensure high standards of governance were met.

There were regular staff meetings, with all members of the service invited. These meetings were a forum for staff to be updated on any changes to practice and policies and to give them a chance to feedback any comments they had about the service.

Management of risk, issues and performance

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

We were shown the risk register for the service. There were three current RAG rated risks on the risk register relating to workplace musculoskeletal injury; Covid -19 and the omicron variant; and evacuation of the floor in the event of any emergency. We were told that Covid-19 had originally been the highest rated risk, but it was now low. All risks were owned by centre director, with items of control with mitigations to those risks which could be assigned to other members of staff.

The workplace musculoskeletal injury risk was managed by ensuring that: Moving and Handling training informed staff's induction training; and there were ergonomically designed couches.

We were told the challenges the service faced related to the balance of providing an efficient service but to also address the needs of the doctors, as well as address the needs of patients too. The divisional director and centre director told us they wanted to ensure there was good flexibility for the doctors and for patients, but to also provide a service where patients get through their patient journey efficiently, without them feeling like they are going through a conveyor belt. The divisional director was complimentary of the doctors working in the service and stated that OneWelbeck were lucky to have an engaged group of doctors.

Some staff had previously received coaching from the divisional director about having confidence, maintaining eye contact with patients and having a caring attitude and just being less self-aware. We were not shown any records to support these conversations.

Information Management

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

All staff logged onto the same server, and computers were password protected with forced password changes every month. There was compulsory information governance training for all staff. The divisional director stressed that all the IT systems used in the service were all healthcare systems.

The service had a system to identify whether a medical executive working on behalf of a consultant had gone into a record that had no relation to their own doctor. On 1 May 2022, the service undertook an audit of access to its electronic patient record system and showed 100% user compliance, with no further investigation needed against unauthorised access.

We were told the service benefited from the appointment of a data protection officer (DPO), whom was shared across all of the OneWelbeck locations and that they received a quarterly newsletter from the DPO. Topics discussed in the

newsletter included information about, phishing emails, patient ID verification, the use of encryption when sending emails to external email addresses when including personal data, and a reminder about reporting information governance incidents. At the end of the newsletter, it included corporate statistics for the quarter against key performance indicators such as: data protection incidents, notified breaches and subject access requests at a corporate level.

We were told that data protection team were constantly doing exercises for phishing, spam, virus and malware and they would feedback to the service on how many people might have opened those emails.

We were told that for staff working remotely, there was a two-factor authentication app that they needed to use to be able to access IT systems.

It was included as part of staff's induction that the service worked to a clear desk policy, as well as logging out of systems. Monitors never faced patients and monitors were on a moveable arm if staff needed to show a patient something.

Staff would sign an information governance workforce statement, to acknowledgement the data that they were working with.

The medical director was the nominated Caldicott guardian and it was also mentioned in staff's mandatory training who the Caldicott guardian was.

Screen savers on staff's computer were about data protection, with reminders about: 'disposing of any work carefully', 'only using authorised IT systems', 'when sending information, making sure it is securely encrypted', and 'ensuring your workspace is acceptable? Make sure you've read your internal policy.'

ID passes & access-controlled doors to stop people wandering around who shouldn't be.

Engagement

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

The administrator team leader for the service had devised a customer engagement programme which staff were soon going to participate in. The programme looked at what good customer service was; body language, conversations and atmosphere; and other aspects of customer service such as email and phone etiquette and complaints handling. The service told us that previously, patients had commented that the greeting they received when they arrived in the service was a bit frosty and from that the customer service programme had been developed.

The service's staff survey showed that, across a number of measures which included: does your manager value your feedback/suggestions; do you feel valued for your contributions; how transparent do you feel the management is; do your superiors communicate company news effectively and in a timely way, staff were generally in agreement "a lot" or "a great deal".

Good

Outpatients

Patients were encouraged to fill out patient feedback forms by staff if they wanted to leave feedback during their visit and we saw an example of where a patient had rated their experience with their consultant and their time spent in the reception area as “exceptional”. Reasons were also given for why they had given the service that rating, and we saw evidence of how the service would use the good or bad feedback it received to make improvements in the service.

We reviewed twelve months of patient satisfaction data, which showed overall positive sentiments towards the service. All patients were automatically enrolled onto the service’s patient app called MyRecovery. This app sent patient satisfaction prompts after each appointment. We were told response rates were approximately 10%. We were also told that all patients who rated the question “How likely are you to recommend this centre to friends and family for similar care or treatment” as unlikely were contacted to offer them a chance to feedback the reasons for the rating.

Learning, continuous improvement and innovation

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

The patient app, MyRecovery allowed for patients to watch a pre-scripted introduction from the: centre director and doctors before they visited the service. We were told the app was linked to the electronic records system, so pre assessment questionnaires completed on the app could be fed through to the electronic records system.