Trustees of The London Clinic Limited

The London Clinic

Inspection report

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

Ratings

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

Summary of findings

Overall summary

Established in 1932, The London Clinic is a charitable hospital 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 registered 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.

The London Clinic was last inspected in November/December 2016 and the report was published on 17 November 2017. The location was rated Good overall. Surgery was rated good overall, with Requires Improvement in the Safe domain, Good in effective, caring, responsive and well-led.

We carried out an unannounced inspection of surgery at the London Clinic on 8-9 June 2021, as we received information that gave us concerns about the safety and quality of services. Those concerns arose from several never events and serious incidents and numerous whistle-blowers around staffing and culture.

As a result of this inspection, we used our enforcement powers to serve a Warning Notice to the provider under section 29 of the Health and Social Care Act 2008. This was served for failing to comply with Regulation 17: Good Governance. As a result, the provider must demonstrate to CQC compliance with the concerns identified in the warning notice by a set date. A future inspection will be held to check compliance.

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Surgery	Requires Improvement 	

Summary of findings

Contents

Summary of this inspection

Areas for improvement

Our rating of this location went down. We rated it as requires improvement because:

- The service had an inconsistent approach to managing patient safety incidents and learning was not always used to improve patient care.
- Although nurse staffing matched the planned numbers during our inspection, the use of bank/agency staff were high. In addition, the service had a high sickness rate and staff turnover rate.
- Most of the policies we reviewed during our inspection were out of date and there were ineffective systems to review policies.
- The service did not have strong systems for monitoring the outcome of care and treatment. Some of the local audit results including controlled drug compliance audits, care bundle audit and consents audits were consistently below the provider's target for the period reviewed.
- The service did not investigate complaints fully and lessons learned were not always shared with staff.
- Leaders did not always have the skills and abilities to run the service.
- The service did not always operate effective governance processes. Staff at all levels were unclear about their roles and accountabilities but did have opportunities to meet, discuss the performance of the service.
- Leaders and teams used systems to manage performance. However, risks were not always identified and escalated appropriately.
- The service collected data and analysed it. However, staff could not always find the data they needed, in easily accessible formats, to understand performance, make decisions and improvements.

However:

- Staff had training in key skills and understood how to protect patients from abuse. The service controlled infection risks well. Staff assessed risks to patients, acted on them and kept good care records.
- Staff gave patients enough to eat and drink and gave them pain relief when they needed it. Staff worked well together for the benefit of patients, advised them on how to lead healthier lives, supported them to make decisions about their care, and had access to good information. Key services were available seven days a week.
- Staff treated patients with compassion and kindness, respected their privacy and dignity, took account of their individual needs, and helped them understand their conditions. They provided emotional support to patients, families and carers.
- The service planned care to meet the needs of local people and took account of patients' individual needs. People could access the service when they needed it and did not have to wait too long for treatment.
- Some staff felt respected, supported and valued. They were focused on the needs of patients receiving care.
- 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.

Our findings

Overview of ratings

Our ratings for this location are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Surgery	Requires Improvement	Requires Improvement	Good	Requires Improvement	Inadequate	Requires Improvement
Overall	Good	Good	Good	Good	Requires Improvement	Good

Requires Improvement

Surgery

Safe	Requires Improvement
Effective	Requires Improvement
Caring	Good
Responsive	Requires Improvement
Well-led	Inadequate

Are Surgery safe?

Requires Improvement

Our rating of safe stayed the same. We rated it as requires improvement.

Mandatory training

The service provided mandatory training in key skills to all staff, however, overall completion rates was slightly below the provider's target.

The provider's mandatory training was delivered through e-learning and face to face training. Most staff had completed their mandatory training; however, overall compliance (87%) was slightly below the provider's target of 90%. The provider stated that a number of modules required annual completion with a large number of people falling out of date across May and June. The provider stated they were confident the hospital would achieve the 90% target in a few weeks, following our inspection.

Consultants with practising privileges completed mandatory training at their employing NHS trust. Staff informed us assurance of mandatory training was checked by the hospital credential team and referred to the Medical Advisory Committee (MAC) for approval.

Managers monitored mandatory training and alerted staff when they needed to update their training.

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. All employees completed safeguarding level two training. Ward managers, senior nurses, safeguarding leads and bleep holders' complete level 3 safeguarding training.

Staff compliance with safeguarding training was mostly in line with the provider's target of 90%.

Staff had access to the hospital safeguarding policies for children and adults via the hospital intranet. We reviewed the provider's safeguarding policies and noted they were in date.

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

Staff knew how to make a safeguarding referral and who to inform if they had concerns. Staff knew how to identify adults and children at risk of, or suffering, significant harm and worked with other agencies to protect them.

Cleanliness, infection control and hygiene

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

All clinical areas we inspected were visibly clean and tidy.

Visitors had their temperatures taken on arrival to the hospital and were prompted to wear a face mask and wash their hands. There was a hand sanitising station at the entrance to the hospital and visitors had access face masks.

Seating had been arranged in the reception area to allow social distancing for patients.

Staff had easy access to personal protective equipment (PPE) such as masks, face shields, gowns and gloves. There was also sufficient access to antibacterial hand gels, as well as handwashing and drying facilities.

Staff were 'bare below the elbow' and adhered to infection control precautions throughout our inspection, such as hand washing and using hand sanitisers when entering and exiting the unit and bed spaces and wearing PPE when caring for patients.

Staff in theatres wore appropriate theatre clothing and designated theatre shoes. Staff were not permitted into any clinical areas within the theatre department in outdoor clothing.

Staff cleaned equipment after patient contact and labelled equipment to show when it was last cleaned. Inpatient rooms and consulting rooms were cleaned after each patient visit.

Disposable curtains were used in clinical areas and were labelled to indicate when they required changing. This meant the risk of cross infection was reduced.

Patients were accommodated in en-suite single rooms thereby reducing infection risks. We noted there were Infection Prevention and Control (IPC) precaution signs on doors when required. All patients had a COVID test within two to three days prior to surgery.

The hospital conducted quarterly hand hygiene audits. We received a copy of the hand hygiene audit results from January 2021 to March 2021, which showed good results.

There were 17 surgical site infections reported from January to May 2021.

The service monitored hospital acquired infections. There were five cases of E.coli bacteraemia, two cases of Clostridium difficile and two cases of Klebsiella species bacteraemia between January and March 2021.

Requires Improvement

Surgery

Environment and equipment

The design, maintenance and use of facilities, premises and equipment kept people safe. Staff were trained to use equipment. Staff managed clinical waste well. However, bath facilities were unsuitable to meet the needs of some patients.

The design of the environment followed national guidance in most clinical areas visited. However, en-suite facilities on the 6th floor which had baths rather than walk-in showers were unsuitable for orthopaedic and spinal patients accommodated on the ward. The provider indicated there was an ongoing project to refurbish the 5th and 6th floors to remove all baths. Following our inspection, the hospital informed us that patients had access to 3 showers located next to the aqua therapy pool on the same floor.

Environmental audits were used to monitor areas throughout the hospital. This included the 10 operating theatres, four of which had laminar flow. This is a circulating air system designed to minimise the risk of infections occurring during surgical procedures.

Patients were accommodated in en-suite rooms on each of the wards visited. There were suitable facilities for administration and housekeeping on the wards.

The service had enough suitable equipment to help them to safely care for patients. Equipment, including resuscitation trolleys had been safety checked and was subject to monitoring. There were adequate arrangements in place for the handling, storage and disposal of clinical waste, including sharps. Staff disposed of clinical waste safely.

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

Staff used the National Early Warning Score (NEWs) tool to identify patients at risk of deterioration. NEWs observations were recorded in all patient records we reviewed, and we saw information which confirmed monitoring of staffs completion of these assessments was carried out regularly.

Staff were aware of the process for escalating deteriorating patients to the resident medical officer (RMO) or intensive care outreach team.

We saw in our review of patient records that staff completed risk assessments for each patient on admission / arrival, using a recognised tool, and reviewed this regularly, including after any incident. The service monitored staff's compliance with the completion of risk assessments.

Pre-assessment for elective surgery took place at a designated pre-assessment unit in the hospital. Staff assessed patient's suitability for surgery. In our review of surgical notes, pre-assessments were clear and detailed.

Staff followed a sepsis pathway for the management of patients whose condition met the criteria. Patient notes reflected staff administered antibiotics in line with guidelines.

Theatre staff used the 'five steps to safer surgery' World Health Organisation (WHO) checklist; this is a nationally recognised system of checks before, during and after surgery, designed to prevent avoidable harm and mistakes during surgical procedures. We observed the WHO checklist was completed appropriately during a surgical procedure.

The hospital had a service level agreement between the hospital and a local NHS hospital for the transfer of deteriorating patients. The hospital also had an internal management of deteriorating patient policy, which included early detection of deteriorating patients using the NEWS 2 scoring tool. The hospital also had an outreach team which could refer into The London Clinic's intensive care unit.

Staff shared key information to keep patients safe when handing over their care to others and between shift changes.

However, there were seven incidents (between January and June 2021) where patients arrived at the theatres without valid pregnancy test contrary to the provider's policy. We found no evidence these women had sustained any harm and the correct testing was eventually carried out before any procedure took place.

Nurse staffing

The service had enough nursing and support 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 and agency staff a full induction. However, staff turnover rate, sickness rate and use of bank/agency staff were high.

We noted the number of nurses and healthcare assistants matched the planned numbers on units visited during our inspection. However, the service was highly dependent on bank and agency staff to fill shifts.

We were provided with the hospital's filled shift data from 3 May 2021 to 13 June 2021. The weekly filled shift rates varied between 94.7% to 99.5% during the period. However, this was not broken down for surgical services.

Data from the hospital indicated there were eight vacancies (3.81%) across nursing wards and five vacancies (4.24%) in the theatres department. The highest rate of vacancies were in the orthopaedic and spinal unit (three vacancies amounting to 15% of staff), plastics (two vacancies amounting to 10% of staff), operating theatres (two vacancies amounting to 4.55% of staff); and anaesthetic and recovery (three vacancies amounting to 7.89%).

Data provided by the hospital showed a high turnover rate for surgical services. The highest turnover rates were for the day surgery unit (33%), anaesthetic and recovery (23%), minimally invasive treatment unit (MITU) (21%), urology, nephrology and neurosciences (17%) and operating theatres (15%). Turnover rates for other surgical wards include gynaecology (12 %), orthopaedic and spinal (12%) and plastics (8%).

Data provided by the hospital showed a high sickness rate for most surgical services. These included day surgery unit (17.47%), gynaecology (8.56%), orthopaedic and spinal (35.51%), plastics (20.54%), pre-assessment (13.08%), urology, nephrology and neurosciences (22.87%), anaesthetic and recovery (13.77%), minimally invasive treatment unit (MITU) (8.35%), operating theatres (19.91%).

The service had a high rate of bank and agency staff usage. This included 43% for the day surgery unit (of which 32% were agency staff), 23% for gynaecology (of which 10% were agency staff), 37% for orthopaedic and spinal (of which 20% where agency staff), 43% for urology, nephrology and neurosciences (of which all were agency staff), 8% for operating theatres (of which 35% were agency staff). In addition, the MITU had 10% bank staff and the anaesthetic and recovery unit had 3% bank staff.

Senior ward staff informed us they requested for agency staff who were familiar with the service.

Managers made sure all bank and agency staff had a full induction and understood the service.

Requires Improvement

Surgery

Medical staffing

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

The service had enough medical staff to keep patients safe.

Resident medical officers (RMOs) provided cover 24 hours a day, seven days a week. This ensured nurses could quickly escalate any issues concerning a deteriorating patient.

Consultants worked for the hospital via practicing privileges. Practising privileges is a term used when doctors have been granted the right to practise in an independent hospital. The right is subject to various checks for example; their professional qualifications, registrations, appraisals, revalidation and fitness to practice declaration. The hospital had a credential team which reviewed records of consultants and took it to the Medical Advisory Committee (MAC) for approval.

The hospital had a medical director who led the medical team in conjunction with the MAC. The service had a surgical and anaesthetic on call rota and RMOs could escalate any urgent concerns to relevant consultants.

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's records were held in paper format and also electronically. Paper based records were stored securely in clocked cupboards at the nurses' stations. Staff could access patient records easily.

We reviewed eight patient records across inpatient surgical wards and the pre-assessment unit. Patient records were detailed and staff had signed and dated all entries. All inpatient records had care plans which identified all their care needs. Care plans had been reviewed when required.

Medicines

The service used systems and processes to safely prescribe, administer, record and store medicines. However, controlled drug audit results in theatres showed staff compliance was below the provider's target.

Staff followed systems and processes when safely prescribing, administering, recording and storing medicines.

Medical, nursing and pharmacy staff reviewed patients' medicines regularly and provided specific advice to patients and carers about their medicines. We reviewed five medication records of patients within surgery services. Records reviewed were legible and completed. Drug allergies were clearly documented in the patient records reviewed. All prescriptions were signed and dated by relevant staff.

Staff stored and managed medicines and prescribing documents in line with the provider's policy.

Medicines (including controlled drugs) were stored securely in locked cabinets and fridges. We checked a random sample of medicines within surgery services and found them in date. We noted that fridges on the wards had automated temperature checks. Staff were alerted in the event of an excursion in temperature and informed us they took appropriate action in line with guidelines.

Requires Improvement

Surgery

We reviewed controlled drug (CD) records in theatres, recovery unit and on the orthopaedic unit. Available records reviewed were for the last two weeks. We observed two members of staff had signed for all controlled drugs in line with national standards for medicines management. Only authorised staff could access CDs using individual keys.

The theatres quality dashboard showed results of CD compliance audits were below the provider's target of 92%. The service was rated amber in January (88%) and May (88.9%). It was rated red (77.8%) in April 2021.

Incidents

The service had an inconsistent approach to managing patient safety incidents.

Staff reported incidents on an electronic reporting system. Data provided by the hospital showed that between January 2021 and June 2021 staff reported 135 incidents with majority being categorised as 'negligible – no harm'.

The service had reported six serious incidents between June 2020 to June 2021. There were three never events within the same reporting period.

The service reported a total of four never events in 2020. All of them occurred between January and September 2020. Three involved retained items following surgery and there was a case of a wrong tooth extraction.

Never events are serious patient safety incidents that should not happen if healthcare providers follow national guidance on how to prevent them. Each never event has a potential to cause No

The provider explained that the events occurred during the coronavirus pandemic. In addition to private work there was partnership with the NHS which saw huge theatre activity, with high volumes of complex work involving several teams new to the organisation.

Each incident was investigated and a root cause analysis (RCA) report was drafted. The provider indicated learning was shared with key staff and the wider team. The provider stated they invited external surgeons to assist with some of the investigations. The provider also invited the Invited Review Mechanism (IRM) team of the Royal College of Surgeons of England (RCS) to inspect our theatres and their safety processes.

We found there was an inconsistent approach to dealing with incidents. For example, we saw there had been 11 incidents categorised as 'negligible – no harm' regarding pregnancy tests carried out prior to surgery.

For two patients, the pregnancy tests were positive and the surgery was cancelled. Two incidents involved delay in conducting pregnancy tests following delivery of samples for testing. Staff could not find the samples in both cases. Seven incidents involved patients arriving at the theatres without valid pregnancy test. We asked to review the Root Cause Analysis (RCA) investigation reports for these incidents. However, staff informed us they did not complete RCA reports because no harm occurred. This meant the service missed the opportunity to learn from these incidents and to prevent a re-occurrence. In contrast, staff informed us they were completing a lot of RCAs for "no or low harm" incidents, yet none was completed for incidents regarding pregnancy tests.

Senior staff informed us they conducted RCA investigations when there was patient harm. They also conducted RCAs for complex complaints (irrespectively of the category of harm). They said they were also producing reports on near misses. They informed us they wanted to build a safety culture to avoid actual harm.

Requires Improvement

Surgery

Staff knew how to report incidents and could give us examples of recent incidents they had raised. Although staff told us learnings from incidents was discussed at morning huddles and team meetings, some of the staff we spoke to could not provide examples of learnings from incidents. For example, four of the staff members we spoke to could not recall any incident regarding patients arriving at the theatres without valid pregnancy tests. Staff were unable to tell us what learning or any actions implemented following these incidents.

We were not assured that all staff recognised incidents. In one case, the service received a complaint on 29 July 2020. This was in relation to an incident that occurred on 2 July 2020. This was not recognised as an incident until 17 August 2020. This led to significant delay in responding to the patient because they had to complete an incident investigation before doing so. We spoke to four staff with responsibilities for handling complaints and incident investigations and they were unable to explain the process of recognising incidents from a complaint.

The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain 'notifiable safety incidents and provide reasonable support to that person. We saw duty of candour had been initiated for each never event we reviewed.

We asked four staff what they understood by the term 'duty of candour', two of the staff could not tell us what this meant.

RCA reports were not always detailed or completed fully. During our inspection, we reviewed five RCA reports and saw each of these were not fully completed. For example, all five reports had missing or incomplete text in the mandatory sections. In two of the RCA reports, the incident investigator was not detailed and three of the reports did not outline any action or recommendations. Two of the RCA reports we reviewed were draft copies and not the final version. Staff with responsibilities for completeness of RCA reports were unable to tell us how many RCA reports were pending completion and how many had been completed. Staff with oversight of RCA reports told us they felt the IT system for monitoring RCA progress was outdated and was not always easy to navigate.

We reviewed the RCA policy, which indicated that staff were required to complete RCAs within 40 days. However, only 13 of 34 RCAs on the RCA log we reviewed had been completed within 40 days. Some of these involved incidents that occurred in September 2020. This meant incidents were not being reviewed in line with the provider's policy. Staff were unable to explain why the RCA's were not completed within the allocated time.

Safety thermometer

The service used monitoring results well to improve safety.

There were 25 reported pressure ulcer incidents from January to May 2021. Of these, 15 were hospital acquired pressure ulcers. Nine of the reported incidents were grade 3 and above.

The service carried out SSKIN care bundle audits to monitor staff compliance.The SSKIN bundle is designed as a resource pack to aid in the assessment and care planning for people at risk of pressure ulcers. SSKIN stands for surface, skin inspection, keep moving, incontinence and nutrition.

The overall hospital compliance ranged from 88% to 80% from January to May 2021. Staff had access to a tissue viability nurse and used equipment to minimise or treat pressure ulcers.

Are Surgery effective?

Requires Improvement

Surgery

Requires Improvement

Our rating of effective went down. We rated it as requires improvement.

Evidence-based care and treatment

The service provided care and treatment based on national guidance and evidence-based practice. However, most of the policies reviewed during our inspection was out of date.

Staff had access to the provider's policies on the intranet. Ten of the 14 policies we reviewed during the inspection were out of date. These included the Implementation of local safety standards for invasive procedures at The London Clinic (26/10/20), Controlled Drug policy (31/05/2021), Incident management and datix policy (26/01/21), Responsibilities of staff groups who can administer intravenous drugs policy (10/10/20), Flushing of peripheral and central vascular access devices – policy (01/11/20), The London clinic patient restraint policy (08/02/20), The London Clinic Complaints policy (10/03/20), Pre-operative pregnancy testing policy (12/10/20), Handover policy (19/03/21) and Laparoscopy surgery post-op care policy (24/02/21).

We asked staff within the governance team about the process for reviewing policies. Staff could not tell us the process for reviewing policies once out of date. Staff were also unable to confirm if there was a system for alerting them to policies which were due to go out of date. As a result, policies were not regularly reviewed to incorporate learning from previous incidents and updated with regard to national or professional guidance.

Following our inspection, the hospital provided further information regarding the sign off of policies. This indicated the relevant head of service was responsible for ensuring policies were up to date. We were told the online portal sent automated reminders to relevant staff (described as the document owner) reminding them ahead of renewal date. The revised document was then reviewed and ratified by the document review group (DRG) which recommenced in May 2021.

The hospital identified six out of date policies (including incident management, responsibilities for staff groups who could administer intravenous drugs, flushing of lines policy, patient restraint policy, complaints policy and pre-operative pregnancy testing policy) as policies under review or going through approval.

The hospital indicated the pre-operative pregnancy testing policy had been approved by the DRG and was uploaded to the intranet on 10/06/2021. We reviewed an updated copy of the pre-operative pregnancy testing policy provided following our inspection. We noted the policy had a new review date (1/4/2022), however, the previous issue and approval date (12/4/2019) remained the same. In addition, the contents of the policy remained the same.

The hospital also provided us with an updated copy of the Implementation of local safety standards for invasive procedures at The London Clinic (review date - 23/11/2023), however, the issue and ratification date were on 23/11/2020.

The service audited staff compliance with guidelines in several areas and reported the results monthly or quarterly. These included the WHO safe surgery observational audit and retrospective audit, infection prevention and control audits, controlled drugs audit and consent audit. Audit results were reflected within the theatres quality dashboard and the hospital's clinical dashboard.

However, results of some of these audits including CD compliance audit, care bundle audit and consent audits were consistently below the provider's target during the period reviewed. For example, the quarterly care bundle audit result for the theatres department was rated red (70%) in January and amber (87%) in April against a target of 100%.

The hospital provided us with the theatres' quality dashboard with quality indicators for the theatres department. There was an overall hospital clinical dashboard, however, this was not broken down for surgical wards. As a result, we are unable to assess surgery ward performance against quality indicators such as care bundle audit compliance and CD compliance audit.

Nutrition and hydration

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

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

Our review of patient records showed staff fully and accurately completed patients' fluid and nutrition charts where needed. Staff used a nationally recognised screening tool to monitor patients at risk of malnutrition.

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

Patients waiting to have surgery were not left nil by mouth for long periods. Patients informed us staff ensured they were well hydrated and provided a choice of food following their procedure.

Dietitians informed us they worked together with chefs to create patient menus as well as offering good options.

Pain relief

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

Our review of patient records showed staff assessed patients' pain using a recognised tool and gave pain relief in line with individual needs and best practice. Patients told us they received pain relief soon after requesting it.

The hospital's clinical dashboard showed between January and March 2021 overall compliance with pain management was between 86% and 88%. This was lower than the provider's target of 100%. This audit was not broken down for surgical services.

Patient outcomes

The service did not have effective systems for monitoring the effectiveness of care and treatment. However, the service achieved good outcomes for patients in the national audit reviewed.

At the time of the inspection, the clinical effectiveness committee was suspended and an interim audit working group was in place. Staff informed us they contributed to national audits but could not tell us which national audits these were.

Requires Improvement

Surgery

Further information received following our inspection indicated the hospital participated in the national joint registry (NJR) audit and the national breast registry audit. We requested for the latest national audit results and received a copy of the national joint registry audit result, which were generally in line with expected standards.

During our inspection, we asked to review audits. Senior staff within the audit team could not access all audits. They informed us some audits were stored on local drives which they did not have access to. They indicated their IT systems were poor and it was difficult to follow through information. They told us this had been highlighted to the information access team and IT colleagues. A senior staff member with audit responsibilities, informed us they did not receive a handover from the previous post holder. As a result, there was a risk that outcomes and recommendations from audits could not be addressed by the provider.

We reviewed the hospital's clinical dashboard covering the period from January to May 2021. This showed there were three unplanned transfers to other hospitals, which was low. During the same period, there were 26 unplanned intensive care admissions within the hospital. The dashboard also showed unplanned return to theatre between January and March 2021 was less than 0.45%. This was better than the provider's target of 1.4%-3%.

Competent staff

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

Staff were experienced, qualified and had the right skills and knowledge to meet the needs of patients.

Staff (including agency staff) completed an induction period and that involved competency training. New staff shadowed experience staff. Senior staff informed us they often used agency staff that were already familiar with the hospital.

Staff informed us they had opportunity to discuss training needs with their line manager and were supported to develop their skills and knowledge.

Resident Medical Officers (RMOs) completed an induction period and mandatory training. Practising privileges of consultants were approved by the Medical Advisory Committee (MAC).

However, in feedback letter dated 30 April 2021 the Invited Review Mechanism (IRM) team of the Royal College of Surgeons (RCS) of England highlighted concern that there were many consultants with practising privileges working at The London Clinic. The report stated it was difficult, if not impossible to ensure they all knew of the current policies and/or changes to procedures. The team concluded the process of granting practising privileges needed to be made more robust and to be regularly reviewed.

The provider indicated a review of consultants with practising privileges was in progress. We saw evidence from MAC minutes that some practising privileges had been withdrawn or suspended due to limited activity.

Multidisciplinary working

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

Staff worked across health care disciplines and with other agencies when required to care for patients. Nursing staff informed us they worked well together with other staff including therapists and consultants.

Requires Improvement

Surgery

Patients had access to a number of allied health professionals, we saw evidence of this in inpatient notes reviewed. This included physiotherapist, dietitians, occupational therapists and pharmacists.

Staff informed us they had a daily huddles and handovers where they discussed the day's activities, each patient, staffing and any issues regarding patient care.

The service held a number of multidisciplinary (MDT) meetings to discuss patients and improve their care. This included plastic, cosmetic and reconstructive surgery MDT meetings and gynaecology MDT meetings.

Seven-day services

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

Staff could call for support from doctors and other disciplines, including diagnostic tests, 24 hours a day, seven days a week. The service had a surgical and anaesthetic on call rota and RMOs could escalate any urgent concerns to relevant consultants.

The pharmacy was open Monday to Friday from 9am to 7pm, on Saturday from 9.30am to 1pm and on Sunday from 11am to 12pm. The pharmacy operated an on-call service outside open hours.

Physiotherapy service was available 24 hours a day and seven days a week. Occupational therapy was available Monday to Friday. Speech and language therapy service was available seven days a week and on call out of hours.

Dietetic service was available from 8am to 6pm on Monday to Friday and on call at the weekend.

Theatres and the recovery unit was open Monday to Saturday. The department had an on-call rota for staff to attend on Sundays in the event of urgent cases.

Health promotion

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

Staff assessed each patient's health when admitted and provided support for any individual needs to live a healthier lifestyle.

The hospital offered patients a detailed therapy service including physiotherapy, occupational therapy, speech and language therapy, dietetics, psychological therapy, clinical rehabilitation therapy, complementary therapy and aquatic therapy. Complementary therapy included reflexology and head massage.

The therapy staff assisted with pre-admission by helping patients to get fit for surgery. They assisted patients through surgery and also for rehabilitation following surgery.

The service had equipment to aid rehabilitation of patients who could not weight bare including anti-gravity treadmill option to upload up to 80% of body weight and single leg exercise bicycles.

The hospital provided aquatic therapy to patients which enabled patients to exercise in the pool even if they could not weight bare.

Requires Improvement

Surgery

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. However, consent audit results were below the provider's target.

Staff gained consent from patients for their care and treatment in line with legislation and guidance. Our review of patients notes (including pre-assessment notes) showed consent forms were completed correctly with all appropriate sections completed.

All patients we spoke with said they had been given information about the benefits and risks of their surgery before they signed the consent form. Patients told us staff always asked their consent prior to commencing care or treatment.

Staff understood relevant consent and decision-making requirements of legislation and guidance, including the Mental Health Act and Mental Capacity Act 2005.

The hospital's clinical dashboard was used to monitor compliance for consent of patient prior to surgery, with a target of 100%. A separate theatre quality dashboard had a different target for consent of 95%. In both cases, audit results for January to April 2021 showed these targets were not met. Theatre exceeded the target in May 2021.

Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS) was part of the mandatory training. Data provided by the hospital showed most staff were up to date with MCA/DoLS training.

Are Surgery caring?

Good

Our rating of caring stayed the same. We rated it as 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 spoke to three patients during our inspection and they were all positive about their care and treatment. Patients said staff treated them well and with kindness. Patients informed us they were happy with the care received. They described the care has "fantastic" and felt staff were nice, comforting and re-assuring.

Patient satisfaction survey results showed over 98% of inpatients surveyed between January 2021 and April 2021 indicated they were extremely likely or likely to recommend the hospital to friends and families.

Staff followed policy to keep patient care and treatment confidential. Patients were cared for in single rooms which protected their privacy and dignity.

Requires Improvement

Surgery

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

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. A patient we spoke to told us staff supported them emotionally when they expressed that they were anxious about their procedure. They said staff were reassuring and engaging and helped them to feel at ease.

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.

Patients had access to psychological therapists who managed psychological support for patients. The hospital also had a palliative Clinical Nurse Specialist for bereavement support.

Understanding and involvement of patients and those close to them

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

Staff made sure patients and those close to them understood their care and treatment.

Staff talked with patients, families and carers in a way they could understand, using communication aids where necessary.

Patients and their families could give feedback on the service and their treatment and staff supported them to do this.

Staff supported patients to make informed decisions about their care.

Patients gave positive feedback about the service.

Are Surgery responsive?

Requires Improvement

Our rating of responsive went down. We rated it as requires improvement.

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.

Admissions to the hospital were elective. This meant admissions to surgical inpatient wards were planned in advance with the patient, at a time and date convenient to them. Patients were admitted under the care of a consultant who had practising privileges at the location.

Requires Improvement

Surgery

The hospital had a large demography of international patients and designed services to meet the needs of this group. The hospital's international office managed all aspects of care of overseas patients and maintained positive working relationships with the relevant embassies.

The service had systems to help care for patients in need of additional support or specialist intervention. Patients add access to therapeutic services and there were clinical nurse specialist to provide specialist care.

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.

The service had information leaflets available in languages spoken by the patients.

Managers made sure staff, and patients, loved ones and carers could get help from interpreters when needed.

Patients were given a choice of food and drink to meet their cultural and religious preferences.

Staff had access to communication aids to help patients become partners in their care and treatment.

Information booklets about the hospital were available for patients. These included room facilities, meals, care expectations, health and safety, discharge and a patient guide which included information on charges, and complaints.

Access and flow

People could access the service when they needed it and received the right care promptly.

Dates for admission for surgery were booked around patients' and consultants' schedule. Patients we spoke with told us they were able to choose a date convenient for them.

Data provided by the hospital showed the service carried out 16,553 surgical procedures between June 2020 and June 2021. There were 457 cancelled procedures within 24 hours of the planned procedure date during the period. Sixty-one per cent (279) of these cancellations were for non-clinical reasons. Of all re-scheduled procedures 86.5% were operated within 28 days.

The service moved patients only when there was a clear medical reason or in their best interest. Patients transfers out of hospital or to other department such as the intensive care unit was low.

Discharge letter were sent to the patients' GP and other relevant practitioners. Discharge for overseas patients was arranged by the international office. The office maintained contact with relevant embassies prior to discharge and afterwards.

Learning from complaints and concerns

The service did not investigate complaints effectively. Lessons were not always shared with staff.

From July 2020 to June 2021 the hospital received 49 complaints in relation to surgical services. The hospital took an average of 37 days to investigate and close complaints.

Requires Improvement

Surgery

The complaint policy reviewed during our inspection was out of date (10 March 2020). It stated, "the complaint will be acknowledged within two days and responded to within twenty working days unless a full response can be sent within five working days". The policy further stated, "If a response cannot be provided within twenty working days, the complainant will be informed in writing for each twenty-day period until a written response is provided".

During our inspection, we reviewed complaints on the complaint log provided. It was unclear if any of them were completed within 20 days. Staff with complaint handling responsibilities were unable to explain whether an update had been provided to the complainant in line with the complaints policy timeframe. We asked to review four complaints chosen at random from the complaint log provided. Staff were unable to provide us with a file where all information relating to complaints were held. Therefore, the provider was unable to provide us with the information required to review these complaints.

Following our inspection, we were provided with a copy of the complaint log. This had an additional column specifying the timeframe for closure. It showed 27 complaints were not completed within the 20 day's timeline. Of these, nine complaints were completed within 31 to 37 days. Three complaints took 49, 71 and 94 days to complete.

Some of the dates on the complaint log were inconsistent. For example, in one case, a complaint was received in December 2020. The log indicated the acknowledgement letter was sent in April 2021 and the response was sent in January 2021. The status indicated the complaint was still 'in progress', yet staff had completed the log to indicate it took 29 days to complete the investigation.

The complaints log caused confusion amongst staff with complaints handling responsibilities as the columns on the complaints log did not corroborate with dates the complaints were received. Staff admitted the system for monitoring complaints was poor and did not provide them with adequate oversight of complaints received. There was a risk that complaints were not being investigated and responded to in a timely manner, and that where any learning or action was required of staff, this was not shared with the complainant. Therefore, we could not be assured there was sufficient oversight and effective handling of complaints.

The service was not measuring improvements made following complaints. Two out of four ward staff could not articulate the complaint process or any changes made as a result of learning from complaints. Whilst all staff we spoke with recognised what constituted a complaint, there were mixed examples given about the difference between complaints and incidents and the reporting processes for these. There was mixed understanding amongst staff regarding learning from complaints. Staff we spoke with were unable to fully articulate any learning or feedback as a result of a complaint. There was a risk that learning arising from the investigation of complaints was not subsequently shared with staff.

The hospital provided us with examples of how they have used learning from complaints to improve the service. In response to complaint about room facilities without walk in showers. The provider indicated they had applied a policy that rooms without walk in showers should not be used for hip replacement patients. They also stated there was an ongoing project to refurbish the 5th and 6th floors and remove all baths.

The provider stated they had employed an additional tissue viability nurse and implemented timely review of all patients with pressure ulcers following a concern about pressure ulcer care.

Are Surgery well-led?

Requires Improvement

Surgery

Inadequate

Our rating of well-led went down. We rated it as inadequate.

Leadership

Leaders were visible and approachable in the service for patients and staff. They supported staff to develop their skills and take on more senior roles.

Senior leaders were clear about their priorities for ensuring sustainable, compassionate, inclusive and effective leadership. The hospital had a strategy for leadership and were keen to promote staff to develop through a comprehensive development programme.

Shortly after our inspection, the director of nursing left their post suddenly. This left the hospital without a registered manager. We were informed that the director of clinical services had taken on the interim position of director of nursing, with an intention of becoming the registered manager. The post for director of nursing was out for vacancy at the time of writing this report.

Staff we spoke with during inspection felt that leaders of departments and teams sometimes left their positions suddenly and this made it challenging for staff to continue with work arrangements without any handover period. Staff mentioned the sudden departure of the clinical governance lead as being a challenge which they were still working to resolve.

During inspection, staff told us that there were lots of fluctuations with the leadership within the organisation than they believed was necessary. For example, staff told us that changes in simple processes such as the way information was collected and scrutinised, had to gain the permission of the director of nursing. Staff felt this slowed down the pace of positive change and was unnecessary considering the governance lead felt responsibility for some changes fell to them. Staff described a battle between some leaders to have more control of internal processes.

Ward staff told us they found their managers to be visible and supportive. Staff told us they felt they had good inter-personal relationships with their leaders and felt they listened and understood their queries.

Post inspection, we had a number of concerns raised to CQC from staff working at the hospital who stated they often felt the matron's team were overbearing and overly critical of the nursing workforce. A common theme identified from these concerns suggested that staff sometimes felt there was a dictatorial approach to leadership within the organisation. It was unclear whether these concerns relating to the surgical services or were more widespread.

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.

Senior staff we spoke with were aware of the hospitals vision for the future. They understood the vision and felt engaged in the development of the hospitals vision and strategy. However, junior members of staff working in the ward areas struggled to outline the hospitals vision for the future and were unclear of any strategy document being in existence. Whilst all staff acknowledged being engaged and contributing to ideas and suggestions, junior ward staff were unclear if their contributions were for the hospitals strategy or for other reasons.

Requires Improvement

Surgery

We observed staff demonstrating the values of the hospital in the way they treated and care for patients. We saw information on staff notice boards relating to the values of the hospital and staff told us the values were a key part to their induction process.

The hospital had a commitment to provide the best care for patients and staff at all levels we spoke with understood this commitment and felt themselves and their colleagues demonstrated this daily in their actions.

Culture

Whilst most staff were positive about the culture and felt valued and respected, we had received communications from a small number of staff where issues raised reflected otherwise.

Staff we spoke with informed us they could raise concerns and have those concerns addressed. They informed us they worked well together with other staff and consultants. They received feedback from senior staff via emails and meetings.

Staff felt supported by their managers. Some staff told us they felt respected and valued by their senior leaders. Staff we spoke with told is they felt positive and proud to work in the organisation. There was a sense amongst staff that the organisation encouraged openness and honesty at all levels. Staff felt they were able to raise concerns without the fear of retribution.

However, there was limited evidence to show that appropriate learning and action had been taken as a result of concerns raised. One member of ward staff told us they had raised a concern regarding the suitability of the environment for patients with orthopaedic conditions and highlighted their concerns that there was an increased risk of patients falling due to unsuitable arrangements in many patient bedrooms. This staff member told us they had not seen any recognition of their concern, which was raised to their immediate superior and no actions had been taken as a result, despite the concern being raised many months prior to our inspection.

The hospital had invited the Invited Review Mechanism (IRM) team of the Royal College of Surgeons (RCS) of England to inspect the hospital's theatre and safety processes. We reviewed the RCS feedback dated 30 April 2021. The review team did not identify any initial urgent patient safety concerns; however, the feedback highlighted several areas of concern including pre-operative care, perioperative care, staffing levels and review of practising privileges. On the issue of practising privileges, it was the IRM team's view that the process of granting practising privileges needed to be made more robust and to be regularly reviewed. The review team was concerned that there were many consultants with practising privileges working at The London Clinic and it was difficult, if not impossible to ensure they all knew of the current policies and/or changes to procedures.

In addition, the team felt that the human factors training provided by the hospital was insufficient to embed the culture change the organisation was seeking to achieve. It was the review team's view that meaningful learning and education should be embedded within the working time allocated to continued professional development.

In response to recommendations following internal and external investigations as well as the RCS review, the provider appointed a new head of clinical governance to strengthen leadership in clinical governance. A new human factors training module was commissioned and given to consultants as part of their statutory training. The provider stated that they intended to roll out the training to all staff.

Ward and theatre managers, we met with, spoke positively regarding their relationships with junior staff and the senior management team. These staff told us they felt their managers were approachable.

Requires Improvement

Surgery

After our inspection, CQC received several concerns raised through our 'give feedback on care' feature on the CQC website. Some of these concerns were from staff members who wished to remain anonymous. The concerns raised stated there was a cultural problem throughout the organisation and that staff felt their voices were silenced or unheard when raising concerns to senior managers. An example was provided whereby staff had raised concerns about work carried out by a consultant with practising privileges, but because this consultant was someone influential at the top of the organisation, staff felt they were made to supress their concerns and not make them known to senior management.

Another example was provided anonymously which stated there was a strong culture of fear amongst junior members of staff and when staff raised an issue relating to equipment going missing, staff were reprimanded for raising these concerns. These were also a theme from the concerns CQC received which suggested junior staffs' perception of consultants was they could do no wrong and any incidents involving medical staff were not treated in the same manner as incidents involving nursing staff. Staff felt there was a divide in the fairness applied to staff depending on their grade and how well known to senior management they were.

However, because some of these concerns were received anonymously to CQC, it was difficult to follow up with further information or to test the validity of the concern.

Following these concerns, the hospital responded in detail and shared plans to capture staffs view and to use these views to improve the service. Senior leaders were holding discussions with staff to ensure that their were mechanisms in place for staff to discuss their views and opinions in an open and supportive environment.

Post inspection, leaders told us that they had held engagement meetings with nursing staff and felt there was a good turn out to listening sessions and engagement had been good. This coincided with a decrease in staff raising concerns to the CQC.

Governance

Leaders did not always operate effective governance processes, throughout the service. Staff at all levels were unclear about their roles and accountabilities but did have opportunities to meet, discuss and learn from the performance of the service.

Prior to the inspection, staff told us there had been turbulence within the governance department with staff leaving post or being moved into other departments at short notice. Staff told us the team currently in post were working hard to develop a standardised way of working and to build a positive culture within the governance department. Staff told us that there was a lot of work to do to improve the governance structures as a result of previous staff not having the right skills to implement the changes required. Senior staff told us they recognised the rapid departure of staff in the department had negatively affected governance oversight.

Leaders did not always operate effective governance processes. Staff at all levels were unclear about their roles and accountabilities relating to governance. Staff told us that the nursing director had overall responsibility for governance across the hospital. However, the nursing director told the inspection team that overall responsibility for governance arrangements sat with the clinical governance lead and their team.

Staff were unclear about their roles and responsibilities when dealing with matters relating to the governance of the service. Although there was good attendance at governance and governance-related meetings, staff were unclear on the actions or learning from these meetings. Staff told us they were sometimes confused on the intended purpose of some of the meetings they attended.

Requires Improvement

Surgery

Leaders and teams used systems to manage and review performance, however, staff told us that because of IT constraints, it was often difficult to find information in a clear and simplified way. Staff could not always find data they needed, and the data was not always displayed in easily accessible formats. Information systems were not always integrated.

Staff showed a commitment to continually learning and improving the service. However, staff we spoke with could not tell us about any changes made through any recent governance meetings.

Leaders did not have full oversight of the risks identified during the inspection and information we requested on site during the inspection, such as risk assessments, could not be produced on site and were provided post inspection. Members of staff with responsibilities relating to governance could not identify their key priorities and the plans for development over the next calendar year.

It was unclear from speaking with staff what arrangements were in place for managing and monitoring any service level agreements (SLA's) the hospital had with third parties. We were provided with copies of SLA's and the arrangements for reviewing them after our site visit. We were not assured that governance staff had a good understanding of the review processes when asked on inspection.

Arrangements with partners and third-party providers were well governed and managed effectively. Meetings with local Clinical Commissioning Groups (CCG's) and Hospital Trusts encouraged appropriate interaction and promoted coordinated, person centred care.

The MAC received reports showing performance against operational standards and it was clear the intended actions which were being taken to improve and sustain surgical performance.

Staff were clear on the roles and responsibilities of the Medical Advisory Committee (MAC) in relation to governance of the service.

Management of risk, issues and performance

Leaders and teams used systems to manage performance. However, risks were not always identified and escalated appropriately.

The hospital did not have detailed assurance systems in place and performance issues were not always escalated appropriately. Although there were structures and processes for the hospitals risks, issues and performance to go through, these systems were not always effective and not regularly reviewed or improved.

The hospital had a number of committee meetings setup for information to pass through, however, whilst speaking with senior staff who attended a majority of these meetings, it was unclear the actions, learning or changes to process which had been changed following these meetings. One senior member of staff with a large portfolio of responsibilities, felt the meetings did not develop and changes were often slow or ineffective. Other staff we spoke with who attended quality meetings felt there needed to be a fundamental change to the way meetings are managed or chaired as they perceived that little to no action came as a result. The provider was unable to evidence their assurance at the time of inspection.

There was no systematic programme of clinical and internal audit to monitor quality or operational processes. Whilst there was an audit schedule, it was a confusing picture as to whom had responsibility to carry out any specific audit and

what information was gained from carrying out the audit. Changes to policy or practice were not demonstrable and staff we spoke with told us there needed to be an overhaul of the auditing process and system for tracking and checking audit compliance. Problems relating to IT infrastructure meant the head of auditing for the hospital could not see the audits carried out in the outpatients department.

There were limited arrangements for identifying, recording and managing risks. A review of the hospitals risk register showed an inconsistent approach to how risk were being identified, logged, managed and mitigated. Staff with responsibilities for overseeing and managing the risk register were confused as to how the hospitals processes worked. During a review of the risk register it was noted that risks were sometimes confused with incidents and the column for 'risk owner' was often missing or had staff names who were no longer working at the hospital. Staff with risk management responsibilities were unclear what was meant by 'accepted risk' and whether any of these were highlighted on the risk register. It was also unclear to staff with risk management responsibilities as to whom was responsible for reviewing the risks or which committee meeting were risk discussed in.

We were unable to corroborate with staff working on the ward areas whether they had received feedback on performance or if they were aware of risks relating to their area of practice. Whilst ward managers could articulate limited learning from incidents, it was unclear from speaking with staff whether they had an oversight of risks within their department. One staff member we spoke with was confused on the difference between an incident and a risk. Although all staff we spoke with were able to tell us how they would raise any concern, incident or risk through the incident management system there was a mixed picture on the information staff received from the concerns they had recorded.

We reviewed Medical Advisory Committee (MAC) meeting minutes for May 2021 which showed discussions around continuous service improvement, practising privileges, risks and incidents as well as complaint discussion.

Information Management

The service collected data and analysed it. However, Staff could not always find the data they needed, in easily accessible formats, to understand performance, make decisions and improvements. The information systems were not always integrated but were secure. Data or notifications were consistently submitted to external organisations as required.

There was a lack of effective arrangements in place to ensure that information used to monitor, manage and report on quality and performance was accurate, reliable and relevant. Staff told us the IT systems they used did not always allow for easy assimilation of information. For example, information relating to audits were held on different systems which some staff had access to and others did not. Staff felt the same or similar information was held on different systems which made it challenging to find what they required.

Quality and sustainability both received sufficient coverage in all relevant meetings. Staff told us that data and information was challenged appropriately during meetings. This was corroborated through a review of meeting minutes from departmental meetings.

Ward staff told us they sometimes had difficulty accessing information relating to their department. For example, when requesting information relating to agency usage, managerial staff said it was difficult to get this information easily and it would require several emails to other teams within the service. Staff felt that whilst information was held within the service, getting hold of it could take longer than they would like.

During inspection, we requested several documents, such as mandatory training compliance breakdown, a full audit schedule and a list of services provided outside of the hospital setting. Some documents were provided to us in part,

whilst others were sent to us electronically post inspection, despite the inspection team requesting them by the end of the first day of inspection. One document, the full list of audit schedule was not recognised by the audit lead and it was often confusing whether the inspection team had the most up to date document or if it had been produced solely due to our request. Due to the sudden departure of the director of nursing, post inspection, several other documents were delayed in being sent to CQC.

Staff felt the implementation of an incident reporting system was a good addition. Staff felt the incident management system was easy to use, they could extract information from it with relative ease and staff had a confidence finding the information they required from it. Inputting information in this system was reported to be simplistic by staff.

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.

Staffs views and experiences were gathered through internal surveys and acted on to shape and the improve the service and it's culture. Equality groups were continually consulted, and their views incorporated into the planning and decision making which shaped surgical services.

Staff felt their views were listened to and felt they had opportunity to contribute to improvements within the service.

People who use the service, those close to them and their representatives were actively engaged in the improvement of the service. We saw evidence of patients being able to provide feedback on their experience and staff told us they discussed patient feedback in their regular team meetings.

The hospital engaged well with external partners, such as the Royal Colleges, to build a shared understanding of challenges within the system and the needs of the population. We were provided with documents outlining some of the approaches the hospital had taken during the Coronavirus pandemic, such as agreeing to undertake additional NHS work. The hospital also engaged in a meaningful and transparent manner when holding discussions with local NHS trusts whom patients were being treated at The London Clinic.

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 the, however, change was often perceived by staff as slow. Leaders encouraged innovation and participation in research.

Leaders told us they strived for continuous learning, improvement and innovation. They told us they consistently looked for ways to participate in appropriate research projects and recognised accreditation schemes.

Whilst the hospital had standardised improvement tools for staff to use, it was unclear the degree to which these tools were assisting in improving the service. Staff we spoke with were aware of data collection tools and methods they could use to contribute to learning and innovation, however, staff were unable to provide examples of improvements when asked.

The hospital had participated in internal and external reviews, including those relating to mortality or the death of a person using the service. However, staff we spoke with felt the learning was not always implemented effectively or quickly.

Requires Improvement

Surgery

One review stated that RCA's were taking a long time to complete and were not always completed by someone external to the incident, however, staff felt whilst this was widely known and highlighted, no changes had yet been made to ensure this action was implemented. Several staff members told us that learning was often shared across the department but improvements and changes to process were slow.

Staff regularly took time to work together to resolve problems and to review individual and team objectives. However, staff again felt that changes to practice were slow.

Whilst the hospital does not admit patients for mental health conditions specifically, we did ask senior leaders if the service had anything planned or in progress in relation to learning, improvement and innovation which will assist in the delivery of mental health care for all patients admitted within the service. At the time of inspection, senior leaders were unable to clearly articulate anything of this nature.

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.

Regulated activity	Regulation
Surgical procedures Diagnostic and screening procedures Treatment of disease, disorder or injury Management of supply of blood and blood derived products	Regulation 17 HSCA (RA) Regulations 2014 Good governance • The service must ensure there is a consistent approach to managing patient safety incidents and disseminate learning from these to all staff. • The service must ensure polices are regularly reviewed and contain the most relevant and up to date information and are accessible to all staff. • The service must ensure there are effective systems for monitoring the effectiveness of care and treatment and ensure audits are meeting the compliance target set by the service. • The service must ensure complaints are effectively investigation and learning shared with all relevant staff. • The service must ensure that leaders have the right skills and abilities to manage their respective departments or teams. • The service must ensure there are effective governance processes in place and that staff are aware of their roles and responsibilities. • The service must ensure there are effective systems in place to monitor, escalate and mitigate risks appropriately. • The service must ensure that data is easily accessible for staff and used to implement positive changes. • The service must ensure there is a culture that promotes openness and transparency amongst staff without the fear of reprisal when concerns are raised.

This section is primarily information for the provider

Enforcement actions

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.

Regulated activity	Regulation
Surgical procedures Treatment of disease, disorder or injury Management of supply of blood and blood derived products Diagnostic and screening procedures	Regulation 17 HSCA (RA) Regulations 2014 Good governance