

HCA International Limited

London Bridge Hospital

Inspection report

27 Tooley Street
London
SE1 2PR
Tel: 02074073100
www.londonbridgehospital.com

Date of inspection visit: 24 May 2023, 25 May 2023
and 05 June 2023
Date of publication: 14/08/2023

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

Outstanding 

Are services safe?

Good 

Are services effective?

Good 

Are services caring?

Good 

Are services responsive to people's needs?

Outstanding 

Are services well-led?

Outstanding 

Summary of findings

Overall summary

Our rating of this location stayed the same. We rated it as outstanding because:

- The service had enough staff to care for patients and keep them safe. They had training in key skills, understood how to protect patients from abuse, and managed safety well. The service managed infection risks well. Staff assessed risks to patients, acted on them and kept good care records. They managed medicines well. The service managed safety incidents well and learned lessons from them.
- Staff provided good care and treatment. They gave patients enough to eat and drink and gave them pain relief when needed. Managers monitored the effectiveness of the service and made sure staff were skilled and experienced. Staff worked well together for the benefit of patients and supported them to make decisions about their care. Patients had access to good information and key services were available seven days a week.
- Staff treated patients with compassion and kindness, respected their privacy and dignity, and took account of their individual needs. Staff spent time providing emotional support to patients, families and carers to minimise their distress. They understood patients' personal, cultural and religious needs and this was reflected in how care was delivered. Staff took the time to support patients, families and carers to understand their condition and make decisions about their care and treatment. Staff empowered patients to feel confident with any new adaptations or adjustments required following surgery. Patients commented on the continuous physical and emotional support staff gave them.
- The service planned care to meet the needs of the patient population and made it easy for people to give feedback. People's individual needs and preferences were central to the delivery of the service. The service was delivered in a way to ensure flexibility, choice and continuity of care. There was a proactive approach to understanding the needs and preferences of different groups of people and to delivering care in a way that met these needs, which was accessible and promoted equality. People could access the service when they needed it and did not have to wait too long for treatment. The service also worked with others in the wider system and local organisations to plan care.
- The service had a vision for what it wanted to achieve and a strategy to turn it into action. The vision and strategy had supporting plans and objectives which were innovative and achievable. There was an embedded system of leadership development and succession planning. Staff felt respected and valued and were focused on providing patient centred care. The service had an open culture where patients, their families and staff could raise concerns without fear. Leaders operated effective governance processes, and a demonstrated commitment to best practice, performance and risk management systems and processes. They identified and escalated relevant risks and issues and identified actions to reduce their impact effectively and in a timely manner. Leaders and staff actively and openly engaged with patients and staff. All staff were committed to continually learning and improving services. Leaders encouraged innovation and participation in research. Staff were actively participating in research and improvement projects.

Summary of findings

Our judgements about each of the main services

Service

Critical care

Rating

Outstanding



Summary of each main service

Our rating of this service stayed the same. We rated it as outstanding 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. They managed medicines well. 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, 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 7 days a week.
- Staff treated patients with compassion and kindness, respected their privacy and dignity, took account of their individual needs. Staff were kind, caring and listened to families and carers concerns. Feedback from people who used the service, and those who are close to them were continually positive about the way staff treat people. People think that staff go the extra mile and the care they receive exceeds their expectations.
- People's individual needs and preferences were central to the planning and delivery of tailored services. The services were flexible, provided choice and ensured continuity of care. People could access the service when they needed it and did not have to wait too long for treatment. There was a proactive approach to understanding the needs of different groups of people who had complex needs and to deliver care in a way that met those needs. Complaints were dealt with locally and drove improvements in the patient experience.

Summary of findings

- There was a well established local leadership team who were visible and had a clear vision for the service. Leaders supported staff to develop their skill and staff had opportunities for professional development and advancement. Staff understood the service's vision and values, and how to apply them in their work. Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. Staff were clear about their roles and accountabilities. The service engaged well with patients and their families to manage services. All staff were committed to improving services continually. Governance and performance management arrangements were proactively reviewed and reflect best practice.

Surgery

Outstanding



Our rating of this service improved. We rated it as outstanding because:

- The service had enough staff to care for patients and keep them safe. They had training in key skills, understood how to protect patients from abuse, and managed safety well. The service managed infection risks well. Staff assessed risks to patients, acted on them and kept good care records. They managed medicines well. The service managed safety incidents well and learned lessons from them.
- Staff provided good care and treatment. They gave patients enough to eat and drink and gave them pain relief when needed. Managers monitored the effectiveness of the service and made sure staff were skilled and experienced. Staff worked well together for the benefit of patients and supported them to make decisions about their care. Patients had access to good information and key services were available seven days a week.
- Staff treated patients with compassion and kindness, respected their privacy and dignity, and took account of their individual needs. Staff spent time providing emotional support to patients, families and carers to minimise their distress. They understood patients' personal, cultural and religious needs and this was reflected in how care was delivered. Staff took the time to support patients, families and carers to understand their condition and make decisions about their care and

Summary of findings

treatment. Staff empowered patients to feel confident with any new adaptations or adjustments required following surgery. Patients commented on the continuous physical and emotional support staff gave them following surgery and the encouragement from staff which helped their recovery journey.

- The service planned care to meet the needs of the patient population and made it easy for people to give feedback. People's individual needs and preferences were central to the delivery of the service. The service was delivered in a way to ensure flexibility, choice and continuity of care. There was a proactive approach to understanding the needs and preferences of different groups of people and to delivering care in a way that met these needs, which was accessible and promoted equality. People could access the service when they needed it and did not have to wait too long for treatment. The service also worked with others in the wider system and local organisations to plan care.
- The service had a vision for what it wanted to achieve and a strategy to turn it into action. The vision and strategy had supporting plans and objectives which were innovative and achievable. There was an embedded system of leadership development and succession planning. Staff felt respected and valued and were focused on providing patient centred care. The service had an open culture where patients, their families and staff could raise concerns without fear. Leaders operated effective governance processes, and a demonstrated commitment to best practice, performance and risk management systems and processes. They identified and escalated relevant risks and issues and identified actions to reduce their impact effectively and in a timely manner. Leaders and staff actively and openly engaged with patients and staff. All staff were committed to continually learning and improving services. Leaders encouraged innovation and participation in research. Staff were actively participating in research and improvement projects.

Summary of findings

Contents

Summary of this inspection

Background to London Bridge Hospital

Page

7

Information about London Bridge Hospital

7

Our findings from this inspection

Overview of ratings

9

Our findings by main service

10

Summary of this inspection

Background to London Bridge Hospital

London Bridge Hospital is a private hospital operated by HCA Healthcare UK who also provide care at several other hospitals in the UK. The hospital opened in 1986 and became part of HCA in 2000. It is based in the London Bridge area in South East London. They offer care to adults only and provide care for privately paying patients and also support the NHS with locally commissioned contracts.

The hospital is registered to provide:

- Diagnostic and Screening Procedures
- Treatment of Disease, Disorder or Injury
- Surgical Procedures
- Management of supply of blood and blood derived products
- Family Planning

The hospital provides a range of surgery and medical care, a level three critical care providing care to adults and several sites providing outpatients and diagnostic imaging.

The service has 191 beds in total, 20 of which are level 3 intensive care beds and 8 high dependency unit beds. This also includes 19 day case beds. They have 10 operating theatres, 2 endoscopy suites and 3 angiography suites. The hospital also has a number of consulting rooms in the London Bridge hospital main site, The Shard and at the Old Broad Street location.

To get to the heart of patients' experiences of care and treatment, we ask the same 5 questions of all services: are they safe, effective, caring, responsive to people's needs, and well-led? Where we have a legal duty to do so we rate services' performance against each key question as outstanding, good, requires improvement or inadequate. Throughout the inspection, we took account of what people told us and how the provider understood and complied with the Mental Capacity Act 2005.

How we carried out this inspection

We carried out an unannounced inspection focussing on surgery and critical care on the 24 May 2023, 25 May 2023 and 05 June 2023 using our comprehensive inspection methodology.

We spoke with 18 patients and 42 members of staff during the inspection, including medical, nursing, administrative and managerial staff. The team also reviewed policies and records.

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>.

Outstanding practice

We found the following outstanding practice:

Summary of this inspection

- The service had a bespoke pain team who had innovated a pain management process, to reduce the need to give high strength pain relief. This was initially trialled for colorectal patients and having received positive feedback from patients it was now being trialled for liver transplant patients. The service was in the process of getting feedback from patients around the effectiveness of the tool.
- In theatres, junior practitioners were empowered to be the team leader of the day to lead the WHO checklist.
- Leaders demonstrated a passion for developing, upskilling and supporting staff to advance in their careers.
- Feedback from people who used the service, and those who were close to them was constantly positive about the way staff treat their loved one. Relatives felt staff went that extra mile and the care they receive exceeded their expectations. Staff always took people's personal, cultural, social, and religious needs into account.
- There was a proactive approach to understanding the needs of different groups of people who had complex needs and to deliver care in a way that met those needs. People's individual needs and preferences were central to the planning and delivery of tailored services. The services were flexible, provided choice and ensured continuity of care.
- There were high levels of staff satisfaction. Staff were proud of the organisation as a place to work and spoke highly of the culture. Staff told us about being supported and empowered and enjoyed being part of a team. Staff had opportunities for professional development and advancement. There was strong multi-disciplinary working and a common focus on improving quality of care and improving outcomes for patients.






Our findings

Overview of ratings

Our ratings for this location are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Critical care	Good	Good	Good	Outstanding 	Outstanding 	Outstanding 
Surgery	Good	Good	Outstanding 	Outstanding 	Outstanding 	Outstanding 
Overall	Good	Good	Good	Outstanding 	Outstanding 	Outstanding 

Critical care

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

Is the service safe?

Good 

Our rating of safe stayed the same. We rated it as 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. Data provided showed mandatory training completion was 95% which was above the HCA UK target of 85%. The training included a range of topics such as equality and diversity, moving and handling, infection control, fire safety, sepsis, learning disability and autism, and health and safety.

Managers monitored mandatory training and alerted staff when they needed to update their training. Mandatory training was comprehensive and met the needs of patients and staff. Staff we spoke with were given time to complete training.

Consultants working under practising privileges were required to provide annual confirmation of completion of statutory and mandatory training requirements as appropriate.

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. Safeguarding children and adults formed part of the mandatory training programme for staff. Records showed 95% of staff had received training in safeguarding children level 2, 100% safeguarding adults' level 2 and 100% safeguarding adults' level 3 which exceeded the hospital's target of 85%.

Staff knew how to identify adults at risk of, or suffering, significant harm and were able to provide examples of concerns that had been raised. The service had a policy for safeguarding adults which had been reviewed in January 2023. Staff knew who to inform if they had concerns and could access support from the service's safeguarding lead if needed.

The critical care service reported 1 safeguarding referral had been made in the 12 month period May 2022 to April 2023.



Critical care

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.

All patients were nursed in single rooms. Infection control guidance was displayed on the doors where required. During the inspection we observed staff and visitors following infection prevention and control (IPC) principles. We saw staff wearing appropriate personal protective equipment when entering the rooms and disposing of it correctly.

All staff were bare below the elbow. There were adequate hand washing facilities and we observed staff using hand cleansing gel appropriately. Visitors were asked to use sanitising gel when arriving on the unit and this was freely available.

Hand hygiene and IPC audits were undertaken monthly. Data provided showed that results were consistently above 90%. From hand hygiene audits undertaken across all critical care areas from February 2023 to April 2023 scored 100% except in April 2023 when CCU3 was 92% compliant. Monthly audits for IPC principles and practices for the same period showed compliance across the CCUs was between 96% and 100%.

Critical care submitted data to the Intensive Care National Audit and Research Centre (ICNARC) for London Bridge Hospital and London Bridge Hospital Private Care at Guy's. The hospital reported critical care had a total of 2 *clostridium difficile* (C. Difficile) infections and 24 blood stream infections in the 12 month period from May 2022 to April 2023. Data provided showed the units were within expected limits for unit acquired infections such as methicillin-resistant staphylococcus aureus (MRSA), carbapenem-resistant enterobacterales (CRE), vancomycin-resistant enterococcus (VRE) and *clostridium difficile* (C. Difficile). All infections were investigated and reviewed by the microbiology team. Any learning identified was shared in staff meetings and in the quarterly Infection Prevention and Control Committee.

All patients admitted to critical care were screened for candida auris (Candida auris (C auris) is a type of micro-organism (germ)) on admission and weekly. The hospital advised patients with this organism had enhanced cleaning regimes which included using enhanced IPC precautions. This included staff wearing long sleeved gowns and gloves, patients having dedicated nurses to reduce the risk of cross contamination. Rooms were cleaned a minimum of once a day on the CCU when infection risks were identified. Once patients were discharged, rooms had an enhanced deep clean. All patients were also screened for MRSA and CRE weekly.

The service completed quarterly audits in the use of invasive devices such as catheters and peripheral devices. Data for March 2023 showed compliance across the 5 audits was mostly between 98% and 100% for the 3 CCU's, however at London Bridge Hospital the CCU's scored 81% for the insertion of urinary catheters audit. The learning identified was shared at staff meetings.

Critical care had a microbiologist who undertook antimicrobial stewardship rounds, post infection reviews, attended critical care multidisciplinary team (MDT) meetings and patient case discussions.

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.

The critical care services were delivered across 3 units which comprised of a total of 22 critical care beds. The critical care unit on the first floor had 6 beds including 2 single rooms, the unit on the 3rd floor had 12 single rooms which included 1



Critical care

room with positive and negative pressure airflow capabilities. London Bridge at Guy's Private Care unit had 4 single rooms. All bed spaces had a ventilator and were appropriate for providing level 3 care to patients. Levels are either 1,2 or 3 and refers to the acuity of a patient. A Level 3 patient will likely be ventilated and need intensive, 24-hour 121 nursing care. We saw evidence that the CCUs complied with the national standards for intensive care Health Building Note (HBN) 04-02.

Emergency equipment for resuscitation and managing difficult airways, were kept in tamper evident tagged trolleys and were easily accessible. We saw the tags were checked daily, and the contents of drawers were checked weekly. The seal was changed when medicines and stock were checked. Critical care airways and ventilator audits were undertaken quarterly. Data provided showed in the period March 2023 to May 2023 the overall compliance across the 3 critical care units was 98%.

Health and safety audits were undertaken monthly. Data provided in the 3 month period February 2023 to April 2023 showed health and safety audits were 100% compliant across the 3 critical care units.

There were arrangements for appropriate segregation and management of waste. Single use items were disposed of appropriately in either clinical waste or sharp bins. Sharps and waste handling audits were undertaken quarterly. Data provided for March 2023 showed the 3 critical care units were 95% compliant.

Electrical medical equipment had a registration label affixed. Portable Appliance Testing (PAT) labels were attached to medical equipment showing when they were last inspected and were safe to use. Medical equipment servicing was undertaken annually in critical care and covered all medical equipment within the area. Data provided for the period May 2022 to April 2023 showed there was a rolling programme for servicing equipment in place.

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.

The critical care outreach team were available 24 hours a day, 7 days a week to follow up on patients who had been stepped down from critical care. They also reviewed and assessed patients who showed signs of deterioration across the hospital. The team was led by a lead nurse and with 4 critical care outreach nurses. The team worked closely with critical care consultants.

Members of the critical care outreach team were part of the hospitals resuscitation team and assisted with all emergencies. They started the process of decision making for do not attempt cardiopulmonary resuscitation (DNRCPR) when required.

Patients' observations were continually monitored electronically and any changes to patients' observations were immediately reported to medical staff via hand held devices. Staff used the national early warning score (NEWS2) to identify deteriorating patients.

Patients in critical care were screened and monitored hourly for sepsis using the sepsis 6 care bundle. Sepsis is a potentially life-threatening illness that occurs when the body's response to infection damages its own tissues and organs. Staff received training in identifying sepsis symptoms and were able to escalate concerns quickly. This allowed for prompt screening and treatment which was in line with the service's policy. Due to the nature of the care delivered in the CCU's the provider advised it was not possible to effectively audit the adherence with the sepsis pathway, as the package of care was altered to meet the needs of patients which took into account the numerous clinical interventions that would be in



Critical care

place. To ensure staff still considered sepsis, the service had "surviving sepsis" documentation which was embedded in the electronic patient record (EPR) that is completed on admission to the CCU, and updated throughout a patient's stay on the ward. Data from the ICNARC for the period April 2022 to December 2022 showed there were 26 patients with sepsis on the CCU's which was similar to other critical care units.

A range of risk assessments were completed for each patient admitted into the critical care services and were ongoing. Nursing risk assessments included pressure areas, moving and handling, acute kidney, nutrition, venous thromboembolism (VTE) and falls. The CCU used an electronic patient record system. The system alerted both nursing and medical staff if any assessments and ongoing reviews were not completed, as well as highlighting variations in patient condition.

The critical care handover tool was developed using the Situation Background Assessment Recommendation (SBAR) communication tool. The handover between shifts were led by the nurse in charge.

Staff handovers were twice a day and was led by the nurse in charge. They used a critical care handover tool which documented staff sickness or training issues, any specific problems with individual patients, admissions, discharges and specific safety issues such as sepsis, breathing problems, risk of pressure injuries or any new equipment being used.

Ward rounds were consultant intensivist led on CCU3 and London Bridge Hospital Private Care at Guy's twice a day. On CCU1 wards rounds were undertaken by the speciality consultant and anaesthetist for the first 48 hours, if there were complications or the patients had not progressed as expected the patient would be transferred to the critical care team.

We saw the service had Local Safety Standards for Invasive Procedures (LOSSIPS) for bronchoscopy, chest drain, tracheostomy, intubation, CVC line insertion which had been introduced in quarter 1 2023.

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.

The service had enough nursing and support staff to keep patients safe. At the time of the inspection there was a base line of 69 nursing staff which included a ward manager, 5 sisters, 1 nurse in charge, 22 senior staff nurses, 36 staff nurses, the critical care outreach team (CCOT) lead and 4 CCOT nurses. There was also a matron and a clinical nurse manager on duty Monday to Friday. Nursing staff worked flexibly across the sites at London Bridge and at London Bridge Private Care at Guy's Hospital. Nurse staffing levels at each site were determined by surgical caseload.

Nurse Staffing in the CCU were planned to ensure staffing levels and the skill mix followed the Intensive Care (ICS) National Standards. Level 3 patients were nursed 1:1 and level 2 patients were 1:2. A supernumerary nurse in charge was on all shifts and runners were allocated based on patient numbers, and or infection status of the patient. This meant staff nursing patient 1:1 did not leave the patient unattended. The nursing staff rota was planned 6 weeks in advance.

At the time of the inspection CCU had a vacancy rate of 5.7% (4). Managers made sure all bank and agency staff had a full induction and understood the service. Nursing staff we spoke with advised that most of the agency staff had worked on the unit for several years. An induction pathway was used for agency staff, and we saw an agency staff induction sheet was completed. Bank and agency staff were used to cover staff sickness and staff vacancies. For the 3 month period February 2023 to April 2023 the use of bank staff was 11.3% and 32.6% for agency staff. During the same period staff turnover was an average of 1.4% there was an average of a 36% sickness level for the CCU.



Critical care

Carers were provided for international patients and provided additional help to the nurses. They helped in bridging the communication gap as well as providing emotional support to the patients and their families.

Nursing staff handovers were at 8.00am and 8.00pm daily.

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.

London Bridge Hospital had 17 consultant intensivists with practising privileges specific to critical care, including 2 consultant intensivists who supported the liver transplant programme. Patient care was led by 4 consultants in intensive care medicine. At London Bridge Hospital the consultants provided on call cover 24 hours a day, 7 days a week attending the CCU at least once a day and would normally be on the unit in the morning and were contactable remotely when not on site. All consultant intensivists were a minimum of 5 years post their certificate of completion of specialist training (CSST). They were required to be able to reach the unit within 30 minutes which met the Intensive Care Society Standard.

At London Bridge Hospital Private Care at Guy's, the intensive care service was covered by 12 consultant intensivists who were resident 24 hours a day, 7 days a week.

London Bridge Hospital directly employed the 12 critical care resident medical officers (CCRMOs) who were at specialist registrar ST5 level or equivalent with a minimum of 5 years' experience in intensive care medicine.

Copies of the 3 month rota from March 2023 to May 2023 showed there was a minimum of 2 CCRMOs present on the units. Medical staff we spoke with advised their day started at 8.00am. The number of CCRMOs flexed between 2 or 3 depending on patient numbers. CCRMOs were allocated to specific patients during the ward rounds. Nursing staff we spoke with told us there was always an CCRMO present and available on the unit.

At the time of the inspection there were no CCRMO vacancies. Bank and agency staff were used to cover staff sickness. For the 3 month period February 2023 to April 2023 the use of bank staff was 27.5% and 3.3% for agency staff. During the same time frame there was an average of a 9% sickness level for the CCU. All CCRMO's had an induction on to the CCU's which included being scheduled for supernumerary shadowing shifts before their first official shift and an induction pack and the checklist that required completion. In addition to the induction pack completion CCRMOs also undertake critical care training which includes advanced life support (ALS), cardiac ALS, and advance airway rescue course. CCRMOs are also required to complete BLS training (in addition to advanced life support training) to ensure they are familiar with the equipment in use at London Bridge Hospital. They also meet with the lead resuscitation officer who ensures CCRMO's are clear on the team roles and who is involved in resuscitation at London Bridge Hospital.

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.

Electronic patient records (EPR) were used to document patients' treatment pathway. The CCU used a EPR which was specifically designed for use in critical care units. When patients were discharged from the CCU discharge paperwork was printed and filed in the patient's paper records. A patient discharge checklist was also completed to be filed in the nursing section of patient's paper notes.



Critical care

All EPRs we reviewed were clear, up to date and legible. EPR records were electronically signed, with time and date of the entry which meant it was clear who had updated the record. Staff had secure access to the EPR. This meant that patient information and records were stored securely. Each of the patient rooms had a computer for staff which meant records could be updated immediately.

Consultants and other health care professionals were able to access records via an app. This meant that all professionals involved in a patient's care could access the records as required, including when they were not on site. Records were shared by doctors, nurses and other healthcare professionals. Medical staff were also able to access results from investigations electronically.

We looked at 5 EPRs and found that assessments included malnutrition universal screening tool (MUST), waterlow, manual handling, falls, infection, Venous thromboembolism (VTE), pressure areas, nutrition and pain had been completed using national risk assessment tools. The records also included nursing notes, multidisciplinary team (MDT) meetings and ward rounds.

The service provided details of the daily record checks completed by the nurse in charge to identify any gaps and prompt improvement. Data provided for quarterly records audits demonstrated the CCU records audit for quarter 3, 2022 was 95%, quarter 4, 2022 was 96% and quarter 1, 2023 was 92%. Where the areas audited scored less than 90%, action plans were in place to address the areas of concern.

Medicines

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

The pharmacy department carry out controlled drugs audits and safe and secure storage of medicines audits quarterly in the CCUs across the hospital. Audits were performed in a "live" environment to reflect practice more accurately. A single finding of non-compliance for any question would result in being non-compliant.

Results for the controlled drugs audits for the last 3 quarters (quarter 3 2022, quarter 4 2022, and quarter 1 2023) showed a mixed result, 1 of the CCUs (CCU3) were partially compliant scoring 88% for quarters 3 and 1. An action plan was in place to address non-compliant areas in relation to CD's which we saw had been completed. The other CCUs were compliant scoring between 90% and 100%

Results for the safe storage of medicines for the last quarter (quarter 1, 2023) was 100% across all 3 CCUs.

Staff stored and managed all medicines and prescribing documents safely. Medicines including controlled drugs (CD) were stored securely. Medicines and equipment for use in emergencies were accessible to staff and were checked regularly. Emergency medicines were stored in tamper evident boxes.

On the CCU the EPR were counter signed electronically when staff administered CDs. Staff told us they signed both the CD register and the EPR. Staff also told us 2 nurses would also check medication intravenously (IV) administered and countersigned the EPR. Electronic records we reviewed confirmed this.

Medicine fridge temperatures were checked regularly, and ambient temperatures of medicines storage areas were monitored. Pharmacists undertook stock reconciliation daily with medicines topped up 3 times a week. A pharmacist was available on the CCU 7 days per week.



Critical care

Patients' medication was stored in medication trolleys at the patient's bedside. Staff told us this had been introduced in the last 18 months and had reduced the need for nurses to go in and out of patient rooms to retrieve medication. In the EPR we saw that allergies were recorded.

Incidents

The service managed patient safety incidents well. Staff recognised and reported incidents and near misses. Managers investigated incidents and shared lessons learned with the whole team and the wider service.

The hospital reported there were no never events or serious incidents in the critical care in the last 12 months. Never events are serious patient safety incidents that should not happen if healthcare providers follow national guidance on how to prevent them. Each never event type has the potential to cause serious patient harm or death but neither need have happened for an incident to be a never event.

The hospital reported there were a total of 469 incidents reported between May 2022 - April 2023 in critical care, 95% (448) of these incidents were reported as no harm or low harm and 1% (5) were reported as moderate harm. There were 12 (2.5%) expected deaths, these are deaths that were expected to happen as part of the patient's care plan and 4 (0.8) unexpected deaths.

There was a good incident reporting culture, staff knew what incidents to report and how to report them and managers investigated incidents thoroughly. The service used an electronic incident reporting system widely used to report incidents. Staff understood the duty of candour. They received feedback from investigation of incidents. Learning was shared with staff in several ways for example as feedback as part of the daily safety brief, CCU staff meetings, Big 5 medication errors posters, and via the CCU staff newsletter.

Staff we spoke with understood the duty of candour. We saw investigations from incidents where the service had applied the duty of candour. The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain 'notifiable safety incidents' and provide reasonable support to that person.

Data provided showed that patients deaths were investigated and followed up in morbidity and mortality meetings which reviewed all deaths across the hospital.

Is the service effective?

Good



Our rating of effective stayed the same. We rated it as 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. Hospital policies we reviewed were up to date, had a scheduled review date and had gone through the necessary



Critical care

governance processes. The policies were developed in line with national guidance such as the National Institute of Clinical Excellence (NICE). Clinical leads were responsible for reviewing policies to ensure they were up to date. The service had clear and robust standard operating procedures (SOPs) and policies which were available on the hospital intranet electronic policy library. Staff knew how to access these policies on a computer.

Critical care participated in the Intensive Care National Audit and Research Centre (ICNARC) database for England, Wales and Northern Ireland, so care delivered, and patient outcomes were benchmarked against similar units nationally.

The service had a detailed audit programme to assess and improve the quality of the service. Actions, learning and results were discussed, and all learning and actions were escalated to the corporate clinical audit and effectiveness committee. All results were shared at the hospital quality governance committee and at the board meeting monthly. The heads of department also discussed results and actions at their local team meetings as well as displaying information on their departmental quality boards. Local audits included insertion and continuing care of urinary catheters, insertion and continuing care of peripheral vascular devices, continuing care of central venous access devices (including Peripherally Inserted Central Catheter (PICC) and ports) and insertion of central venous catheters.

The critical care service was a member of the North West London Critical Care Network.

Staff protected the rights of patients subject to the Mental Health Act and followed the Code of Practice. As part of the twice daily critical care safety brief, staff routinely referred to the psychological and emotional needs of patients, their relatives and carers.

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. The service made adjustments for patients' religious, cultural and other needs.

Specialist support from staff such as dietitians and speech and language therapists were available for patients who needed it. They used special feeding and hydration techniques when necessary. Food was able to be adjusted in flavour, texture, and strength in relation to patient health needs. The service made adjustments for patients' religious, cultural and other preferences.

Nursing staff completed assessments in nutrition and hydration. Staff weighed patients weekly to assess patients' nutritional needs. These were seen to be completed on the EPR.

The service provided an example of where dietetics and the catering teams worked with a long stay patient who was finding the renal menu repetitive to create new dishes to meet the patient's nutritional requirements. This meant that the patient was eating better, which aided their recovery, rehabilitation and wellbeing.

Dietitians and speech and language therapists (SALT) were part of the daily MDT meeting. SALT were available 24 hours a day, 7 days a week.

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.



Critical care

Staff assessed patients' pain using a recognised tool and gave pain relief in line with individual needs and best practice. Staff assessed patients pain at least hourly using recognised tools, for example a pain score 0-3 for conscious patients and the Critical Care Pain Observation Tool (CCPOT) for unconscious patients or patients who were unable to communicate.

Pain levels were regularly reviewed and discussed at daily MDT ward rounds, and this was recorded in the EPR. Staff told us pain relief medicines were reviewed frequently to ensure pain control was optimised.

The hospital advised a new auditing tool was launched in August 2022. Pain audits were undertaken quarterly which required 1 observation per location. Data provided for April 2023 reported London Bridge Private Care at Guy's Hospital scored 98%, the CCU1 and CCU3 at London Bridge Hospital scored 94%.

Patient feedback in critical care for the 12 month period May 2022 to April 2023 showed patients scored staff 100% in 9 of the 12 months for controlling their pain. In May 2022 patients scored staff 95%, June 2022 91.7% and March 2023 92.6%.

Patient outcomes

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

Critical care participated in the Intensive Care National Audit and Research Centre (ICNARC) audit programme for England, Wales and Northern Ireland, so care delivered, and patient outcomes were benchmarked against similar units nationally. Data provided for the quarters 1 to 3 covering period April 2022 to December 2022 showed the units at London Bridge Hospital and Private Care at Guy's were green which meant they were in the predicted range of 95% in the 11 indicators measured on quality indicator dashboard.

Critical care audits were continuously audited against The Guidelines for the Provision of Intensive Care Services (GPICS) standards; the service advised the latest self-assessment was completed in October 2022. The tool kit helped the service to identify gaps in their provision, the self-assessment showed the critical care service had met the standards scoring 100% in the 72% (31) of the measures and 100% in 51% (22) of the recommendations. One of the recommendations was highlighted as red which was helping patients to communicate (eg speaking valves for patients with a tracheostomy, wipe boards or flash cards).

Key performance indicators (KPI) and quality indicators (QI) for critical care were used to identify outcomes and any areas for improvement. These included pressure ulcers including waterlow and MUST, medication management, antimicrobial stewardship and pain audits. Audit outcomes were reviewed at monthly meetings and any action plans completed.

The critical care outreach team (CCOT) followed up on patients who had been discharged from the CCUs and transferred to wards. Data provided for the 3 month period January to March 2023 showed the number of patients to be seen by the CCOT following their discharge from critical care was 308. The number of clinical reviews undertaken following critical care discharge in less than 48 hours was 294 (95.4%). The number of patients on the CCOT seen following their discharge from critical care in more than 48 hours was 11 (3.5%) and the number of clinical care reviews following discharge in more than 48 hours was 11 (100%).

Physiotherapists used the critical care physical assessment tool (CPAx) scoring to monitor the physical function of patients' who were undergoing physiotherapy. The CPAx assesses 10 domains including respiratory function, cough, bed mobility, supine to sitting on edge of bed, dynamic sitting, standing balance, sit to stand, transferring bed to chair, stepping, and grip strength.



Critical care

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.

Managers gave all new staff a full induction tailored to their role before they started work. All new nursing staff across the critical care service at London Bridge Hospital had an induction. We saw this included tracheostomy, airway and hemofiltration study days.

Managers supported staff to develop through yearly appraisals of their work. The critical care service reported 98% of staff had an up to date appraisal for the period January to December 2022.

The critical care service reported 61.5% (40) of its nursing staff had a post-registration award in critical care nursing. This met the Guidelines for the Provision of Intensive Care Services (GPICS) V2 2019 which suggests a minimum of 50% of registered nurses on the units should hold a post-registration award in critical care.

Staff had opportunities to develop and progress through a range of internal and external training opportunities which included critical care professional development pathways for senior staff nurse and staff nurses new to critical care, clinical training opportunities, study days, short courses, conferences, post graduate academic programmes or apprenticeships. Staff told us they had been able to access further training opportunities. Staff also had access to ongoing specialities training supported by a dedicated practice development nurse (PDN) for the critical care service. All staff also had access to the Learning Academy which was an online resource for staff.

Consultants with practising privileges were required to provide evidence of appraisals, revalidation and professional registrations. Consultants told us checks were undertaken annually and their scope of practise was reviewed to ensure they working within it. Most consultants scope of practise was the same as they had within the NHS.

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 held regular and effective multidisciplinary meetings to discuss patients and improve their care. Multidisciplinary ward rounds were undertaken daily at 09.30am, led by a consultant intensivist, with critical care resident medical officers (CCRMOs), the nurse in charge, pharmacist, physiotherapist, occupational therapist (OT), SALT, dietitians, and a nutritionist who attended twice a week. In patient records we saw evidence of MDT input including from tissue viability nurses (TVN), podiatry, neurological specialists and nutritionists.

The multidisciplinary team (MDT) met weekly to review patients and undertook ad hoc MDT meetings for complex patients. Relatives we spoke with confirmed they had been part of ad hoc MDT meetings when discussing their loved one.

The CCOT was available 24 hours a day, 7 days a week to assess deteriorating patients across the hospital and they followed up patients who were discharged from the critical care unit (CCU).

The physiotherapists worked with medical and nursing staff to plan and implement ventilator weaning programmes and developed rehabilitation plans. Most patients had access to physiotherapy daily. During the inspection we observed physiotherapists reviewing patients.



Critical care

Patients were referred to OT for assessment for example for support with activities of daily living (ADLs - fundamental skills required to independently care for oneself, such as eating, bathing, and mobility) and equipment needs. To support patients who were being discharged from the hospital OT's worked closely with the patient, family, equipment suppliers, community rehabilitation teams and carer agencies. They also worked with Embassies if the patient was international.

Seven-day services

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

At London Bridge Hospital, consultant led ward rounds were twice daily 7 days a week on the CCUs. Consultants worked an on call rota, they were accessible 24 hours a day, 7 days a week and were able to attend within 30 minutes. CCRMOs were present on the CCU 24 hours a day, 7 days a week.

At London Bridge Private Care at Guy's Hospital, a resident consultant intensivist were available 24 hours a day, 7 days a week.

The critical care outreach team (CCOT) were available 24 hours a day, 7 days a week to follow up on patients who had been stepped down from critical care. They also reviewed and assessed patients who showed signs of deterioration.

The CCU had a dedicated dietetics service which was available 7 days a week.

A critical care pharmacist was based in the CCU 7 days a week and was available on call from 6.00pm Monday to Friday and from 1.00pm at weekends.

The service has access to 24 hours a day, 7 days a week respiratory physiotherapy and physiotherapist services. The occupational therapist service was in the process of developing a 7 day a week service but was available Monday to Friday.

A team of 4 consultant microbiologists covered the hospital providing 24 hours a day, 7 days a week cover.

The critical care service was also able to access 24 hours a day, 7 days a week support from theatres, catheter lab, and a range of diagnostic services, including interventional radiology.

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. Staff identified patients who needed additional support and had long term conditions. Patients were assessed by specialist teams including occupational therapy and physiotherapy services, and the dietetics team.

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.

The hospital had an adult conscious sedation policy which had been reviewed in May 2022 and was due for review in November 2024.



Critical care

The service advised all patients were screened for delirium at least daily (as recommended by GPCS guidelines), and when changes or fluctuations in behaviour occurred, this was recorded in the patient's EPR. If a patient had a positive delirium screen, further investigations were carried out to determine whether a patient truly lacked capacity to make a decision about their treatment.

The hospital provided documentation which medical staff used in the CCU when the treatment decisions were being made in an adult's best interest due to the patient lacking capacity to make the decision themselves. The hospital advised many patients in the CCU have lacked capacity, as they are often too ill to understand the options being considered, and in these instances the medical team made the treatment decisions in patients' best interest. The documentation also recorded the involvement and signature of the patient's family and others close to the patient, including their appointed lasting power of attorney or court appointed deputy.

In 1 patient record we saw documented discussion between the consultant and the patient's family about the patient's best interest's determination. Mental capacity documentation had been assessed and the patient had been assessed as lacking capacity to make decisions for themselves.

Records showed all staff received training in the Mental Capacity Act and Deprivation of Liberty Safeguards.

Is the service 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. Relatives reported that staff were polite, courteous and attentive. Staff were seen to be considerate and empathetic towards patients. During our inspection, we spoke with 7 relatives who were all very positive about their relatives care and treatment. They told us the staff were kind, caring and listened to their concerns. One relative told us their experience had been "nothing but excellent" and they had "nothing but positive things to say".

Patients were treated with dignity and respect. Staff made sure patients were comfortable and had the opportunity to air any concerns. Staff followed policy to keep patient care and treatment confidential. The privacy and dignity of patients was maintained as patients were treated in individual rooms and patient's information was kept secure.

At London Bridge Hospital Private Care at Guy's smart screen were placed between the individual rooms, the rooms had observation windows which meant staff were able to monitor patients where appropriate outside of the patient's room to optimise patient privacy with their family whilst being observed and monitored. On CCU3 we saw that patient rooms also had observation windows.

Staff understood and respected the personal, cultural, social and religious needs of patients and how they may relate to care needs. Leaders advised that cultural differences were considered to manage the gender of staff supporting some



Critical care

patients. The service also provided carers to patients to provide assurance to patients and their families they spoke the same language as the patient, with the same cultural and religious orientation. Leaders advised this had improved patient experience in particular the removal of language barriers resulting in effective communication and an immediate response to the patient's requests and needs.

The hospital gathered monthly feedback from patients and about the quality of care they received in critical care. Responses for the 12 month period May 2022 to March 2023 showed the service scoring between 89.3% and 100% between May 2022 and March 2023. In April 2023 the service scored 69.2%. However the number of patients giving feedback was lower than in the other months.

Emotional support

Staff provided emotional support to patients, families and carers to minimise their distress. They understood patients' personal, cultural and religious needs and made sure this was reflected in how care was delivered.

Staff gave patients emotional support and advice when they needed it. Staff in all areas showed sensitivity and support to patients and understood the emotional impact for them and their relatives of being treated on critical care. A relative told us the nurses were lovely and they felt so reassured by the 1:1 care they provided; 1 relative commented it had been good for keeping up their morale.

Relatives described staff as very caring and always smiling. One relative told us that even when they were off the unit a couple of the nurses would come over to see them to ask how they were. They said they had really appreciated this.

Children were not allowed to visit on the unit except in special circumstances. The service provided details of where this had been facilitated. The patient had been in critical care for a significant period of time and had not been able to see their 4 year old child. Staff realised that this was important for the patient's mental health and recovery so facilitated an initial orientation visit for the child with members of the international team to prepare them for the visit before the patient and their child were reunited.

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.

Relatives told us that staff took time to explain the care and treatment, and they had good communication from the medical staff. Relatives we spoke with told us they had been part of ad hoc MDT meetings and consultants provided reassurance as they were always explaining their decisions. One patient told us that the dietetic specialist had spent time talking to the family to prepare the family for the changes and adjustments that would be required when their loved one returned home.

Treatment plans and rehabilitation goals were discussed with patients and family where possible. The rehabilitation plan for each patient was discussed with their families throughout their stay and when they left critical care.

Following the inspection, the hospital provided examples of patient journeys. One example provided detail of a patient who was critically ill and given a poor prognosis, but after a year of being ventilated and tracheostomised, the patient slowly recovered. Following MDT input and rehabilitation in the CCU, the patient was decannulated, was able to eat and



Critical care

drink, walk again and reconnect with their family. While at the hospital, family involvement in their care was encouraged. Carers from the same culture and nurses were allocated to provide assurance to the patient and family and continuity of care. The CCU also facilitated the patient going out of the hospital with relatives which improved the patient's mental health.

The hospital gathered monthly feedback from patients and about how well patients or their visitors were kept informed during their time in critical care. Responses for the 12 month period May 2022 to April 2023 showed the service scoring between 61.5% and 95.20%. There were 3 months when the service scored between 61.5% and 65%. However the number of patients giving feedback was lower than in the other months.

The units had photo boards of all the staff, and friends and family were encouraged to speak to staff if they had any concerns or questions.

Is the service responsive?

Outstanding



Our rating of responsive stayed the same. We rated it as outstanding.

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 to plan care.

The facilities and premises were appropriate for the services being delivered. Critical care services were delivered across 3 units. The CCU1 on the first floor was mainly for post-surgical patients who were anticipated to be on the unit for a maximum of 48 hours under surgical/anaesthetic review. The CCU3 on the third floor was consultant intensivist led and was primarily for long stay patients. London Bridge at Guy's Private Care had 4 single rooms which were used for mainly post-surgical patients.

The CCU's had a multidisciplinary approach to discharging patients from the CCU's to ensure continuity of care and reduce the risk of readmission. The London Bridge critical care policy set out the discharge procedures for the process to discharge patients to a less intensive level of care.

A large proportion of patients cared for on the CCU were international patients who were transferred directly from CCU's in the Middle East with patients requiring intensive therapy support and rehabilitation. The CCU's also supported surgical patients. Admissions to the units were primarily complex patients who had undergone elective surgical, oncology and medical procedures. The hospital did not take emergency admissions from other hospitals or critical care units.

The service worked with the NHS and Embassies to plan patient care. The hospitals international team provided a range of services including interpreters who worked directly with each health office, doctor and embassy liaison, patient advocacy, critical care and bereavement support. Complex elective admissions were planned, and critical care consultants worked with other consultant colleagues where for example, patients were undergoing transplant surgery.

Specialist respiratory physiotherapist worked with the MDT when weaning patients, they also undertook airway clearance techniques, ventilator management and tracheostomy care.



Critical 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. They coordinated care with other services and providers.

The critical care service attracted a large number of international patients and their families mainly from the Middle East requiring intensive therapy support and rehabilitation. To cater for these patients the service was able to provide carers with the same cultural and religious orientation who could relate to a patient's individual needs and provide assurance to patients and their families that there is someone who can speak the same language with the patient. The hospital advised this improved the patient experience in particular the removal of language barriers resulting in effective communication and an immediate response to the patient's requests and needs. This had also provided families with an additional support person allowing them to rest overnight with assurances that someone was physically around with their loved one and able to facilitate communication.

Critical care staff participated in cultural awareness training for middle eastern patients which we were advised were led internally by the hospital's Arabic speaking/Islamic staff members who were part of the hospital international team. The international team also provided translation services. The service had plans to introduce patient diaries on the CCU's.

The hospital also had Arabic versions of menus to improve access and understanding and in patients' rooms Arabic Word/Phrase sheet was available with an extensive list of common phrases, words, greetings, body parts, and objects.

Patients were given a choice of food and drink to meet their cultural and religious preferences. There was a wide range of choices for patients who required halal, kosher or vegetarian meals. The menu also catered for patients with food intolerances or allergies. Patients could also request food that was not on the menu and a form was available which was sent to the catering team with the specific requests.

The CCU's had 3 dementia trained champions who worked across the service. Patients on the CCU were supported to orientate themselves to real time; for example, dementia friendly clocks clearly displayed the time and date in analogue and words. This is me documentation was utilised for long term patients who were unconscious and a patient passport template for patients living with dementia and patients with learning disabilities. Details were usually provided by the patient's family and described for example, what the patient liked to be called and things to make them comfortable. Staff had access to additional resources to support patients living with dementia or learning disabilities. Training to support caring for patients with dementia was incorporated into safeguarding modules. Staff also completed learning disability and autism training level 1 and 2 was part of the mandatory training programme, 100% of staff had completed the training.

The critical care MDT worked to meet the needs of a long-term patients with complex needs. For example, a long term patient who was wheelchair bound and had wanted to leave their room and see the riverside view of the hospital. The CCU provided a customised wheelchair for the patient, which allowed them to mobilise out of bed and organised a change of ventilator so the patient could leave the unit and enjoy the view over the river.

To ensure continuity of care occupational therapist (OT) remained with patients when they were discharged from critical care to the ward. When the patient made sufficient progress, they were handed over to the ward OT. The hospital OT's also provided home assessments to ensure the patients had appropriate aids to support them when they returned home.



Critical care

The hospital provided evidence of information leaflets on Rehabilitation: posture and seating needs, and Daily Care Routine: 24 hour management. The therapy team had developed the leaflets as patients and family/cares resources to provide assurance whilst on the CCU and when leaving the CCU.

The palliative care clinical specialist nurse (CNS) provided support to the CCU's when patients were identified as being on a palliative care pathway. The hospital's oncology CNSs was also trained in palliative care, and provided support when required. If further clinical input was required, the CCU could contact the palliative care consultant team who were available to provide support or guidance 24/7. Patients identified as being at end of life were started on an end of life care plan, which was part of the CCU's EPR.

Following a patient's death, the hospital would continue to support families by providing bereavement follow up calls and cards. The hospital also held an annual service of remembrance and thanksgiving which was facilitated by the lead chaplain. There was also multi-faith room available for use and families were offered access to a range of multi-faith leaders to support them if required.

Visiting times on critical care were from 10.00 am to 10.00pm. Staff told us if a patient was receiving end of life care a room would be provided for relatives to stay overnight.

Families had access to lounge facilities which had complimentary refreshments such as tea, coffee and biscuits. Arrangements could be made for a family member to stay overnight if required.

Access and flow

People could access the service when they needed it and received the right care promptly. The service admitted, treated and discharged patients in line with national standards.

The decision to admit and discharge patients to and from critical care was consultant led. The London Bridge critical care operational policy detailed the process for the admission and discharge of patients from critical care.

Leaders we spoke with told us most of the patients were elective and would be in critical care for about 2 days and would remain under the care of their surgeon and anaesthetist. If the patient was high risk or if there was a complication, then the CCU would be involved from the outset. If the patient did not progress as expected, the patient's care would be transitioned to the critical care team.

In the period May 2022 to April 2023 across critical care, there were 55 non-elective admissions with an average length of stay between 3.6 days and 50.2 days. Over the same period there were 878 elective discharges with an average length of stay of between 1.2 days and 342.2 days.

Critical care did not have a waiting time for patients to be able to access the service. The hospital advised on average, from the decision to admit to critical care to admission, patients waited 1 to 2 hours. This was within the Guidelines for the Provision of Intensive Care Services (GPICS) standard of 4 hours. At the time of the inspection the service had 10 patients who were all being treated on CCU3.

The critical care outreach team reviewed patients who had been discharged from critical care to the wards. Data provided showed that across all the critical care units in the 12 month period from January 2022 to December 2022 a total of 87.5% (1070) patients were seen within 48 hours and 12.5% (154) patients were continued to be seen more than 48 hours after discharge to the wards.



Critical care

In the 12 month period January 2022 to December 2022 at London Bridge a total of 745 patients were discharged from the unit and 1.1% (8 patients) were unplanned readmissions to CCU with 48 hours. 1.1% (8) patients were unplanned readmissions in more than 48 hours. At London Bridge Hospital Private Care at Guy's a total of 218 patients were discharged from the unit and 0.9% (2 patients) were unplanned readmissions to CCU within 48 hours and 2.0% (5 patients) were unplanned readmissions in more than 48 hours.

The service advised there was 1 unplanned transfer out of critical care to a local NHS hospital for clinical reasons over the last 12 months.

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.

The service had an up to date complaints policy which was available online. Staff we spoke with understood the policy and knew how to handle them.

Critical care received 1 complaint in the last 12 months which was investigated and resolved locally. Complaints were investigated, learning was identified, and the service apologised to patients when something went wrong. In staff meetings we saw that learning was shared.

Following the inspection, the service provided details of the action implemented, which was also displayed on patient information boards under 'You said, we did...'. A change implemented from patient feedback was to promote patients' privacy, dignity and respect for culture, by ensuring same gender nurses could be allocated to female patients.

The hospital was a member of the Independent Sector Complaints Adjudication Service (ISCAS), and displayed information about how to raise a concern in patient areas and on their website.

Is the service well-led?



Our rating of well-led stayed the same. We rated it as outstanding.

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.

There was a clear leadership structure within the critical care service with defined lines of responsibility and accountability. The critical care director led the medical team which included consultant intensivists and critical care resident medical officers (CCRMOs). The nursing team was led by the acute and critical care matron with support from sisters and nurses. The matron reported to the chief nursing officer. The leaders had the skills, knowledge, experience and integrity they needed for their roles.



Critical care

Senior members of the executive team were visible and undertook walkabouts across all the 3 CCUs. Staff told us senior leaders were approachable and knew their names. Staff also described their immediate managers as accessible and had confidence in them. Staff were motivated to provide high quality of care and we saw there was a strong emphasis on working as a team and there was strong effective clinical leadership. Staff we spoke with were clear about the management structure of critical care and who they could contact in case of any issue.

There was an open and learning culture and high levels of staff satisfaction across the CCU. Staff had opportunities to develop through leadership and management programmes and through the staff nurse and senior staff nurse development programme. This included all staff being mapped using an employee assessment tool (9 box grid) to identify staff for leadership or senior roles. For example, the critical care matron had recently been promoted having previously been the clinical nurse manager. They were initially recruited as a staff nurse in 2017. The service advised that 19 CCU staff who were initially employed as staff nurses had been promoted to senior staff nurses.

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.

The vision and strategy for the critical care services reflected the hospital's mission and values. Staff we spoke with knew about the hospital's mission statement 'Above all else, we are committed to the care and improvement of human life.' We saw the hospital's values and objectives were displayed in staff break rooms. Staff we spoke with knew and understood the provider's values and their role in achieving them. Staff were committed to providing safe care and improving patient's experience.

London Bridge Hospital's strategic growth plan was reviewed and created annually and aligned with the 'One HCA' overall vision. The 5 year strategic plan focused on the following: growing as one HCA UK, exceptional people exceptional employer, partnering with outstanding consultant teams, proving our value, sustainable business, routes to new patients, seamless patient support and geographical growth. Each member of the senior management team was responsible for the development of each element of the hospital strategy.

The critical care service had a clear vision and set of departmental objectives, which were focused on delivering safe, high quality, patient centred care. This was monitored for example via patient feedback and the critical care programme of audits.

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 multidisciplinary team in critical care worked together to provide high quality patient care.

There was a culture of honesty, openness and transparency. Staff were encouraged to report incidents and learning from incidents were discussed at safety huddles, handovers and in newsletters to staff. We saw when the service had applied the duty of candour.

Staff had access to the Freedom to Speak Up champions within the hospital who they could approach to raise concerns.



Critical care

Staff were proud to work in critical care; they were enthusiastic about the care and services they provided for patients. Staff felt valued and supported. Staff told us they felt supported by the team members and management. Some of the staff we spoke with had worked at the hospital for many years and described the hospital as a good place to work. Staff were proud of the positive feedback they received from patients and families.

Patients had opportunities to give feedback on their patient experience whilst in the hospital. The service was responsive to patient concerns and provided examples of changes that had been made to improve patient's experience such as same gender patient to nurse allocation.

The DEIB (diversity, equality inclusion and belonging) strategy was launched in 2022. The strategy sets out the HCA UK key strategic goals and initiatives to embed inclusion within their core values.

Staff could access various services to promote their wellbeing, these included a 'go to area' when staff needed time away from their clinical area or a place for reflection. Pastoral care colleagues were always available to offer practical, compassionate and emotional support to staff, support for staff to reflect on their clinical practise and career development conversations.

The service had procedures in place for staff to raise 'whistleblowing' concerns outside of their line management arrangements. Staff also had access to an employee assistance programme which gave them access to services to promote staff financial, physical, mental and social wellbeing which were available 24 hours a day, 7 days a week, 365 days a year. The critical care staff also had access to mental health first aiders. Data provided showed a member of the critical care team had been trained to undertake this role.

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.

There were effective structures and process of accountability to support the services within the critical care services. Clinical governance structures were in place and staff felt these were effective.

Staff understood their role and function within the hospital and how their performance enabled the organisation to reach its objectives. Staff we spoke with demonstrated a good awareness of governance arrangements. They detailed the actions taken to monitor patient safety and risk. This included incident reporting and undertaking audits. Meetings took place monthly, and minutes from meetings including CCOT meetings, CCU team leaders and senior staff meetings, CCU senior staff meetings and CCU operational meetings confirmed that learning from incidents and audits were discussed.

The critical care clinical director sat on the medical advisory committee (MAC) which met quarterly and reviewed clinical quality and governance matters including risks, incidents, new services, patient experience, recruitment and applications for practising privileges.

The mortality review group (MRG) was chaired by the head of patient safety and met monthly reported into the clinical governance committee. The MRG reviewed the mortality across the hospital and identified any learning to be shared via MDTs. The outcome of reviews from critical care morbidity and mortality meetings were reported to the MRG. The critical care matron and acute service matron and the ward manager attended the meetings.



Critical care

The hospital produced a quarterly clinical operating report (QCOR) and monthly clinical operating report (MCOR). The reports monitored and reviewed patient safety, clinical effectiveness, patient experience regulation and development via the quarterly clinical operating report meetings.

The critical care service introduced updated Local Safety Standards for Invasive Procedures (LocSSIPs) in quarter 1 2023.

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.

The hospital identified risks through different sources including audits, concerns raised by patients or staff and incidents. Risks were raised by the head of department with the support of the risk manager and then presented at the weekly CLIP (complaints, litigation, incidents and patient experience) meeting. We saw mitigations were discussed and the risk score assessed which was uploaded onto the hospital's electronic risk register. All risks were discussed at the hospital's board meeting, quality governance committee and MAC.

The critical care local risk register had 4 risks identified. Each risk was given a rating, review date, control measures and allocated with a risk owner. The issues and risks which managers identified were in line with what we were made aware of during the inspection. The hospital risk management dashboard was refreshed twice daily so it ensured that the risk register was up to date which ensured risk across the hospital were effectively monitored and managed on an ongoing 'live' basis.

The critical care quality service meetings reviewed the data from the quarterly ICNARC reports, quality improvement projects, incident reporting, and patient feedback. The hospital advised these quarterly meetings had been put on hold during Covid-19 and oversight of quality was provided through the hospital QCOR and quality governance committee meetings. The critical care quality service meeting was reinstated in February 2023.

Activity dashboards were in place to monitor key performance indicators on critical care which included performance measures including patient feedback, hand hygiene performance and pain scores.

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.

Service performance measures were reported and monitored. Critical care service performance data was reported to the Intensive Care National Audit and Research Centre (ICNARC). Quality key performance indicators (KPI's) were monitored and reported using the quality dashboard.

The critical care services used EPRs. Staff were aware of their responsibilities in relation to confidentiality and data security. All staff had password access to the EPR's.

Staff had secure access to the service's intranet, which gave them access to a range of policies, procedures and guidance and their training and personal development records. The units had information boards for staff, patients and visitors.

Privacy and security training was part of the mandatory training programme with 90% staff having completed the training.



Critical care

The critical care service participated in the national surveillance system reporting to the UK Health Security Agency and Public Health reporting infection control audit data that was collected as part of ICNARC.

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.

Patient experience on the critical care unit helped shape how the service was provided. Patient feedback gave patients and their relatives an opportunity to raise concerns or make suggestions. Patient feedback for overall quality of care was consistently over 95%. On CCU3 we saw 'you said, we did' boards to show the improvements the service had made in response to patient feedback. For example, providing dementia friendly clocks in patients rooms to ensure all patients knew the date, day and time and introducing same gender patient to nurse allocation. Critical care also introduced initiatives from other teams such as introducing green food allergy wrist bands to alert the catering staff when serving food.

In team meeting minutes we saw examples of how staff were encouraged to make suggestions about how the service could be improved. This included updating equipment for example new bedside monitors for monitoring patients. Another initiative we saw that had been implemented was a staff recognition board, so staff could nominate and celebrate colleagues' achievements when they had done something well. The service also had 6 team days with team building days over the past 12 months and various social gatherings were promoted to encourage inclusivity and promote good culture.

We were told the October 2022 staff survey for the CCU's saw an improvement in their engagement index which had increase to 72, from 70, with a response rate of 83% (65 out of 78 staff). Of the 13 questions asked 11 had improved scores, and only 2 questions decreased. Following the survey specific objectives were set to ensure resources were identified to create a culture of inclusion, build a community in the team, and ensure displays of staff recognition and management rounding were ongoing.

In 2022 the hospital launched the innovation bridge which was a virtual space where staff could share ideas and innovations to help improve colleague and customer experience at the hospital. Please refer to the surgery report for more information.

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 critical care service encouraged staff to develop their skills and undertake training. In minutes we saw, staff were encouraged to enrol on different programmes that were on offer. The hospital through its partnership with a charity recruited nurses who were refugees. A member of the nursing team on critical care had come through the programme and was a practising registered nurse currently undertaking their foundation training in critical care.

A member of staff had started a patient diary project trial which part of their contribution to the critical care service. The project was due to progress and continue throughout 2023 for its implementation. Intensive care patient diaries are a simple but valuable tool in helping patients come to terms with their critical illness experience.








Critical care

Staff were supported to make improvements to the service. For example, a nurse we spoke to told us of a training piece that was identified, and she was encouraged to organise it. The hospital provided financial resources and support so the training could be organised.

The consultant intensivists at London Bridge Hospital Private Care at Guy's CCU provide internal training in advanced airways management. The course was developed in response to an incident, and the training has been expanded to the whole critical care division.

The hospital established a Learning Improvement Panel (LIP) to support the oversight of the patient safety incident response framework (PSIRF). This purpose of LIP is to have effective oversight of all the various and action plans generated within the hospital and to provide follow up and evidence of continued learning and change in practice. The LIP is going to be established across HCA UK.

Surgery

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

Is the service safe?

Good 

Our rating of safe stayed the same. We rated it as 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. Mandatory training modules were a mixture of face to face and online training. At the time of our inspection mandatory training compliance levels for theatre, pre-assessment and surgical wards was 98%, which exceeded the hospital's target of 85%.

Mandatory training was comprehensive and met the needs of patients and staff. Modules included but were not limited to, safeguarding adults and children, equality and diversity, learning disability and autism training, mental capacity act and the deprivation of liberty safeguards, infection control, immediate life support and basic life support.

Bank and agency staff also completed the hospital's mandatory training programme.

Staff told us they had protected time to complete their mandatory training. Clinical nurse facilitators and ward managers were responsible for monitoring mandatory training completion and received two weekly reports from the learning platform to ensure that staff were up to date.

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.

We reviewed the service's safeguarding adults policy. This was in date and available on the hospital intranet system. The policy detailed individual responsibilities, processes for reporting and escalation of concerns and who to contact.



Surgery

All staff were trained to level 2 and 3 safeguarding adults and level 2 and 3 safeguarding children. There was a safeguarding lead who was trained to level 4 safeguarding. Compliance rates for level 2 safeguarding adults was 100% and 94% for level 3, which exceeded the hospital's target of 85%. Compliance rates for level 2 safeguarding children was 99% which exceeded the hospital's target of 85%.

Staff we spoke with had good awareness and knowledge of female genital mutilation (FGM) which was part of safeguarding training.

All staff we spoke with demonstrated a good understanding of safeguarding vulnerable adults and children. Staff were able to identify the potential signs of abuse, the process for raising concerns and what would prompt them to make a referral. Staff knew how to escalate concerns to their manager and safeguarding lead. We saw safeguarding posters around the wards with information on how to raise safeguarding concerns.

The surgical service had made 9 safeguarding referrals in the last 12 months.

Cleanliness, infection control and hygiene

The service managed 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 observed were visibly clean. Ward areas had suitable furnishings which were clean and well-maintained.

Theatre areas were visibly clean and free of clutter. There was access to hand sanitisers throughout the hospital and we saw handwashing posters above sinks.

Staff cleaned equipment after patient contact. Cleaning checklists of clinical areas and equipment were completed on a daily basis. The service had infection prevention and control (IPC) link nurses who supported the ward and ensured audits were undertaken and any actions were in place.

We viewed the infection control policy which was in date and accessible on the hospital intranet. Infection control was part of mandatory training for staff and compliance rates were 100%.

The service completed monthly infection control audits, which were overseen by the IPC lead. Areas covered included hand hygiene, IPC principles and practice, continuing care of central venous access devices, continuing care of peripheral vascular devices, continuing care of urinary catheters, medical devices, sharps and waste handling and transmission-based precautions. Results for March 2023 were consistently above 90%. Actions were in place where areas scored under 100% which included putting in additional staff to audit compliance. Hand hygiene audit compliance rates across surgical wards at both sites, and theatres were consistently at 100%.

There was easy access to personal protective equipment (PPE) such as gloves and aprons and we saw that staff followed infection control principles and were bare below the elbow. We observed theatre staff wearing appropriate PPE in theatres and practising good hand hygiene.

If a patient was infectious, a sign was put on the door of their room to indicate this to staff and visitors.



Surgery

Staff worked effectively to prevent, identify, and treat surgical site infections. There had been six surgical site infections in the last year. We viewed the post infection reviews for these and found them to be comprehensive with actions in place and completed. Learnings were also shared at the provider's IPC committee. The service had 24 hour seven day a week access to a consultant microbiologist for advice and support during investigations and sign off of post infection reviews.

There had been no cases of methicillin-resistant staphylococcus aureus (MRSA), one case of methicillin-susceptible staphylococcus aureus (MSSA) and one case of C. difficile in the last 12 months at the hospital. We saw service level agreements between the central sterile services department (CSSD) and theatres. The standard turnaround for sterilising surgical equipment was 24 hours. However, at the request of theatre staff, the turnaround could be expedited to 12 hours or fast tracked to a turnaround of 4 hours.

We witnessed housekeeping staff cleaning the ward areas and filling in a cleaning checklist throughout the day.

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.

Surgical wards and theatres were within the main building of London Bridge Hospital and the provider's other site which was called Private Care at Guy's. There were 6 theatres at the main site and 4 theatres at the Private Care at Guy's site which were available for both elective and urgent surgery. Of the 6 theatres at London Bridge Hospital, 5 were laminar flow. Laminar flow theatres aim to reduce the number of infective organisms in the theatre air by generating a continuous flow of bacteria free air. Access to theatres was by keypad locked door.

All patients were cared for in private single rooms with en-suite facilities. Call bells and emergency buzzers were in the main patient bedroom area as well as the en-suite bathroom.

Emergency trolleys were available on each ward, in the pre-assessment clinic and in theatres. We checked the emergency trolleys on the wards and theatres and found that they were secured with a plastic snap lock, so it was clear if someone had accessed the resuscitation equipment. Equipment in emergency trolleys were checked daily and we saw record check sheets that had been signed to confirm checks had been made. We checked various consumables and found they were sealed and in date.

We also checked the service's sepsis trolleys which was checked daily. We checked the consumables within the trolley and found them to be in date.

We checked and saw evidence that technical equipment had been serviced and calibrated regularly. We saw safety checks had been completed and logged for anaesthetic machines. Staff told us equipment faults could be reported electronically and were seen to quickly by the equipment maintenance team. Equipment we checked such as defibrillators and suction machines had up to date electrical safety tests.

Oxygen cylinders were stored securely and were in date. We inspected two sharps bins and found them to be correctly labelled and not filled above the maximum fill line.

The medicines rooms on surgical wards were locked to prevent unauthorised entry. We checked consumable equipment and found items we sampled were in date and packaging was intact, indicating it was sterile and safe for use in patient care.



Surgery

Theatres, patient rooms and clinical areas were visibly clean and uncluttered.

The hospital had access to bariatric equipment such as bariatric wheelchairs and beds. Bariatric equipment could be requested by staff at the pre-assessment stage and delivered to the ward prior to a patient arriving.

Linen cupboards and storage rooms were appropriately stocked and tidy.

Staff kept substances which met the Control of Substances Hazardous to Health (COSHH) regulations in a locked cupboard in a room accessible by staff only. We saw these were stored appropriately.

Resident medical officers had their own dedicated room to use to rest when on duty overnight or between shifts.

Staff told us there was enough access to computers and equipment such as PPE and consumables.

Waste management was handled appropriately, with different colour coding for general waste and clinical waste. All clinical bins were seen to be operated with lids and were not overfilled. Waste management and removal including those for contaminated and hazardous waste was in line with national standards.

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 we spoke with were aware of escalation protocols for deteriorating patients and the use of national early warning scores (NEWS2). This is used to monitor the patient condition and included recordings of blood pressure, pulse, respirations, and temperature. We checked patients' NEWS2 charts and found them to be correctly filled in.

Staff on wards used a portable handheld device where they could record patients' NEWS2 scores and observations. Observations were assessed and scored automatically which removed the chance of human error. The information was accessed and monitored in real-time by the resident medical officers and the critical care outreach team so any indication of patient deterioration could be responded to quickly.

NEWS2 was audited quarterly and overall compliance scores for the surgical ward were consistently at 100%.

As part of handover before the morning and evening shifts, the nurse in charge read a safety briefing to the team. This was a briefing where nurses were made aware of patients who were high risk such as those who were unstable, susceptible to falls or had a high NEWS score. Medicines prescribed at the last shift were also discussed so that no medicines were missed or delayed. In addition, staff with known safety risks such as those that were pregnant were highlighted so that staff allocations for the day was safe and appropriate.

Theatres held a daily huddle where a variety of topics were discussed to keep staff up to date about safety and activity in theatres such as staffing, any materials or IT issues, new risks or changes to policies.

The use of the World Health Organisation (WHO) five steps to safer surgery checklist was embedded in practice. Audits were carried out monthly and the latest audits from October 2022 to April 2023 showed consistent 100% compliance for



Surgery

WHO checklist completion. At our last inspection we saw that the hospital's own audits indicated that end of list debriefing to complete the five steps were not being consistently carried out. At this inspection, audits showed full compliance, and we found from patient notes we reviewed and observations we undertook in theatres that the checklist was completed comprehensively.

Staff confirmed that they had received training in sepsis and the sepsis six care bundle which consists of 3 tests and 3 treatments for the management of patients with presumed or actual sepsis. Sepsis training was recorded within each staff member's individual competency file. The service also had sepsis trolleys which contained the six elements of the sepsis six care bundle including the antibiotics needed to deliver the care bundle.

Sepsis audits took place monthly. From November 2022 to April 2023, audits showed compliance rates which ranged from 74% to 87% on the second, fourth and fifth floor surgical wards. There were no cases which triggered sepsis six on the surgical ward at the Private Care at Guy's site.

Although audits showed that recognition of sepsis by staff was quick and sepsis 6 was initiated in less than hour, the lower compliance rates were mainly due to a variation in practice around oxygen and IV fluids and cases where there were isolated spikes in fever with no other accompanying signs of sepsis. Actions were in place to address this including immediate review by the resident medical officer, additional learning sessions for staff on sepsis and an accompanying leaflet for staff to keep and refer to.

Patients were assessed in the pre-assessment clinic by a nurse prior to their surgery. This was conducted either over the telephone or face to face depending on certain criteria. The pre-assessment team provided advice and information to patients prior to their surgery which included ensuring any individual needs such as access to interpreters or mobility needs were arranged, as well as arranging diagnostic tests. The team told us they were able to contact the patient's consultant to ask any questions about the patient as well as engaging early with clinical nurse specialists, physiotherapists, occupational therapy, theatre staff or surgical ward staff. This ensured that everything was in place for the patient when they arrived at the hospital for their procedure.

The service did not treat complex patients, such as those with mental health conditions, but did treat some patients with multiple co-morbidities, in line with the admission criteria.

The service followed National Institute for Health and Care Excellence (NICE) recommendations for pre-operative tests. We saw evidence in patient notes that risk assessments had been completed. For example, patient notes recorded falls risk assessments and patients were assessed for venous thromboembolism (VTE) risk on admission and after admission, in patient documentation. Patients who were at risk of falls had a yellow card placed outside of their rooms so staff could be made immediately aware of the risk. VTE risk assessments were completed for all patients and the risk was reviewed at each shift. There were two hospital acquired VTE and one pulmonary embolism following surgery in the last 12 months.

The service used the aSSKING care bundle which stands for 'assess risk; skin assessment and skin care; surface selection; keep moving; incontinence and moisture; nutrition and hydration; and giving information or getting help' and is a tool which ensures all fundamental aspects of pressure ulcer prevention are included in patient care. The service had dedicated tissue viability nurses who attended wards regularly. Nursing staff were also encouraged to attend tissue viability courses so that they could provide additional support. The pressure ulcer audit from the last 6 months showed no patients had acquired pressure ulcers while staying at the hospital on the surgical wards.



Surgery

There were twice daily ward rounds. Consultants reviewed their patients' condition as part of the daily ward round. Resident medical officers were on site 24 hours a day, 7 days a week and would conduct the second ward round. They would call the consultant surgeon if they had any concerns. If a patient deteriorated, nursing staff would escalate for support from the resident medical officer.

The resident medical officer would contact the patient's consultant and notify the hospital's critical care outreach team for transfer to the hospital's critical care unit. Arrangements were in place for transfer to a local NHS hospital in the case of stroke or if the patient was an NHS patient requiring complex care.

Surgeons were responsible for attending to their patients in an emergency in line with the provider's practising privilege policy. Consultants were always required to be contactable by telephone and available to attend their patient in the event of an emergency. As part of their practising privileges agreement, consultants were required to live within 30-60 minutes of the hospital. In addition, consultants were required to identify and ensure a 'buddy' was in place and there was named cover during any leave. Anaesthetists were responsible for the care of their patients until discharge or 24 hours post operatively, whichever was earliest. The service was also supported by on-call anaesthetists and consultants who worked to speciality specific service level agreements.

There was an on-call team which included a radiographer, theatre team and senior staff who were supported by the on-site duty manager who covered 24-hours day 7 days a week. The on-call theatre team were available for emergency returns to theatre out of hours. There was 24-hour access to diagnostic imaging. There was access to an on-call radiographer and access to theatres in an emergency any time of the day, which would be coordinated by the duty manager.

All nursing staff had completed immediate life support training, all healthcare assistants had completed basic life support training and resident medical officers had completed advanced life support training.

If a patient clinically deteriorated, there were transferred to the hospital's critical care unit unless the patient was recognised as having a suspected or confirmed stroke, where they would be transferred to the hyper acute stroke unit at a local NHS trust via 999 ambulance. On occasions, if a planned, elective/surgical, NHS patient required an extended length of stay due to clinical complexities, a decision would be made to transfer the patient to the NHS for ongoing care.

Bed meetings were conducted twice a day where staff shared key information about staffing pressures, patients being admitted and any issues throughout the hospital.

Patients received a discharge information pack when they were discharged from the hospital. Cancer surgery patients had alert cards to ensure that staff were aware of what treatment the patient was undergoing.

Within the discharge information pack there was a telephone number which patients could use to call the ward at any time of the day as well as a number for the clinical nurse specialist if they had any questions or concerns. The clinical nurse specialist called patients post-discharge to check that the patient was recovering well and if there were any questions they had. All cancer surgery patients received follow up telephone calls from their clinical nurse specialist. Staff told us they had begun a quality improvement project to implement a post-discharge call service for general surgical patients as well.

Nursing and support staffing



Surgery

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.

Staffing levels were reviewed and planned in a timely manner by ward managers using a staffing tool. Staff told us they received their rotas a month in advance, so they knew what shifts they were working. We saw that actual staffing levels reflected the planned numbers.

Staffing levels for the day were discussed at handovers and bed meetings at 11am and discussions included any need for cross cover across wards.

Across surgical services, there were 23 vacancies out of a staff base of 197 which gave a vacancy rate of 11.6%. Seven of the vacancies were due to internal promotion of staff members. There was a plan in place to fill the posts in the form of biannual talent reviews to discuss the top 10% of staff ready for succession, external and internal advertisement of roles, a nursing referral scheme initiative and overseas recruitment. Staff told us that the service had recently had an intake of nursing staff from Lebanon as part of the provider's involvement in the talent beyond boundaries programme whereby support is provided to healthcare professionals who have been forcibly displaced from their home countries by conflict and civil unrest.

Staff in theatres, wards and pre-assessment reported generally good levels of staffing and use of regular agency staffing where there were shortfalls. Some staff reported that on occasion, agency staff did not attend a shift and this put pressure on the wards. All agency staff received a full induction and held the same competency folders that the nurses on the ward had.

The service undertook elective surgery and was able to plan staffing accordingly. During our inspection we saw there were enough staff allocated to theatres, recovery and the surgical wards. The service also upskilled staff members to support wards and theatres. For example, the theatre coordinator had recently completed training to be a surgical first assistant.

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.

The service had enough medical staff to keep patients safe. The service was consultant led. Consultants and anaesthetists worked under practising privileges agreements. Under practising privileges, a medical practitioner is granted permission to work within an independent hospital. Practising privileges were granted to consultants by the medical advisory committee (MAC). Consultants with practising privileges had their appraisal and mandatory training provided by their NHS trust or independently, depending on where their connection for medical revalidation was with. Their revalidation recommendation was provided by their responsible officer and London Bridge Hospital required ongoing updated evidence of this.

The MAC reviewed and advised upon the continued eligibility of consultants' practising privileges every 2 years for those with a continuing NHS practice and annually for those consultants working exclusively in the private sector.



Surgery

Consultants reviewed patients daily and we saw evidence of this in patient notes we reviewed. The hospital used resident medical officers who provided a 24 hour, 7 day a week service on a rotational basis. Resident medical officers attended ward handovers and daily bed meetings and had constant access to the electronic observations system so they could monitor patients and attend to them quickly. We were told that the hospital had a waiting list of resident medical officers who wanted to join the service.

Staff reported that if they needed a patient's consultant to attend, they were able to contact them easily. In the event the consultant was unavailable, the consultant would ensure there was another consultant who covered for them.

The service was also supported by on-call anaesthetists and consultants who worked to speciality specific service level agreements. Surgical consultants had access to support from consultant physicians via a service level agreement (as part of their practising privileges contract) and an on-call rota.

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.

The hospital used a mixture of paper and electronic patient records to record patient needs, care plans and risk assessments however there were plans in place to move to a completely electronic patient record system. Staff told us the current paper and electronic record system was not always cohesive. Although we did not find any examples of this impacting patient care, staff told us that this potentially could be an issue.

Consultants sent letters to the patient's general practitioner (GP) with the patient's consent, with information around the outcome of consultations and procedures.

Patients who were admitted to the hospital would also have a discharge summary sent from the consultant to the patient's GP with the patient's consent.

Patient notes were kept securely in locked cupboards within the nurse's station. Electronic patient records were kept on a secure server and staff had logins to be able to access the system. There was a plan to transfer all records to a fully electronic records system.

Pre-assessments were completed by nursing staff either face to face or over the telephone depending on the type of surgery the patient was to have. Pre-assessment records included the patient's medical history, allergies, additional needs such as interpreter requirements and fasting instructions.

We were told stickers would be placed on the records of patients who for example were living with dementia or were receiving palliative care so staff could immediately be alerted to the patient's needs.

We saw in patient records that risk assessments had been completed such as a pressure ulcer risk assessment, and a falls risk assessment.

We reviewed 8 sets of patients records and found they were comprehensive and detailed. Records noted patients' additional needs such as if a patient required additional support with regards to mobility. We saw national early warning score system (NEWS2) observations and venous thromboembolism (VTE) risk assessments had been completed.



Surgery

Care plans were in place and there was evidence these were reviewed daily. Allergies were also recorded on drugs charts. We saw evidence in patient records, and from our observations in theatres, that staff completed the safety checks undertaken during procedures using the World Health Organisation (WHO) five steps to safer surgery checklist.

Operation notes were legible and postoperative plans were clearly documented. We saw there were stickers on records in order to be able to trace medical devices used. Implants and medical devices were recorded in the implant register book and all cosmetic implants were recorded on the Breast and Cosmetic Implant Registry.

We observed staff logging off computers after use. Information governance formed part of privacy and security mandatory training for nursing and medical staff.

Medicines

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

The hospital used systems and processes to safely prescribe, administer, record and store medicines. We saw staff on the surgical ward wearing disposable red tabards during medicines rounds so that it was clear to other staff they should not be disturbed thus reducing the risk of medicines errors.

The hospital used an automated medication dispensing system which ensured secure medication storage with electronic tracking of medicines. We saw that staff followed systems and processes when safely prescribing, administering, recording and storing medicines. The medicines room was locked and only accessible to authorised staff.

Nursing staff we spoke with were aware of the policies on the administration of controlled drugs (CDs). CDs were stored in line with required legislation and recorded in a controlled drugs logbook. We viewed the logbook where staff recorded when CDs had been used and stock was checked. Two members of staff checked the controlled drug stock levels. We checked a sample of these and found them to be accurate and the medicine in date. We saw in the CD logbook in theatres that a discrepancy had been identified. Staff told us that this had been escalated and investigated as a recording error made by a member of staff and that the individual had been provided with additional training as part of the learning from this.

We saw the service had an up to date medicines management policy. Medicines for patients to take away with them on discharge were packed and stored securely in the medicines room prior to their discharge. This also helped ensure patients could be discharged in a timely manner.

Medicines used in patients' procedures were clearly listed in the patient records. We saw in patient records that allergies were clearly documented.

Prescription pads were kept in a locked drawer accessible only by the consultant and resident medical officers.

A pharmacist visited the wards daily and checked prescription charts and controlled drug books. Staff told us they could contact the pharmacist at any time if they had any concerns regarding medicines patients were taking. There was an on-call pharmacist for out of hours requests.

Microbiology protocols for the administration of antibiotics were available on the hospital intranet.



Surgery

Room temperatures and fridge temperatures of treatment rooms were recorded daily. We checked the medicines fridge temperatures and ambient room temperature during our inspection and found them to be within expected range.

The service completed controlled drug audits and safe and secure storage of medicines audits on a quarterly basis. A medicines reconciliation audit took place biannually.

Results of the last controlled drugs audit showed compliance in 5 of the 8 areas (over 90%). 2 areas scored partial compliance (scoring between 80-89%) and 1 area of non-compliance (below 80%).

The themes of non-compliance were mainly around documentation errors in the CD logbook. There was a comprehensive action plan which included additional training packages and refresher sessions for staff.

Results of the last safe and secure storage of medicines audit showed compliance in all areas apart from theatres which were partially compliant which was around the temperature checking documentation. An action plan was in place with the theatre team to improve results in this area.

Medicines reconciliation is the process of accurately listing a patient's medicines before they were admitted and comparing this to what has been prescribed whilst in hospital. Results of the last medicines reconciliation audit showed full compliance in all areas.

Incidents

The service managed patient safety incidents well. Staff recognised and reported incidents and near misses. 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.

The service managed patient safety incidents well. Staff recognised and reported incidents and near misses and knew how to raise concerns using the hospital's electronic incident reporting system in line with the hospital's incident reporting policy. Managers investigated incidents and shared lessons learned and feedback with the team at team meetings. There was evidence that changes had been made as a result of feedback. We viewed the minutes of team meetings which showed discussion of incidents and the learning from them. There were various forums where surgical incidents were discussed such as at debriefs in theatres and wards, multidisciplinary team meetings, mortality and morbidity meetings where appropriate and weekly. All learning outcomes were shared and discussed at team meetings and also monitored at the weekly complaints, litigation, incidents and patient experience (CLIP) meetings.

In the last 12 months, a total of 994 incidents were reported. 98% of the incidents were reported as no or low harm, 16 were moderate harm, 3 were expected deaths and 2 were unexpected deaths.

Never events are serious patient safety incidents that should not happen if healthcare providers follow national guidance on how to prevent them. Each never event type has the potential to cause serious patient harm or death but neither need have happened for an incident to be a never event. There had been one never event for surgical services. Learning from this incident was shared among all teams and all staff we spoke with knew about the never event, the actions and learning from this incident.



Surgery

We viewed the service's incident log which documented the actions taken, investigations and lessons learned from each incident. The service had hot boards which were posters that were disseminated to staff with information on learning and actions from incidents, policy changes and new additions to the risk register. Hot board posters ensured staff who were not on shift during ward meetings or briefings could still be informed of important changes, learning and actions.

The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain 'notifiable safety incidents' and provide reasonable support to that person. Staff we spoke with were able to explain the duty of candour fully. We saw investigations from incidents where the service had applied the duty of candour.

Is the service effective?

Good



Our rating of effective stayed the same. We rated it as 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.

The service delivered care in line with national clinical guidance. Staff had access to policies and procedures based on national guidance on the hospital intranet.

We reviewed a sample of hospital policies including policies for safeguarding adults, infection control, stroke standard operating procedure, medicines management and the early warning scores policy. These were all in date and appropriately referenced national guidance and best practice such as that recommended by the National Institute for Health and Care Excellence (NICE), the association of surgeons of Great Britain and Ireland and royal college of physicians.

We saw the patient pathways and protocols were based on national guidance. We reviewed several patient pathways for example for spinal and cardiac procedures.

Local safety standards for invasive procedures (LocSSIPs) were embedded in practice. The service had a single theatres LocSSIPs policy to ensure all surgical procedures that take place within theatres followed the same LocSSIPs and the relevant WHO checklist dependent on the type of procedure taking place. Theatres LocSSIPs awareness was part of the induction programme for temporary staff and new starters with reading of the policy a mandatory requirement for all staff members.

The provider was also in the process of further developing and updating their LocSSIPs following the updated publication of the National Safety Standards for Invasive Procedures (NatSSIPs 2) earlier this year. NatSSIPs brings together national and local learning from the analysis of 'never events', SI's and near misses through a set of recommendations that enable staff in providing safer care for patients undergoing invasive procedures.

The service used evidence based 'care bundles'. A care bundle is a set of evidenced based interventions that, when used together, can improve patient outcomes. Changes and updates to policies were disseminated to staff at team meetings and by email.



Surgery

We saw there was a formal annual clinical audit programme to evidence performance monitoring, quality measures or patient outcomes relating to surgical services. The audit programme detailed the frequency at which the audits should be undertaken and included but not limited to, audits for WHO five steps to safer surgery; infection control; hand hygiene; sedation; consent documentation; DNACPR; sharps and waste handling; chaperone documentation, and early warning scores.

The service used an audit reporting tool and dashboard which summarised audit results so staff could identify any gaps and taken appropriate actions. Actions and learning from audits were discussed at monthly meetings with the head of department and departmental audit champions. Learnings and actions were then further escalated to the corporate clinical audit and effectiveness committee. Audit results were also shared at the provider's monthly quality governance committee and board meetings. We saw from theatre and ward team meeting minutes that audits results and any actions were also discussed in detail.

Nutrition and hydration

Staff gave patients enough food and drink to meet their needs and improve their health. Staff followed national guidelines to make sure patients fasting before surgery were not without food for long periods. The service adjusted for patients' religious, cultural and other needs.

There were appropriate arrangements to ensure patients' nutrition and hydration needs were met on the wards. The service used evidence-based tools to screen for malnutrition. We saw in patient records a malnutrition universal screening tool (MUST) tool was used for assessing patients' nutrition. We saw fully completed fluid charts which were used to monitor patients particularly after a surgical procedure.

The service had dedicated dietitians to support nutritional planning for patients. The hospital had its own catering team who provided fresh food to patients. Food menus catered for different patient groups including those with specific dietary requirements such as allergies, intolerances and religious needs.

Admission times were staggered so fasting times could be minimised. Fasting instructions were given to patients at the pre-assessment stage and patients told us the staff checked with them that they understood the instructions.

Pain relief

Staff assessed and monitored patients regularly to see if they were in pain and gave pain relief in a timely way.

Staff assessed patients' pain using a recognised tool and gave pain relief in line with individual needs and best practice. Pain audits were undertaken on a quarterly basis and results from the last three audits for all surgical wards was consistently 100%. The service had access to alternative pain tools for patients with communication needs.

We saw in records that patients had been prescribed and administered pain relief and this had been recorded accurately. Records we reviewed also showed that patients' level of pain was assessed as part of their observation records.

The service had a bespoke pain team who had innovated a pain management process, to reduce the need to give high strength pain relief. This was initially trialled for colorectal patients and having received positive feedback from patients it was now being trialled for liver transplant patients. The service was in the process of getting feedback from patients around the effectiveness of the tool.



Surgery

Patients' pain levels were reviewed by the anaesthetist in the recovery area to ensure they were comfortable before returning to the ward. There was also a pain management team who assisted the surgical wards to support patients in pain.

Patients we spoke with told us their pain had been managed appropriately and they generally received pain relief in a timely manner.

Patients were given a telephone number of the ward and their clinical nurse specialist and encouraged to call if they had any concerns about pain.

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. Actions and learning as a result of the audit programme were discussed by heads of department and departmental audit champions and disseminated to individual surgical ward team meetings.

Audits were completed on an electronic auditing system. This allowed for results and trends to be generated and shared effectively. Staff received training in the use of the electronic auditing system during their induction. On the wards staff were allocated to undertake various audits so that the team were fully involved in the auditing process and could take ownership of the specific audits, actions and learning.

To monitor the quality of care and outcomes, the provider monitored key performance indicators such as activity reviews of surgeons. Reviews of a consultant's activity were undertaken annually if they had private practice only or every two years if they practised within the NHS as well as private.

In the last year, there were 34 unplanned returns to theatre, which was 0.19% of the total of procedures undertaken. All returns to theatre were discussed at the hospital's monthly quality governance committee where themes, trends, learning and actions were identified. Findings were presented at the hospital's monthly board meeting, the quarterly medical advisory committee meeting and quarterly clinical operating report meeting.

There were no unplanned transfers for surgery in the last 12 months due to patient deterioration.

Rates of infections for surgical categories such as coronary artery bypass graft (CABG) was zero rate of infection per 100 bed days. Spinal surgery had an infection rate of 0.3 per 100 bed days; total knee replacements (TKR) had an infection rate of 1.2 per 100 bed days; total hip replacement (THR) had an infection rate of 0.6 per 100 bed days and abdominal hysterectomy had zero rate of infection per 100 bed days.

Adherence to and understanding of NICE guidelines was embedded and evidenced through the use of audit programmes to benchmark practice. The hospital collected data and benchmarked against international and national audit standards.

The hospital provided a live liver donor transplant programme. Outcomes for the 45 live liver transplants performed since the programme was established in 2008 were 100% survival rate of over 5 years which was better than the national average of 85%.



Surgery

Cardiac surgery data was compared against National Institute for Cardiovascular Outcomes Research (NICOR). The latest report for the provider concluded that the adult cardiac surgical outcomes continue to remain excellent for the 3-year reported period. The crude survival rate 99.2% (including 8.9% Redo surgery) was greater than 99% for the 3 years reported and higher than the national average of 96.7% in 2022.

Patients admitted to hospital for spinal surgery were consented to have their details submitted to the British Spine Registry (BSR) in line with national standards for spinal surgery, supported by the British Association of Spinal Surgery (BASS).

Orthopaedic patients for hip, knee and shoulder joint replacements were consented for their details to be submitted to the National Joint Registry (NJR) to align with national standards.

The hospital received a notification from the NJR in January 2023 about higher than expected revision rates for primary hip replacement which the hospital investigated by conducting an independent review. As part of the actions following the investigation, the provider started a hip and knee NJR audit meeting where all full time private orthopaedic surgeons working at HCA are required to attend.

The hospital also collected data for patients undergoing breast and cosmetic surgery to the Breast and Cosmetic Implant Registry.

The service participated in patient reported outcome measures (PROMS). Patient reported outcome measures assess the quality of care from the patient perspective. Each patient is invited to give feedback on the outcomes of their surgery by responding to questionnaires before and after their procedures. Improvements in health could then be assessed by comparing the answers. Results were generally positive with patients reporting an improvement in health status following procedures on shoulders, hips and knees.

During the first wave of the COVID pandemic, London Bridge Hospital undertook elective surgical operating pathway on behalf of a local NHS trust working to a strict elective operating framework to reduce the risk of post-operative COVID-19 infection. The patients who were treated were followed up 4 weeks postoperatively and results showed that the risk of contracting COVID-19 in the elective operating framework was very low. The rate of COVID-19-related death in the cohort was 0.25% (1 patient out of 398). This demonstrated that high-volume major surgery was achievable even at the peak of the pandemic, if patients were screened appropriately preoperatively. The results were published in the Royal College of Surgeons medical journal.

Departmental performance was also presented to monthly hospital board meetings. This was where key performance indicators such as unplanned returns to theatre, and incidents were discussed.

Patients were given surveys to complete including post discharge and these were collated and submitted to the private healthcare information network (PHIN). PHIN is an independent patient information network which works to empower patients to make informed choices about their care provider. PHIN data was presented and discussed at monthly board meetings.

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.



Surgery

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

The service used regular agency staff to ensure continuity of care. There were specific induction packs for agency staff.

New staff received a comprehensive corporate induction as well as a department specific local induction. In theatres, the induction was separated out into key areas (surgical, anaesthetics and recovery). All new starters were allocated a 'buddy' and were supernumerary for their first 2 weeks. Staff were given the HCA orientation booklet containing sets of objectives which were required to be achieved and completed during their probationary period.

In theatres, new starters were paired up with a buddy for their first 30 days and were supernumerary while they got introduced to the team and department. Theatres had a 'who's behind the mask' initiative to help welcome new starters to the theatre team by helping current staff recognise them and help support them during their induction period.

Staff told us their training needs were met, and managers were always willing to support their development. The provider had an education centre at the main hospital site which was a dedicated space for staff to use for reflection, and different types of learning such as simulation, classroom teaching, one to one teaching/coaching, computer access for virtual learning or professional study. All staff working within robotic surgery attended study days and were trained in theoretical knowledge and practical skills for robotics with competencies requiring sign off.

Staff told us they had been supported to access leadership and management courses, attend conferences or gain further qualifications in specialities that they were interested in. At the time of inspection, 100% of staff in surgical services had completed their appraisals. There was also a clinical practice facilitator for surgical wards and theatres who supported the development of staff.

Revalidation was introduced by the Nursing and Midwifery Council (NMC) in 2016 and is the process nurses must follow every three years to maintain their registration. Nursing staff told us they were supported with their revalidation through clinical supervision.

Leaders demonstrated a passion for developing, upskilling and supporting staff to advance in their careers. Several staff had taken on roles as link nurses in various specialities such as colorectal, infection control and pain management. In theatres, we were told that junior practitioners were empowered to be the team leader of the day to lead the WHO checklist.

The service also had a team of 32 clinical nurse specialists specialising in, for example, spinal, liver, colorectal, thoracic, tissue viability, renal and breast care.

All consultants under practising privileges received an induction pack which included details on what was required of them to practise at the hospital. Each application for practising privileges was assessed by the medical advisory committee (MAC) and we saw evidence of this in the MAC minutes we reviewed.

If a surgeon wished to bring surgical first assistants to theatre, they were required to submit a recommendation to the provider and the first assistant would then have to have their competencies signed off by the provider before they began working at the hospital.

Resident medical officers had advanced life support training. All nursing staff had immediate life support training and healthcare assistants were trained in basic life support. The hospital also had a critical care outreach team who supported



Surgery

the wards in the event of a patient deterioration. The critical care unit resident medical officer, consultant intensivist and the nurse in charge were part of the team. All members of the critical care outreach team were trained in advanced life support (ALS) and were contactable by dedicated phones and were also alerted through the portable electronic handheld device which recorded patients' NEWS2 scores.

The hospital was accredited to train perfusionists and the head of perfusion held the College of Perfusionists examiners role and was part of the executive committee of the society of perfusionists.

Multidisciplinary working

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

We saw evidence of good multidisciplinary team (MDT) working within the surgical service.

Nursing staff said consultants and resident medical officers were always available for advice and support and there were good working relationships between colleagues. We observed in theatres that each member of the team was treated with respect. Minutes from the theatre user group showed a good multidisciplinary discussion around audits and celebrated good practice by team members as well as improvements required.

We observed multidisciplinary approaches to care planning for patients and families. Patient records demonstrated input from the full clinical team of doctors, nurses and allied health professionals such as physiotherapists and dietitians, from pre-operative assessment through to post-operative care. There was a discharge multidisciplinary team meeting on the ward which involved staff but also families so they could be fully involved in the plans for their loved one.

Letters were sent to a patient's general practitioner (GP) with the patient's consent, to share outcomes and discharge information. The discharge letter included contact details should another health professional require further advice about patients care or treatment post discharge.

Handovers and daily huddles included the full multidisciplinary team. Bed meetings were multidisciplinary and included nursing staff, resident medical officers, clinical nurse specialists and physiotherapists.

We saw physiotherapists liaising with nursing staff and saw the patient records had input from physiotherapists.

There were formal multidisciplinary team meetings (MDT) held for surgical patients. The hospital held 26 MDTs which took place either weekly, bi-weekly or ad-hoc.

Staff we spoke with who attended the MDT meetings spoke of how there was a holistic discussion about the patient's needs and how communication was clear and inclusive. We attended an MDT meeting and observed good attendance by the full multidisciplinary team including radiologists, physiotherapists and surgeons where discussions and challenges were detailed, holistic and considered the patient's needs.

Patients could be discussed at any of the MDTs held at other facilities managed by the provider to ensure there are no delays to patient treatment.

Patients received care by a multidisciplinary team. For example, records showed that patients received input from consultants, nursing, pharmacy, physiotherapy and nurse specialists.



Surgery

Seven-day services

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

Consultants led daily ward rounds on all wards, including weekends. In addition, there was a resident medical officer on every shift who was available 24-hours a day, seven days a week.

Staff could call for support from doctors and other disciplines such as pharmacy, and diagnostic tests, 24 hours a day, 7 days a week.

Patients who had been discharged were given the number of the surgical ward to call if they had any questions or queries and a nurse or doctor would be able to provide advice if required. Patients were also given the number of their clinical nurse specialist regarding specific questions about their condition.

Health promotion

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

Patients' health was assessed at the pre-assessment stage and staff provided additional information to support patients to live a healthier lifestyle.

The service had relevant information promoting healthy lifestyles and support on wards including leaflets on healthy eating, smoking cessation, and getting active.

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.

We saw completed consent forms in all 8 patient records we reviewed. We observed consent being confirmed with patients in theatre prior to anaesthetisation. Written consent including anaesthetic and surgical consent was sought from the patient. Written consent was also sought prior to surgery and on the day of surgery. Patients undergoing reconstructive cosmetic surgery were given a cooling off period of 14 days where they could change their mind about their decision.

The consent audit documentation from the last quarter (January 2023 to March 2023) showed scores achieved ranged from 80 to 100% for the surgical floors. Areas of non-compliance identified from the audits were around patients signing but not printing their names on forms and the lack of documentation around if the patient required the transfusion of blood products. Actions were in place to improve these results for the re-audit in 3 months' time.

Staff understood how and when to assess whether a patient had the capacity to make decisions about their care.

All records we reviewed showed that staff clearly recorded consent in patient records. Staff understood the relevant consent and decision-making requirements of legislation and guidance, including the Mental Health Act and Mental Capacity Act 2005 and they knew who to contact for advice.



Surgery

Staff received training on the Mental Capacity Act (2005) and Deprivation of Liberty Safeguards (DoLS). Staff were able to give clear explanations of their roles and responsibilities under the Mental Capacity Act 2005 (MCA) regarding mental capacity assessments and deprivation of liberty safeguards (DoLS).

Is the service caring?

Outstanding



Our rating of caring improved. We rated it as outstanding.

Compassionate care

Staff were highly motivated and inspired to offer care that was kind, compassionate and promoted patients' privacy and dignity. There was a strong, visible person-centred culture. Patients' individual preferences and needs were always reflected in how care was delivered. Feedback from patients who used the service and those close to them was continually positive.

Staff were discreet and responsive when caring for patients. We observed staff on the ward building a rapport with patients and taking the time to interact with patients and their loved ones. We saw nursing staff celebrating a patients' birthday and singing to them. During our inspection we saw a patient leaving the ward after their stay and thanking staff for their support.

All patients we spoke to praised the nursing staff and commented on the 'fantastic care' provided by the nurses at the hospital. We spoke with patients who told us that staff were 'incredible' and 'were always available whenever I needed anything.'

A patient recalled that following surgery, they were feeling distressed and uncomfortable and had wanted their sheets changed but had felt too embarrassed to discuss it. However, a nurse had noticed how the patient was feeling and discreetly changed the pillows and sheets for them.

Another patient told us that they really appreciated the efforts of a nurse who worked with them to protect their dignity when assisting them to go to the toilet.

Staff were focused on delivering patient centred care and respected the individual needs of each patient, showing understanding and a non-judgmental attitude when caring for patients. Staff described how they had supported a patient living with dementia and ensured that the same nurses were allocated to care for the patient to ease the patient's anxieties. We saw in theatres that staff made efforts to maintain the patient's dignity at all times.

Staff in pre-assessment told us they ensured input from all members of the team such as interpreters and physiotherapists were involved at an early stage, so patients felt at ease when they were on the ward.

Staff we spoke with understood and respected the personal, cultural, social and religious needs of patients and how they may relate to care needs. Patients we spoke with told us staff were 'respectful and kind', 'accommodating, friendly and helpful'.



Surgery

Patient feedback from the last 12 months was consistently positive and results were between 98% and 100% for the question 'did you feel you were treated with respect and dignity while you were in the hospital'.

Staff on the surgical ward spoke to us about attending the annual service of remembrance and thanksgiving which was held at the local cathedral to remember patients who have passed away at the hospital or for those who have passed away in the community having been previously treated in the hospital. They told us it was always very moving and an opportunity for staff to pay their respects.

Emotional support

Staff provided emotional support to patients, families and carers to minimise their distress. They understood patients' personal, cultural and religious needs and made sure this was reflected in how care was delivered. Staff recognised and respected the totality of patients' needs and the emotional and social needs of patients were seen as being as important as their physical needs. Patients were respected and valued as individuals and were empowered as partners in their care, practically and emotionally.

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. Staff described to us how they had supported patients who had additional needs and also made time to support family members and carers to allay any anxieties they had.

Patients told us staff supported them emotionally when they were feeling tearful and spent time with them to understand their needs and concerns. They told us staff were respectful of their cultural needs including choice of food.

Staff empowered patients to feel confident with any new adaptations or adjustments required following surgery. Patients commented on the continuous physical and emotional support staff gave them following surgery. Patients told us that surgeons and nurses were very sensitive when talking to them about their condition and clinical nurse specialist called on them regularly after their surgery to check on their progress including how the patient was feeling emotionally.

Patients told us that staff gave them a lot of encouragement which helped their recovery journey.

We viewed thank you cards which praised staff for their care and support. Cards we viewed said 'thank you for being a shoulder to cry on' and 'for helping me and my family through a difficult time.'

Patients were given a telephone number for the ward as well as the direct telephone number of their clinical nurse specialist for advice and support. Clinical nurse specialists told us they called patients once they were discharged to check on their progress and answer any questions or concerns they had. They also reiterated to patients that they could call them directly for advice or support.

A clinical nurse specialist explained how they provided support to patients to give them the confidence to lead a normal life with a stoma. They told us that a patient had called them for advice as they were anxious about how they would manage their stoma on holiday so the clinical nurse specialist provided the patient with a leaflet of information translated into the holiday destination's language so that the patient could take it with them.

Understanding and involvement of patients and those close to them



Surgery

Staff supported patients, families and carers to understand their condition and make decisions about their care and treatment. Patients who used the service and those close to them were active partners in their care. Staff were fully committed to working in partnership with patients and making this a reality for each person.

Staff involved patients in decisions about their care and treatment. Patients told us they felt comfortable asking their consultant any questions they had and felt involved in their treatment plan. Patients told us that staff respected and supported them as individuals and doctors talked to them on a 'human level and not a patient with a disease'.

Patients told us they felt informed throughout their treatment and that staff also kept their family members informed. They told us the risks and benefits of surgery were explained to them in detail and they were given time to think it through and ask questions. They said consultants were happy to repeat explanations so that they could understand better. Patients told us they 'never felt rushed' and could ask as many questions as they wanted.

Patients told us that clinical nurse specialists empowered them to be prepared for what to expect after surgery and develop goals for the patient to work on.

A patient commented that 'everything was explained on arrival right the way through to exit' and that this reassured them and made them feel at ease as they were informed at every stage and time was given to digest answers to questions. They commented that information was shared between staff so they didn't need to explain themselves twice.

We observed staff accompanying a patient who was being discharged, to the exit and checking they had all the information they needed and understood when their follow-up appointments were.

We were unable to speak with patients who were self-pay but staff told us that finances would be discussed in detail prior to a patient's admission into hospital. If they had any questions while in hospital, there was dedicated team who could be called.

The hospital gathered patient feedback on several aspects of care throughout the patient journey. In the last 12 months, results were consistently between 98% and 100% for the questions: 'did your consultant show you understanding when assessing your need for treatment' and 'did your consultant explain everything to you in a way that was easy to understand.'

Is the service responsive?



Our rating of responsive improved. We rated it as outstanding.

Service delivery to meet the needs of local people

The service planned and provided care in a way that met the needs of the patient population. People's individual needs and preferences were central to the delivery of the service. The service was delivered in a way to ensure flexibility, choice and continuity of care. It also worked with others in the wider system and local organisations to plan care.



Surgery

London Bridge Hospital provided day surgery and inpatient care for adults requiring a variety of surgical procedures. The consultant led service included orthopaedic, cardiothoracic, transplant and general surgery including cancer surgery. The hospital provided surgical treatment for private patients from the UK as well as from overseas. All surgical services were based in the main building and the service's Private Care at Guy's site. All patient rooms were ensuite.

The top three procedures performed in 2022 were robot assisted laparoscopic prostatectomy (including cystoscopy), multiple arthroscopic operation on knee, and hysteroscopy.

The hospital had a service level agreement with a local NHS trust to carry out some robot assisted surgery at the hospital to increase the trust's capacity. In the last 12 months 8.7% of the total surgical procedures performed at London Bridge Hospital were under an NHS contract.

The hospital had 6 theatres at the main site and 4 theatres at the Private Care at Guy's site which were available seven days a week. The service was open 7 days a week and admissions to the surgical inpatient wards and theatre lists were planned in advance. Emergency readmissions were accepted and surgeons were notified of these by the hospital's admissions office. Urgent unplanned admissions were also accepted once they had been triaged by the provider's centralised acute admissions service which provided a 24 hour 7 day a week nurse-led, medical concierge and triage service with the support from a consultant physician for referrals which met the provider's admission criteria. The team could allocate patients to one of the provider's hospitals depending on where they lived and what kind of treatment they required.

Managers planned and organised the service so they met the needs of the patient population. As the hospital provided private elective surgery, appointments could be planned to suit patients' schedules.

The surgical service provided an enhanced recovery after surgery (ERAS) programme. ERAS is an evidence-based approach to surgical care aimed at minimizing the stress of surgery and supporting patients to recover quickly through maintenance of normal physiology.

Prior to surgery, patients are encouraged to play an active role in their care by ensuring they are in the best health possible by eating well, being physically active and cutting down on smoking and drinking alcohol.

Following surgery, patients are encouraged to stay active, drink plenty of clear fluid and eat as soon as they are able and keep an ERAS programme diary in order to monitor their progress. Patients were also offered physiotherapy to speed up recovery and aid a faster discharge from hospital. The hospital also had an on-site rehabilitation gym.

The hospital was located in central London, with good public transportation links, making it accessible to patients from a wide geographical area.

Facilities and premises were appropriate for the services being delivered. Plans were in place to refurbish the second floor surgical ward at the main hospital site.

Patients we spoke with told us that visiting times were flexible and they were able to see their loved ones when they wanted.

Meeting people's individual needs



Surgery

The service was inclusive and tailored to meet the needs and preferences of individual people. Staff made reasonable adjustments to help patients access services. There was a proactive approach to understanding the needs and preferences of different groups of people and to delivering care in a way that met these needs, which was accessible and promoted equality.

The service was inclusive and took account of patients' individual needs and preferences. Patient records detailed a patient's additional needs such as mobility, hearing aid use or interpreter requirements. Staff made reasonable adjustments to help patients access services. Plans were in place prior to admission so that suitable equipment such as bariatric chairs were ready for the patient in their room. Where possible, staff told us if a specific room was requested by a patient who needed to be readmitted, they would accommodate for this.

Patients we spoke with told us they were able to book surgery dates to suit their plans and commitments.

Upon discharge, patients were given a discharge information leaflet and pack which contained a telephone number to call at any time if they had any concerns. They were also given the telephone number of the clinical nurse specialist for their condition whom they could contact with any questions they had.

Staff understood and applied the policy on meeting the information and communication needs of patients with a disability or sensory loss. Patients living with dementia or with learning disabilities were flagged at the pre-assessment stage and patient passports were used to support the patient throughout their stay. Stickers were used on patient records so staff could easily and quickly identify the needs of the patient. Staff told us they had access to communication aids if required.

The hospital had internet (Wi-Fi) for public use. Patients we spoke with said they were able to access the Wi-Fi easily.

The hospital had on-site Arabic interpreters in response to a high number of patients who used the service being Arabic speakers, and used an external contractor to provide interpretation services for other languages as well as British sign language. Interpreter services would be arranged from the point of booking at pre-assessment.

The on-site Arabic interpreter team also provided support to patients' families and carers to help them stay informed about the care and treatment of their loved one. They also liaised with the provider's international patient team to help support and signpost international patients to other services they might require while in the UK.

Patients were given a choice of food and drink to meet their cultural and religious preferences. We saw food menus and saw that there was a wide range of choices for patients who required halal, kosher or vegetarian meals. The menu also catered for patients with food intolerances or allergies. Patients could also request food that was not on the menu and a form was available which was sent to the catering team with the specific requests.

There was a chaperone service for both inpatient and day surgery patients. We saw posters reminding patients about the service. These posters had also been translated into other languages.

There was a spacious multi-faith room at both sites. The hospital chaplaincy service was multi-faith and provided spiritual support 24-hours a day, seven days a week. Staff were aware of how to contact chaplaincy services for patients and their families however some patients we spoke with told us they were not aware of the services and would have used them had they known they were available.



Surgery

Leaflets we saw on the wards were mostly in English, but staff told us patients could request the leaflets in another language and this could be provided to them. There were some posters on walls in patient rooms and nurse's stations that had been translated into other languages.

Access and flow

People could access the service when they needed it and received the right care promptly. There were no waiting times or delays in accessing services and people could access appointments in a way and at a time that suited them.

There was timely access for surgical services at London Bridge Hospital. Admission could also be facilitated at short notice to meet patients' individual needs. There were no waiting times for referral to treatment or delays in accessing services. Any waiting times to access services were driven by patient choice and patients could be seen within days. Patients we spoke with told us they did not have to wait long for their procedure to be arranged.

Admissions for surgical procedures were elective and planned in advance. Patients were admitted by consultants with practising privileges following an outpatient consultation.

Patients requiring urgent unplanned admissions were managed by the duty manager who was available 24 hours a day, 7 days a week and supported by the provider's centralised acute admissions service.

The service had implemented the first case on time initiative ensuring the first operative case was started on time to prevent any delays with later cases on the list. Patients had a designated room on one of the surgical wards which was reserved from admission so there were no delays moving patients back to the ward.

There were enough beds on the wards for patients who required an unexpected stay overnight, for example patients undergoing day case surgery. The number of expected admissions was discussed at daily bed meetings. The average length of stay across all specialities for elective surgery was 2.5 days.

The service did not treat patients, such as those with mental health conditions but did treat some patients with multiple co-morbidities, in line with the service's admission criteria.

Staff told us the discharge process was effective and they had few cases of delayed discharges. Medicines to take away were prepared before discharge so a patient did not need to wait for this upon discharge. There was a multidisciplinary team meeting for complex discharges where family members were involved in the planning of a patient's discharge. This included making sure the patient had the right equipment such as crutches to take with them, a care package in place if appropriate, enough spare compression socks and future appointments booked.

Of the 3860 surgeries performed at the hospital in from January 2023 to April 2023, 305 (8.3%) were cancelled. The main reasons for cancellations were due to the patient being unfit for surgery, cancellation by surgeon for clinical reason, patient testing positive for covid and cancellation by the patient.

Learning from complaints and concerns



Surgery

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. Staff were involved in regular reviews of how the service managed and responded to complaints. The service was able to demonstrate where improvements had been made as a result of learning from complaints.

The service had an up to date complaints policy which provided guidance on how to manage complaints. Complaints were overseen and investigated by the ward manager and any learnings from complaints were discussed with teams during team meetings and huddles as well as being displayed on departmental quality boards to help improve daily practice. Patients we spoke with were aware of how to make a complaint and told us they felt comfortable about speaking directly with staff if they wanted to complain.

In the last 12 months, London Bridge Hospital received 167 formal complaints at stage 1, 12 complaints at stage 2 for internal review and resolution and 3 complaints were referred for independent adjudication. The surgical service (including theatres and preassessment) generally received a low number of complaints. Data from the hospital showed that in the last six months, the service had received 18 formal complaints. Complaints were investigated, learning was identified, and the service apologised to patients when something went wrong. Staff were able to describe actions and improvements that had been put in place as part of learning from a complaint.

The main themes from the complaints were around unclear communications and correspondence from secretaries, booking errors and cost agreements. All learning outcomes were shared and discussed at team meetings and also monitored at the weekly complaints, litigation, incidents and patient experience (CLIP) meeting. Learning and final outcomes were also shared at the quality clinical operations report meeting, the monthly board meeting and the quality governance committee meeting. Learning was also shared among heads of governance at other HCA facilities.

Patients and families could give feedback by filling in feedback forms which were given to patients on discharge.

The hospital was subscribed to an independent adjudication service that investigated complaints objectively when they could not be resolved locally. The service clearly displayed information about how to raise a concern in patient areas and on their website.

Is the service well-led?



Our rating of well-led stayed the same. We rated it as outstanding.

Leadership

Leaders had the experience, capacity and abilities to run the service. They understood and managed the priorities and issues the service faced. There was an embedded system of leadership development and succession planning. They were visible and approachable in the service for patients and staff.

There was a clear management structure with defined lines of responsibility and accountability.



Surgery

Day to day leadership of the surgical service was managed by the ward and theatre managers and overseen by the chief nursing officer and surgical services manager.

Departments collaborated well and shared a common focus of delivering high quality patient centred care.

Leaders at all levels demonstrated high levels of experience and capability to deliver sustainable care. They had a comprehensive understanding of challenges and had a good grasp of the priorities of the surgical service such as the implementation of the new electronic patient record system and refurbishment of the second floor surgical ward at the main site.

All staff spoke highly of their managers. They commented on the friendliness and visibility of the senior leaders. Staff we spoke with knew the names of the senior leadership team and told us that senior leaders regularly visited the wards. Staff told us that they could request one to ones with the chief executive if they wished. Staff told us there was good teamwork and support within surgical services.

Leadership development was embedded within the service. Staff told us they were supported by their managers to develop their skills, access development opportunities and take on more senior roles. Staff across wards and theatres consistently told us how they were supported to access courses and gain additional qualifications.

The hospital used the '9 box grid' which was an employee assessment tool that plots employees across nine key data points in order to develop tailored professional development plans to strengthen their role and prepare them for further career advancement. The hospital followed a 'one ready now' strategy where there was a focus on developing staff so there was always someone ready to step into key roles within the hospital.

There was inclusive and effective leadership at all levels. Senior staff told us how they empowered staff to develop professionally and contribute to the development of the service. There were various study days which staff could attend and ward managers also conducted away days twice a year for staff to provide extra training and development opportunities. Ward managers told us that the sessions presented by guest speakers at away days helped bridge the gap between theory and practice for staff. For example, staff on the surgical ward had been upskilled by physiotherapists who had presented a teaching session at the away day, so that they could support patients to mobilise safely to the toilet rather than using a bedpan. In addition, ward managers encouraged staff to observe cases in theatre to help with their learning and development. Staff told us that consultants were very welcoming and encouraging of this.

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. The vision and strategy had supporting plans and objectives which were innovative and achievable.

Staff we spoke with knew about the hospital's mission statement: "committed to the care and improvement of human life."

London Bridge Hospital's strategic growth plan was reviewed and created annually and aligned with the 'One HCA' overall vision. The strategy and supporting objectives were challenging and innovative while remaining achievable. The five-year strategic plan focused on the following: growing as one HCA UK, exceptional people exceptional employer, partnering



Surgery

with outstanding consultant teams, proving our value, sustainable business, routes to new patients, seamless patient support and geographical growth. Each member of the senior management team was allocated to and responsible for the development of each strand of activity. There was a clear focus on creating succession plans for all heads of departments and leaders and celebrating staff who have provided excellent patient care and customer experience.

We saw the hospital's values and objectives were displayed in staff break rooms and staff told us that service objectives formed part of discussion in team meetings and away days. Staff we spoke with knew and understood the values and objectives for their service, and their role in achieving them. They spoke to us of their commitment to providing safe care and improving patient experience.

The surgical service had a clear vision and set of departmental objectives, which were focused on delivering safe, high quality, patient centred care. There was a focus on professional development, upskilling of staff on wards and celebrating exceptional care and work through feedback and awards systems.

The surgical service had several strategic growth drivers for each speciality within surgery. For example, the strategy for cardiovascular services included establishing the hospital to be a centre for education and a centre for case demonstrations to support international teaching and conferences for thoracic, vascular, cardiac surgery and interventional cardiology. The service planned to continue to grow the vascular and thoracic surgical service and cardiac surgical programme including the international adult congenital programme. There were also plans to further establish robotic gynaecological procedures through consultant recruitment and engagement including training at the hospital. There were also plans within surgical services to grow metabolic surgical services and the gastrointestinal robotic surgical programme. The service planned to continue recruiting and embedding NHS robotic surgeons from the local community and further. The spinal and orthopaedic service aimed to create an all-encompassing musculoskeletal service with leading consultants working within the network of the provider's complex care hospitals and outpatient centres.

The service also aimed to continue to help reduce pressure on local NHS hospitals in the provision of surgical services across a range of specialities.

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 opportunities for career development. The service had an open culture where patients, their families and staff could raise concerns without fear.

Staff spoke of good teamwork in a patient-centred environment. They were passionate about their work and we saw this in our observations of positive and supportive relationships between senior leaders, consultants and staff at all levels within the surgical service.

We found an open and honest culture and staff told us they felt supported by their managers to develop. They gave examples of how they were encouraged to develop, such as attending conferences, and completing extra courses. Staff of different grades told us they had presented their work to the provider's corporate team, had completed a masters course, neuroscience course and pain link development programme. Staff told us that they were empowered by their managers to raise their profiles and develop in their careers.

Staff told us ward managers were visible and approachable. They commented on how they often saw senior leaders on the wards and how leaders would know everyone by their first name.



Surgery

Staff throughout surgical services were welcoming and friendly and focused on providing high quality care for their patients. Leaders promoted a positive culture which supported and valued staff. Staff consistently told us they were proud to work at the hospital. They consistently spoke of good teamwork and collaboration between teams at the hospital.

The safety and wellbeing of staff was promoted. There were various forums such as the colleague council, which staff were encouraged to join. Staff were aware of the Freedom to Speak Up champions within the hospital and other champions across HCA UK facilities whom they could also approach as an alternative route to raise concerns.

Staff told us the management team listened to any concerns or issues they raised. There were consistently high levels of constructive engagement with staff in surgical services. As a result of the most recent staff survey, the theatre leadership team had implemented the '5 day look out' which was a meeting to improve communication between all teams that support theatres. Topics covered included supplies, implants, theatre utilisation staffing, procedures and caseload. Staff on the surgical ward gave examples where they had requested additional storage or equipment and would be allowed to take the lead in acquiring these. Staff told us that they had taken the lead in creating a pathway in relation to cardiac monitoring. They were empowered by management to take ownership of the project and the monitoring chart they had created was now embedded on the ward.

Staff we spoke with told us they felt valued and were treated fairly and equally. Staff told us managers were considerate of and helped facilitate their working hours around childcare responsibilities and personal circumstances.

Staff told us each ward arranged social gatherings, picnics and meals together as well as celebrating milestones such as birthdays and long-service awards at the hospital. The ward manager also told us they brought snacks in for staff as part of the staff meetings.

The provider had a diversity, equality, inclusion and belonging (DEIB) strategy which focused on inclusive and accountable leaders that embraces and enables DEIB; a culture where people valued and heard; fair and equitable practices that support a healthy diverse talent pipeline; and exceptional healthcare that recognises and values patients as unique and individual.

Staff at all levels were actively encouraged to raise concerns and told us they felt able to report concerns to their managers. Staff, patients and families were encouraged to provide feedback and raise concerns without fear of reprisal. Staff confirmed there was a culture of openness and honesty and they felt they could raise concerns without fear of blame.

The service promoted equality and diversity in daily work and information was readily available to staff to improve their knowledge and understanding of the needs of people with protected characteristics. The hospital held a 'around the world initiative' which was a celebration of the diversity of staff at the hospital and was led by the colleague council. Colleagues were invited to put a pin on a map to indicate where they are from and to write on postcards details about their culture that they would like to introduce to the hospital campus such as recipes and foods.

Governance

Leaders operated effective governance processes, throughout the service. 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.

Staff we spoke with had a good awareness of governance processes and knew how and where to escalate their concerns.



Surgery

Ward and theatre teams held monthly team meetings to discuss incidents, audit results and safety alerts. We reviewed a sample of minutes from teams within the surgical service and found they showed a comprehensive discussion of departmental audit results, patient feedback, risks, incidents and learning, welcoming new staff as well as employee of the month. Ward managers told us that debriefs occurred on the ward following an incident, in addition to the monthly team meetings.

There was a theatre user group which comprised a multidisciplinary team of staff including consultants, the medical director, the chief operating officer, the surgical services manager, theatre managers, theatre practitioners and anaesthetists. Discussions were around theatre utilisation, WHO checklist audit results and actions, staffing, pharmacy updates and governance updates. Staff told us these meetings were very useful and was a responsive system of allowing staff to voice concerns or suggestions and be heard by senior leaders in the meeting who could take ideas forward at pace.

The medical advisory committee (MAC) met quarterly and reviewed clinical quality and governance matters including risks, incidents, new services, patient experience, recruitment and practising privileges.

Medical practitioners had their appraisals monitored by their responsible officer as part of the requirements of their practising privileges agreement. The chair of the MAC assessed applications for practising privileges and these applications would be discussed at the MAC meeting.

There were weekly complaints, litigation, incidents and patient experience (CLIP) meetings which were attended by staff from all departments so that any emerging trends could be identified, issues escalated swiftly and lessons learned are shared widely. Minutes we reviewed included feedback from audits, incidents including actions and learning, complaints and patient feedback, mandatory training compliance levels across the hospital and the risk register.

The hospital had committees such as patient experience, resuscitation, quality governance, IPC, learning and improvement where representatives from the surgical service would attend and feed back to their teams at the monthly team meetings.

The hospital held monthly mortality review group meetings which provided oversight of all in-hospital mortality and assurance that mortality reviews were being undertaken. Attendance at the meetings were multidisciplinary and included the medical director, the chief nursing officer, clinical nurse specialists, ward managers and the lead resident medical officer. Minutes showed comprehensive discussion of each case which was then shared with the relevant MDT.

The hospital produced a quarterly clinical operating report (QCOR) and monthly clinical operating report (MCOR). The reports reviewed and monitored key performance indicators (KPI) such as mortality and unplanned returns to theatre, as well as infection control, surgical site infections, incidents and patient experience. We saw from minutes that clinical operating reports were reviewed and discussed at the monthly hospital board meetings.

The hospital held a service level agreement with a local NHS trust for the provision surgical services. Operational discussions between clinical teams took place on a daily basis to ensure continuity of patient care. In addition, the two organisations' senior teams met monthly.

Management of risk, issues and performance



Surgery

Leaders and teams demonstrated commitment to best practice performance and risk management systems and processes. They identified and escalated relevant risks and issues and identified actions to reduce their impact effectively and in a timely manner. They had plans to cope with unexpected events.

The hospital identified risks through different sources such as audits, incidents, patient and staff feedback, inquests, risk assessments and safety alerts. Risks were raised by the head of department and risk manager and presented at the weekly complaints, litigation, incidents and patient experience meetings. We saw mitigations were discussed and the risk score assessed which was uploaded onto the hospital's electronic risk register. All risks were discussed at the hospital's board meeting, quality governance committee and MAC.

The surgical service had a local risk register which was reviewed monthly. Each risk was given a rating, review date, control measures and allocated with a risk owner. The issues and risks which managers identified were in line with what we found on inspection. For example, risks within surgical services included, non-attendance of temporary staff booked for a shift, the balcony area at the Private Care at Guy's site did not have an alarm in case of an emergency, falls on the orthopaedic surgical ward and availability of stock for medicines. Mitigations were in place for these and managers as well as staff were able to explain these in detail.

The hospital also had a risk dashboard which outlined risk status across the hospital to ensure risks could be monitored and updated continually and in real-time.

There was a formal audit programme for theatres and surgical wards. Heads of department and departmental audit champions discussed audit results and actions at monthly team meetings. Audit findings were also discussed at the theatre user group meetings. Results were shared at the monthly quality governance committee meeting and board meeting and quarterly MAC.

All learning and actions from the audits were escalated to the corporate clinical audit and effectiveness committee and the quarterly clinical operations report (QCOR) meeting.

The service had appropriate emergency action plans for incidents such as power loss or fire. These outlined clear actions for staff to take and contact details of relevant individuals or services. The service had back-up generators at the main site and at the Private Care at Guy's site. The back-up generators were supported by uninterrupted power supply systems which provide 60 minutes of battery power to critical infrastructure. As procedures were elective and if they were non-life threatening, procedures could be stopped safely if required and then rebooked.

Information Management

The service collected accurate, valid, timely and 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.

Staff had access to patients' health records and the results of investigations and tests in a timely manner. The hospital used electronic systems which allowed the service to manage quality and compliance processes and ensure audit completion. The service also used an electronic observation tool to help with early identification of sepsis in real-time.



Surgery

There were effective arrangements to ensure the confidentiality of patient identifiable data. Paper based patient records were stored securely in lockable cupboards at the nurse's station and electronic information was on a secure server which was only accessible by authorised staff members.

We observed staff logging off after using computers and staff reported that they had a sufficient number of computer stations.

The hospital was planning to transfer over to a fully electronic patient records system. Staff were aware of the plans and some staff from the surgical service had also joined the team leading the project on the development and rollout of the new system.

Staff commented that the IT system was user friendly and showed us they could easily find policies on the hospital intranet and access various systems without issue.

Engagement

Leaders and staff actively and openly engaged with patients and staff to plan and manage services.

Patients were encouraged to share their views on the quality of the service through the patient feedback questionnaires.

The service used patient feedback to guide the service delivery and responded to any concerns raised or suggestions made by people who used the service. Patient questionnaire results were consistently positive. We saw 'you said, we did' boards on wards to show improvements the ward had made in response to patient feedback. For example, in pre-assessment, patients had fed back that they would like the online health questionnaire which was to be completed prior to admission, to be compatible with smart devices. In response, the service redesigned the form to be compatible with all devices with the facility to be filled out in stages. The team were now also sending reminders to help prompt patients if they hadn't finished filling out the form.

The hospital had set up a patient experience group which was an initiative, made up of lots of different patients to help improve patient experience of their care and treatment at the hospital.

Staff were engaged in the planning and delivery of the service. Staff told us they felt able to suggest new ideas to their managers and they were listened to. For example, a ward manager had suggested the use of portable ice machines instead of ice packs for orthopaedic patients. They had researched and made a case to acquire portable ice machines which deliver compression alongside cryotherapy and benefits patients in pain management, swelling reduction as well as aiding a fast recovery.

There were several staff award and recognition programmes at the hospital for example, epic awards which managers could give to staff to recognise colleagues for their commitment and contribution to the hospital, daisy awards which were nominations of recognition made by patients.

The hospital had various staff engagement forums such as the colleague council and staff listening forums where all staff were invited to join.

Staff had access to an employee assistance programme which was a telephone line, which was available 24 hours day, 365 days of the year to provide counselling following incidents and to support staff should they require additional support. There were also mental health first aiders on site to provide additional support to staff.



Surgery

In 2022 the hospital launched the innovation bridge which was a virtual space where staff could share ideas and innovations to help improve colleague and customer experience at the hospital. Ideas which were put forward were then discussed at the colleague council and shortlisted for review by the executive team where winning ideas would be selected for implementation. A recent example was the implementation of the introductory guide to the hospital and London for the hospital's new talent beyond boundaries colleagues. The guide was designed to help new international colleagues settle into the hospital and the city with information on where to eat, tourist attractions, local shops and directions around London.

We were told that London Bridge Hospital had continuously achieved the highest staff engagement score in HCA UK. The latest staff survey results released in May 2023 showed that the surgical service had a slight decrease in the engagement index score overall from 78 to 75 however the participation rate increased by 15% to 93%. The decrease in the index score was linked to remuneration within the cardiology department at the time of the survey however this was due to be reviewed in June 2023. The second floor surgical ward achieved an engagement index score of 90 which was the highest score across the hospital.

In November 2022 London Bridge Hospital achieved investors in people platinum award.

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. Staff were actively participating in research and improvement projects.

Staff at all grades were committed to continuous learning.

All staff we spoke with told us they were supported by their managers to develop their leadership skills and access development opportunities. The hospital offered e-learning, classroom courses and specialist training programmes for both clinical and non-clinical staff.

The hospital collaborated with a local university's business school to support staff through executive masters and MBAs. Some staff we spoke with told us they had completed masters in medical leadership, and leadership and management courses.

Staff were also involved in various quality improvement projects. For example, the second floor surgical ward was currently leading on a quality improvement project called the golden discharge project which focuses on the discharge process and improving patient experience. The golden discharge project seeks to find out what the barriers are which prevent timely discharge. As part of the project, a new discharge assessment tool was designed to collect data around patients who were discharged. The tool is filled in by members of the MDT who were involved in the patient's care in order to better understand any issues and areas of improvement that can be made. Following further evaluation of the data and any changes made as a result of the tool, a recommendation would be made to the other surgical wards so that they can implement the changes to ensure timely discharge.

Staff commented on how they valued the various study days that they were able to take part in for example, orthopaedic study days, cardiac study days and learning sessions with the clinical nurse specialists.

The service was actively involved in research. A number of resident medical officers were also involved in PhD programmes with a local university.



Surgery

The hospital specialised in offering robotic surgery for urology, renal, thoracic, head and neck, gastrointestinal and gynaecology procedures. The service worked with a local NHS trust to support urgent cancer cases with the multi-speciality complex robotic programme. The hospital collaborated with an NHS trust to co-train consultant gynaecologists under the Royal College of Surgeon's accredited training programme.

The surgical service also presented webinars and real-time multi-disciplinary meetings to an international audience. The service used technology that allowed them to conduct live case filming or pre-recorded filming in any surgical environment including cardiac theatres and catheterisation lab which were used for the webinars and multi-disciplinary meetings.

This capability had also been extended to other specialities including robotic surgery.

The service also provided personalised external aortic root support (PEARS) which is a procedure in which a 3D model of the patient's aorta is made by computer-aided design. The model is then used to construct a bespoke mesh 'sleeve' for the aortic root which meant that unlike the conventional surgical treatment to replace the aorta, there was usually no need for cardiopulmonary bypass (heart and lung machine) during the procedure.