

HCA International Limited

London Bridge Hospital

Inspection report

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

Ratings

Overall rating for this location	Outstanding	☆
Are services safe?	Good	●
Are services effective?	Good	●
Are services caring?	Outstanding	☆
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. 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 seven days a week.
- Staff truly respected and valued patients as individuals and empowered them as partners in their care. 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.
- The service was delivered in a way to ensure flexibility, choice and continuity of care. 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. 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 leadership and governance were used to drive and improve the delivery of high-quality person-centred 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 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

**Medical care
(Including
older people's
care)**

Rating

Outstanding



Summary of each main service

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

Summary of findings

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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 Southeast 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 3 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.

The service had a registered manager who had been in place since October 2017.

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 a 48 hour announced inspection of the medical services on the 26 July 2023 using our comprehensive inspection methodology. The inspection team consisted of two inspectors and two specialist advisors.

We spoke with patients and members of staff during the inspection including medical, nursing, administrative and managerial staff. We also reviewed policies and patient 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 was able to perform open heart surgeries in the catheter lab in the event of a deteriorating patient as the room had adaptable lighting, air flow and equipment. They had an on call cardiac team who were trained to take over the procedure in the event of an emergency. This allowed for timely intervention in time critical clinical situations.
- Staff recognised and respected the totality of people's needs. They always take people's personal, cultural, social and religious needs into account, and found innovative ways to meet them.
- Feedback from people who used the service, and those who were close to them were consistently positive about the way staff treat their loved one. Relatives said staff went that extra mile and the care they receive exceeded their expectations.
- The hospital offered a 'holiday service' for dialysis treatment for international and non-local patients of HCA. This allowed patients to continue their dialysis treatment whilst visiting London.
- There was an embedded system of leadership development and succession planning where staff were given opportunities to progress to more senior positions. In 2022, 110 staff were supported into more senior roles across the hospital.

Areas for improvement

Action a service SHOULD take is because it was not doing something required by a regulation but it would be disproportionate to find a breach of the regulation overall, to prevent it failing to comply with legal requirements in future, or to improve services.

Action the service SHOULD take to improve:

- The service should consider improving staff awareness of what support is available to them in the care of patients who cannot consent.






Our findings

Overview of ratings

Our ratings for this location are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Medical care (Including older people's care)	Good	Good	Outstanding 	Outstanding 	Outstanding 	Outstanding 
Overall	Good	Good	Outstanding 	Outstanding 	Outstanding 	Outstanding 

Medical care (Including older people's care)

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 rates as of June 2023 were 99% against a target of 85%. Staff told us they were given protected time to complete mandatory training.

The mandatory training was comprehensive and met the needs of patients and staff. It included but was not limited to equality and diversity, moving and handling, infection control and sepsis and basic life support.

Clinical staff completed training on recognising and responding to patients with mental health needs, learning disabilities, autism and dementia. We saw 100% of eligible staff had completed level 2 learning disability and autism training.

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

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

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. We saw evidence that 92% of eligible staff had completed level 3 safeguarding adults training and 100% of eligible staff had completed level 2 safeguarding adults training. Although the hospital did not provide services for children, staff received training on identifying signs of abuse and neglect for children visiting the hospital. The compliance rate for safeguarding children level 2 was 98%.



Medical care (Including older people's care)

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

Most staff knew how to identify adults and children at risk of, or suffering, significant harm and worked with other agencies to protect them. We saw examples of recently completed safeguarding referrals including a referral to social services due to risk of neglect after assessing a patient on admission and discovering they had a grade 3 pressure ulcer.

We spoke to 3 health care assistants that were unable to clearly describe what safeguarding meant and how to protect patients. However, they were able to clearly describe how they would escalate any concerns they had. All senior staff we spoke to were able to describe how to identify and escalate safeguarding concerns.

The service had an up-to-date safeguarding policy which described responsibilities of staff and how and when to make a referral. Staff we spoke to knew how to make a safeguarding referral and who to inform if they had concerns. The service displayed posters around the wards and units on how to raise safeguarding concerns.

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.

Ward areas were clean and had suitable furnishings which were clean and well-maintained.

The service generally performed well for cleanliness. The service audited infection prevention control (IPC) such as hand hygiene, insertion of urinary catheters and sharps and waste handling. The service scored 100% in the IPC audits in March and April 2023.

The service submitted mandatory data requirements to relevant national agencies for healthcare associated infections. The service had no MRSA infections reported from May 2022 to April 2023. During this period the service had one reported case of MSSA and two cases of *Clostridioides difficile* (C.Diff). However there had been no identified lapses in care following review. There was one hospital acquired *Pseudomonas* and *Klebsiella* in April 2023 in the H3 haematology oncology medical ward. This was investigated and reviewed by the hospital microbiology consultant. We saw that the service had conducted a post infection review into the cause and the root cause analysis identified an intravascular device as the cause. Infection rates and performance of audits were discussed at the quarterly infection control committee.

Staff cleaned equipment after patient contact and labelled equipment to show when it was last cleaned. Cleaning records were up-to-date and demonstrated that all areas were cleaned regularly. We saw housekeeping staff cleaning throughout the day and observed conversations between nurse staff and housekeeping staff about the cleaning priorities on the ward.

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



Medical care (Including older people's care)

The oncology wards had patient rooms with positive pressure adaptability. This meant that any patient who was easily susceptible to infection due to their condition or treatment could be easily isolated from others who could infect them. We spoke to a patient who had recently been isolated and they told us they felt at ease as the staff followed infection control measures to protect them. They minimised entry to the room where possible with the use of door blinds and telephones to see and hear the patient.

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

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.

On medical wards, all patients were cared for in private single rooms with ensuite facilities. We saw call bells near patient beds with extra-long cables that allowed patients to move around the room. We saw staff respond promptly to call bells when called. Nurse stations had screens that showed how long ago the patient had pressed the call bell so staff could easily track how long they had been waiting.

Staff carried out daily safety checks of specialist equipment. We reviewed checklists of resuscitation trolleys and sepsis kits and found there were no discrepancies. Staff were required to sign their initials against the checklists that they had performed. Any discrepancies that were found during auditing processes were raised with the appropriate staff for learning.

The service had suitable facilities to meet the needs of patients' families. Patients' families were able to stay in the patient's rooms for day case procedures. Inpatient wards had access to a family room where family members could relax when required.

The service mostly had enough suitable equipment to help them to safely care for patients. For example, the endoscopy unit had two sets of washers for medical equipment that were connected to separate water supplies. This meant that if one set of machines were to be faulty due to contamination or mechanical failure, the service could continue to safely carry on delivering care. However, the service had identified some of the endoscopy equipment such as the dryer and some of the endoscopes themselves were aging and were at risk of failure. The service had identified this as a risk and were continually monitoring the functionality of the equipment and had mitigations in place.

During a procedure being performed in the catheterisation lab, we observed staff use an adjustable and portable radiation shielding system that provides full-bodied radiation protection for interventionalists and their technicians. This gave an added layer of protection in addition to traditional lead aprons.

The service completed annual safety checks of medical and non-medical equipment. We reviewed the service logs for medical equipment and non-medical equipment and saw that each item was clearly labelled with a description, its location and when next test was due. We were told that if any piece of equipment were to fail safety checks, then they would be labelled and withdrawn from service. The service conducted a medical devices audit which checked for equipment useability, readiness, and staff awareness as per national guidance. The results for this audit showed between 91% and 100% compliance for the months of March and April 2023.

We saw that the dialysis unit had hoists available for patients with long term weakness so they could be safely moved around the department.



Medical care (Including older people's care)

The service managed the storage and disposal of waste in line with national guidance. Results for the sharps and waste handling audit for the period of December 2022 and March 2023 showed 100% compliance.

All areas we visited were clean and uncluttered. Linen cupboards and storage rooms were appropriately stocked and tidy. Each medical item used was scanned out and allocated to individual patients. Although the service identified the age of some equipment on the risk register, staff told us that there was enough equipment to keep people safe.

Assessing and responding to patient risk

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

Staff used a nationally recognised tool, the National Early Warning Score (NEWS2) to identify deteriorating patients and escalated them appropriately. This is used to monitor the condition of patients and included recordings of blood pressure, pulse and temperature. In the event of patient deterioration, the patients were monitored by the services critical care team and transferred to the critical care unit if needed. The exception to this was if the patient had a suspected or confirmed stroke, they would be transferred to a local hyper acute stroke unit at a local NHS hospital via 999 as part of an established pathway or if an NHS patient with complex clinical needs required an extended length of stay, they would be transferred to the NHS for ongoing care as requested by the NHS team. There were 3 unplanned transfers of deteriorating patients in the period of April 2022 to March 2023.

In the oncology and transplant ward, patients at high risk of deterioration and infection could be monitored remotely with specialist equipment if needed. The service conducted quarterly audits to assess compliance of escalation of patients using NEWS2 scoring system and the latest result found that 100% of patients had been escalated appropriately or had justified reasons why they were not escalated. For example, patients approaching end of life.

Staff confirmed that they had received training in sepsis, including neutropenic 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.

We saw staff completed risk assessments for each patient on admission, using a recognised tool, and reviewed this regularly, including after any incident. This included but was not limited to falls risk, pressure ulcer risk and malnutrition risk assessments. Staff knew about and dealt with any specific risk issues. The service conducted audits of Waterlow (a tool used to determine risk of developing pressure ulcers) recording in patients notes and scored between 98% to 100% in March and April 2023. The service conducted monthly observational venous thrombosis embolism (VTE) audits to check compliance of staff completing risk assessments in line with national guidance. Results for the period of February to April 2023 showed 100% compliance in medical wards.

Although the service did not treat patients for mental health conditions, staff had 24-hour access to mental health liaison and specialist mental health support if they were concerned about a patient's mental health. We saw updated lists of specialist consultants that staff could contact if needed.

Consultants were responsible for attending to their patients in an emergency in line with the provider's practising privilege policy. They reviewed the patient's condition daily as part of the daily ward round. 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



Medical care (Including older people's care)

required to identify and ensure a 'buddy' was in place and there was named cover during any leave. Resident medical officers were based on inpatient wards and were available 24/7. The service had recently employed 4 consultant general practitioners who were available on site or on call 24/7. They could support either medical and non-medical staff with emergency admissions to general medicine or support when stepping down from intensive care.

Staff shared key information to keep patients safe when handing over their care to others. Shift changes and handovers included all necessary key information to keep patients safe. We saw completed nurse handover sheets on the wards that had all relevant physical, mental and emotional health of patients discussed. Any concerns or updates from the patients that occurred in the shift were clearly highlighted to onboarding staff. We saw team briefs occur for every list of patients per consultant where they discussed the caseloads and staff were encouraged to raise any concerns they had. Any concerns or praise would be shared with the rest of the team at the next morning huddle and via a daily email to other relevant staff.

Between November 2022 and April 2023 there were five patient falls reported in medical wards, all were classified as 'no harm'. The hospital analysed their 2022 falls and published a falls analysis. The publication discussed the main themes of falls in the hospital, times at which the most falls occurred and their locations. This allowed staff to focus on key areas to minimise the risk of falls to patients. All inpatient falls were discussed using the hospital's post falls protocol which facilitated a multidisciplinary discussion at the monthly falls committee meetings.

Staff followed national guidance when performing procedures. We observed staff fully completing the World Health Organisation (WHO) safety checklist when performing invasive procedures.

The service could transform the catheterisation laboratory into a surgical theatre in the event of a deteriorating patient in complex procedures as the room had adaptable lighting, air flow and equipment. The service had an on call cardiac team including a cardiac surgeon and anaesthetist who were trained to take over the procedure in the event of an emergency. This allowed for timely intervention in time critical heart related situations.

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

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. All wards and units we visited met the required number of nursing and health care assistant staff to safely care for patients. For example on the endoscopy unit, there were 3 nurses on shift on the ward which met the staff to patient ratio of 1:3. Staff told us there were enough staff on the wards.

The ward manager could adjust staffing levels daily according to the needs of patients. The service held daily meetings with the heads of departments to discuss patient number and complexity and staffing levels and could redistribute staff appropriately where needed. The meeting was attended by the heads of each department or by a nominated representative. This meeting was supported by a staffing coordinator who assisted in the re-distribution of staff.



Medical care (Including older people's care)

Managers accurately calculated and reviewed the number and grade of nurses, nursing assistants and healthcare assistants needed for each shift in accordance with national guidance. They used an online tool which was underpinned by a staffing grid which guided the number of senior nurses, registered nurses and health care assistants required according to predicted patient numbers.

The service had a vacancy rate of 11.8% and a turnover rate of 25%, which was higher than the hospital nursing staff turnover rate of 16.1%. The turnover rate was higher because higher than normal amount of nursing staff left the endoscopy and dialysis units in 2022. Feedback from staff leaving the endoscopy unit resulted in a change of shift patterns which allowed more structure within the department and allowed staff to work less unplanned overtime. In the dialysis unit at the time of the inspection, all vacant roles had been filled.

Managers limited their use of bank and agency staff and we saw that they requested staff familiar with the service. Managers made sure all bank and agency staff had a full induction and understood the service.

Medical staffing

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

The service had enough medical staff to keep patients safe. The service was consultant led and had 180 consultants that worked under practising privileges within the medical core service at the hospital. 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). 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. 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.

Consultants were responsible for their patients for day case procedures and on inpatient wards. They reviewed patients daily and we saw evidence of this in patient notes we reviewed. Patients we spoke to told us that they had daily contact with their consultant in the hospital.

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 hospital also has 18 whole time equivalent resident medical staff and access to further staff on bank. All resident medical doctors for the medical core service were specialist registrar level 4 or above and were based on inpatient wards 24 hours a day, 7 days a week. They attended ward handovers and daily bed meetings and had access to the electronic observations system so they could monitor patients and attend to them quickly.

The service had a low vacancy rate of 2.3% for medical staff but had a turnover rate of 25%. Staff told us that this was due to the majority of resident medical doctors being engaged in PhD research projects whilst employed at the service and leaving once the projects had finished.

Managers could access locums when they needed additional medical staff. Managers made sure locums had a full induction to the service before they started work. However, locums were rarely used.



Medical care (Including older people's care)

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.

We reviewed 6 patient notes and saw they were comprehensive, and all staff could access them easily. They contained input from multidisciplinary professionals including doctors, nurses and pharmacists. They contained details about the patients' conditions, their needs and completed risk assessments such as falls and pressure ulcer risk assessments.

The service used a separate record system for managing patients receiving cancer treatment. Staff told us that it was a steep learning curve to learn the various systems but told us it was manageable once learnt and they could access them easily.

When patients transferred to a new team, there were no delays in staff accessing their records.

Paper records were stored securely in a lockable cupboard in the nurse's station and electronic records were only available to relevant staff with individual login details.

A biannual nurse record keeping audit was conducted which checked the quality of records and of various assessments had been completed within timeframes indicated in the provider policy. Results for previous audit which used entries from the period of March 2022 to September 2022 showed 100% compliance.

Medicines

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

Staff followed systems and processes to prescribe and administer medicines safely. We saw staff wear medicine round tabards that indicated they should not be disturbed whilst administering medicines to patients which reduced the risk of administration errors.

Staff reviewed each patient's medicines regularly and provided advice to patients and carers about their medicines. Staff followed national practice to check patients had the correct medicines when they were admitted, or when they moved between services. We saw completed medicines reconciliation (a check of a patient's medication history) on admissions to the service. The medicines reconciliation audit results for the period of January to March 2023 showed 100% compliance on the medical wards. All patients we spoke to told us that the service informed them about their medicines and staff gave them time to ask questions about their medicines.

Staff completed medicines records accurately and kept them up-to-date.

Staff stored and managed all medicines safely. The service used an automated medication dispensing system for staff to access medicines. This area was kept locked and only available to authorised staff via fingerprint. Agency staff were granted 24-hour access at the start of their shift. Results for the safe and secure storage of medicines audit for the period of January 2023 to March 2023 showed a mixed result ranging from 86% to 100% compliance across all medical areas. There was an action plan for improvement for the area with the lowest score.



Medical care (Including older people's care)

Staff described to us when and how they would escalate concerns if storage conditions for medicines were not met. This included fridge and room temperatures.

Staff we spoke to were aware of controlled medicine (CD) policies. On the day of inspection we saw CDs were stored in line with required legislation and recorded in a controlled drugs logbook. However, results for the controlled drug audit for the period of January 2023 to March 2023 showed a mixed result, the two medical inpatient wards had the lowest compliance with 70% and 62% respectively. All other medical areas had 100% compliance. The main areas of non-compliance were around controlled drug documentation in the controlled drug register. We saw that there were action plans for the individual areas and an overarching pharmacy team action plan to improve compliance.

We saw patients' allergies clearly document in their records.

Each inpatient ward had a ward-based pharmacist. Pharmacy support was available out of hours in their absence. Staff on the medical units told us that they could easily contact a pharmacist if they had any concerns about patients' medications.

Staff learned from medicines safety alerts and incidents to improve practice.

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.

All staff knew what incidents to report and how to report them. Staff raised concerns and reported incidents, including serious incidents, and near misses in line with the services policy. They received feedback from investigation of incidents that they submitted via the services incident reporting system once investigations were complete. Learning was then shared with the wider team if relevant. We saw examples of incidents being reported in a timely manner and immediate actions and learning discussed at daily team meetings. Information was further shared through regular newsletters and social messenger apps for staff who were not on shift. For example, we saw a reminder being shared on the ward regarding specific types of blood to be used with specific patients after a recent near miss. Another example given by staff was barcode labels on blood cultures not being stuck properly to samples, so they were unreadable. Learning had been shared and staff had been reminded to stick labels on correctly so that they could be scanned by staff in the lab and to label the tubes inside the patient rooms to reduce the risk of mixing up labels.

There was evidence that changes had been made as a result of feedback. For example, on patients records, types of blood required for each patient was highlighted in colour in patient notes to remind staff following a near miss that had occurred recently.

Staff received regular bulletins from ward leaders which covered relevant information such as recent incidents and learning. The service also 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.

In the period of May 2022 to April 2023 there was a total of 1107 incidents with 98% of them being no or low harm. Six were classified as moderate harm. There were 12 expected deaths, these are deaths that were expected to happen as part of the patients care plan.



Medical care (Including older people's care)

We spoke to staff who could describe the latest learning on the wards. Immediate actions and learning from incidents were shared at morning huddles and also shared through a messenger app.

Managers shared learning with their staff about never events that happened elsewhere. Staff were able to describe to us a never event that had occurred in a surgery procedure earlier in the year.

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. Information about the duty of candour was clearly displayed in staff areas.

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 followed up-to-date policies to plan and deliver high quality care according to best practice and national guidance. We saw care pathways follow guidance from the National Institute for Health and Care Excellence (NICE). For example, we saw up to date guidance reflected in the standard operating procedures in the catheterisation laboratories.

Staff had access to policies relevant to them on the hospital intranet. Other policies that we reviewed included safeguarding adults and children, infection control, sepsis management and medicines management. Updates to NICE guidance were monitored at corporate level and disseminated to staff when changes were made. As of April 2023, we saw there were no outstanding policy to be actioned at London Bridge Hospital.

Any instances of consultants recommending new or alternative treatments that were not written in national guidance were discussed at multidisciplinary teams and at the medical advisory committee to determine if the treatment or procedure could bring clinical benefit.

The endoscopy unit was Joint Advisory Group (JAG) accredited. This is a voluntary programme of service and quality improvement in relation to endoscopy procedures. It ensures the service maintains the standard of excellence around clinical quality, patient experience and workforce.

Nutrition and hydration

Staff gave patients enough food and drink to meet their needs and improve their health. The service made adjustments for patients religious, cultural and other needs.

Staff made sure patients had enough to eat and drink, including those with specialist nutrition and hydration needs. Patients we spoke to told us that staff regularly checked in if they were hungry or thirsty and we saw staff filling water jugs for patients on the wards who were not fully mobile.



Medical care (Including older people's care)

Staff fully and accurately completed patient's fluid and nutrition charts where needed. Staff used a nationally recognised screening tool to monitor patients at risk of malnutrition. We saw in patient records a malnutrition universal screening tool (MUST) was used for assessing patient's risk of malnutrition.

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. Patients with kidney health related issues were able to order off a specific menu tailored to meet their health needs.

Pain relief

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

Staff prescribed, administered and recorded pain relief accurately. Staff assessed patients pain using a recognised tool and gave pain relief in line with individual needs and best practice. Although we did not see records of communication tools in patient notes we reviewed, staff were able to describe the tools they would use to measure pain in patients with communication needs.

Patients received pain relief soon after requesting it. We saw staff consulting with patients about their pain needs regularly during procedures. Patients on the ward told us that staff regularly checked in with them regarding their pain levels. We saw records containing pain scores and updates on pain related issues.

Complementary therapies were also available to patients to help manage symptoms and side effects. The complementary therapies team offered reflexology and massage to patients as part of their treatment plan.

The service had a pain team that staff could contact to provide support for patients whose pain could not be controlled and if they had any pain related query.

Patients told us that they felt their pain was controlled in the units and on the wards. This was reflected in the patient feedback data as the service scored between 98% and 100% from May 2022 to April 2023 when patients were asked if the hospital staff did everything they could to help control their pain.

Patient outcomes

Staff monitored the effectiveness of care and treatment. They used the findings to make improvements and achieved good outcomes for patients. The service had been accredited under relevant clinical accreditation schemes.

Managers and staff carried out a comprehensive programme of repeated audits to check improvement over time. The audit programme clearly outlined frequency and mandatory status of the proposed audits and had the flexibility to be changed if non-compliance was found. Actions and learning as a result of the audit programme were discussed by heads of department and departmental audit champions and disseminated to individual ward and unit team meetings. We saw examples of action plans that had been introduced as a result of audit results that were ongoing. The service displayed audit results in areas visible to staff. For example, we saw infection control audit results on the dialysis unit that showed they had scored 100% in the most recent audit.



Medical care (Including older people's care)

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.

The service participated in most relevant national clinical audits. They service submitted data to relevant national audits such as the British Society for Blood and Marrow Transplantation (BSBMT) where they benchmarked against similar services. The latest report in 2021 that covered transplants from 2014-2018 showed that the service performed similarly to other services for probability of survival after 5 years. The services next report was due later in 2023.

However, the service did not contribute data to the National Institute for Cardiovascular Outcomes Research (NICOR). The service told us that was due to a GDPR issue with concerns around patients' data and were working with NICOR to resolve this. Although they did not submit data, they compared their own data to the national data and found that they had survival rates of 99.2% vs a national average of 96.7% in 2022.

The service submitted data to Private Healthcare Information Network (PHIN). PHIN is intended to improve the availability of information to patients for private healthcare services, making the information comparable with that which is already available for the NHS. 97% of patients submitted to PHIN said that the care they experienced at London Bridge was good or better.

Patients receiving palliative and end of life care were cared for on the wards, with advice and support from members of the specialist palliative care team. Medical or nursing staff on the oncology unit would make a referral to the palliative care team if appropriate. The palliative care consultant and clinical nurse specialist would then review patients accordingly. We saw related documentation in medical records. There was a "Excellent care in the last days of life" booklet to support staff and good communication when managing patients at end of life. This described information for staff on symptom management, religious and spiritual needs, key contacts and preferred place of death. We spoke to the palliative care clinical specialist who told us they worked closely with local social services and families to try and ensure patients preferred place of death was met where possible.

Monthly morbidity and mortality meetings were held where both expected and unexpected deaths could be discussed. We saw examples of well-documented mortality review sheets with named attendance of each member of the multidisciplinary team (MDT), including the admitting consultant.

The hospitals oncology services had been awarded the Macmillan Quality Environment Mark which demonstrated the service had maintained a standard of excellence in their cancer services. The service was due to be reassessed in 2024.

Competent staff

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

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

All nurses received annual appraisals, which looked at their development needs and set achievable and realistic targets to measure progress against. Appraisal rates for staff were reported at 100%. In addition to this, nurses had a mid-year assessment carried out against their objectives to measure their performance and progress.



Medical care (Including older people's care)

Managers gave all new staff a full induction tailored to their role before they started work. We saw there was an induction learning and competency folder that defined the induction process their role required. New nursing staff had a mentoring system provided by more experienced nurses. This ensured that new staff worked alongside the more experienced nurses and that competency checks were signed off appropriately.

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 and development such as simulation, classroom teaching, one to one teaching/coaching, computer access for virtual learning or professional study. We spoke with a member of staff who had recently joined the oncology ward and they told us that they were well supported to learn by their manager and their peers. We saw clinical practice facilitators work with them on the ward for training and development.

Staff had access to a range of learning on the hospitals learning academy. This included courses and workshops that covered a variety of clinical and non-clinical topics. The service also offered leadership and executive development programmes to help staff progress within the organisation.

The service offered virtual bite size learning sessions for staff to attend which included subjects such as giving effective feedback and managing conflict.

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. Consultants who were granted practicing privileges worked within their scope of practice and the service investigated when the performance of the consultants dropped or they worked outside of their scope of practice. For example, leaders told us they had placed a consultant on suspension after they identified they had over-diagnosed a gastric condition in their cohort of patients compared to local and national standards. A learning schedule was devised with the consultants NHS appraiser which allowed the consultant to return to work at the service.

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. Patients had their care pathway reviewed by relevant consultants. The service held regular daily multidisciplinary meetings at ward level that discussed day-to-day care of the patients. On oncology wards, a multidisciplinary team (MDT) was set up for each patient admitted that involved consultants from various backgrounds discussing patient pathways and treatment plans to meet the patient's clinical needs. Each speciality held MDTs to discuss their caseloads and share advice and learning. These were well attended and worked to the benefit of patients due to clinical input from various specialists and other healthcare professionals.

The service also had pathways for MDT working for non-cancer patients. In the cardiac unit, lead consultants described to us comprehensive four-weekly cardiac MDT meetings for all complex patients attended by cardiologists, cardiac surgeons, radiology, perfusionists and allied health professionals. The MDT meetings included the four HCA International Limited hospital locations in London that provided cardiac care.

Inpatient wards had daily MDTs that involved nurses, therapists and resident doctors and discussed patient's needs.



Medical care (Including older people's care)

Staff referred patients for mental health assessments when they showed signs of mental ill health, depression. We saw updated lists of psychiatric consultants who staff could refer patients to if identified as needing mental health support.

The palliative care nurse on the oncology wards worked closely with social services when discharging palliative care patients to their home or community.

The services had access to physio, dietician and pharmacy support when needed. We saw input from each of the professions in patients notes we reviewed. They attended patient MDT meetings when relevant to them.

The service gave copies of letters to patients explaining the treatment they had received to pass onto their GP. The service told us they could send the copy to the patients GP on their behalf with their consent.

The service sent letters to patients GPs once they were discharged from the service explaining the treatment they had received. Patients told us they also received a copy of the letter.

The endoscopy ward and catheterisation laboratories ward held debriefs for all staff who attended the procedure after each patient to discuss what went well in the procedure and what could be improved. Any noteworthy discussions were passed to ward leaders to discuss at the next handover.

The service held daily bed meetings that was attended by representatives of each speciality. They discussed performance, patient numbers and patient acuity to determine where best to distribute staff if required.

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. Patients were reviewed by consultants depending on the care pathway.

Staff had on-call access to support from doctors within their specialities and other disciplines, including mental health services and diagnostic tests, 24 hours a day, seven days a week in case of emergencies through a dedicated triage service. They could seek information on medicines, post-care advice and anything else related to their treatment.

Pre-booked endoscopy services ran Monday to Friday from 7.30am to 7pm and dialysis services ran Monday to Saturday from 7.30am to 5pm.

Services such as pharmacy, dieticians and physiotherapists were available during normal working hours and also available on-call outside of these hours.

Health promotion

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

The service had relevant information promoting healthy lifestyles and support on wards and units. For example, we saw leaflets related to gastric conditions on the endoscopy unit and saw leaflets on smoking cessation and reducing alcohol consumption on oncology wards.

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



Medical care (Including older people's care)

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

Staff supported patients to make informed decisions about their care and treatment. They followed national guidance to gain patients' consent.

Staff understood how and when to assess whether a patient had the capacity to make decisions about their care. Staff gained consent from patients for their care and treatment in line with legislation and guidance. Records we reviewed showed that staff clearly documented consent.

Although the service rarely treated patients who could not give consent, staff could describe how they would support patients including taking into account the patient's wishes and needs. They described how to access policies regarding consent, but they were not able to tell us if the service had a Mental Capacity Act team or champion who would be able to support staff when assessing capacity in these patients.

Patients told us that they were well informed from the nurses and medical staff when consenting to treatments and care.

Staff received and kept up-to-date with training in the Mental Capacity Act and Deprivation of Liberty Safeguards. We reviewed training records and saw 100% of eligible staff were up-to-date with the training.

Consent audit results from January to March 2023 showed that the service scores ranged from 93% to 98% to areas providing medical care. This was against a target of 90%.

Is the service caring?



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. Staff took time to interact with patients and those close to them in a respectful and considerate way. We saw an example of a patient who was deaf who struggled to communicate with staff as they had to wear masks when near her. Staff in the department learnt basic phrases and words in sign language to help communicate with the patient and identify needs. The patient voluntarily returned to the ward months later after travelling to show the staff how she had recovered after receiving treatment with the service. We also saw nursing staff had learnt basic phrases and words in Arabic to help communicate with Arabic speaking patients. We saw patients being responsive to this gesture.

We saw continual positive interactions between staff and patients. Patients told us they felt relaxed and at ease in the staff's presence even though they were suffering from complex medical conditions. They told us that 'they could not fault a single member of staff' for their kindness and capabilities. They told us that nurses always made time for them and that their needs were always being met. From May 2022 to April 2023, 100% of patients fed back to the service that they were treated with dignity and respect.



Medical care (Including older people's care)

Patients said staff treated them well and with kindness. We observed interactions between staff and patients during procedures and saw there was calm and relaxed atmosphere. The patients were put at ease with staff talking to them and even saw patients and staff sharing a joke during a stressful procedure. If patients were cold in the procedure rooms, they were offered heat pads to place under blankets to remain warm.

Staff followed policy to keep patient care and treatment confidential. Screens in the nurse areas which had details of patients that were on the ward were confidential and did not display any sensitive personal information. Patient rooms were labelled with patient initials and their doctors name instead of using patient's full names to protect confidentiality. Staff locked computers when not in use.

We saw messages from family members of patients who had died who had commended the nurses and the service for caring with 'respect, friendliness and compassion'.

We observed staff respond quickly to patients. They acknowledged patients when they were mobile on the ward and asked if they needed any help.

The service consistently scored highly in patient satisfaction surveys. For example, during June 2023, 100% of patients said the care they received was 'very good' or better on endoscopy wards.

Staff on the cancer ward spoke to us about attending the annual service of remembrance and thanksgiving organised by the service. It 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.

Staff gave patients and those close to them help, emotional support and advice when they needed it. For example, nurse staff told us about a patient who had been transferred to the service from the NHS whose son suffered from mental health issues and asked the same questions every day. The resident doctor spoke with the son every day and answered the same questions that were asked each time.

Staff were focused on delivering patient centred care and respected the individual needs of each patient. We saw laminated signs on some patient's rooms reminding staff to confirm with the nurse in charge if they could enter the room so they could comply with the patients cultural or religious needs.

From October 2022 to April 2023, 100% of patients fed back to the service that there was always staff to talk to about their worries and fears. We spoke to patients on the transplant and oncology ward and they told us that staff were 'hugely supportive' to them.

Relevant clinical staff undertook training on breaking bad news which equipped them to deliver information effectively but with compassion.

We saw thank you cards from patients displayed on wards, thanking staff for the 'exceptional care' they had received and thanking them for 'helping them through a difficult time'.



Medical care (Including older people's care)

Staff understood the emotional and social impact that a person's care, treatment or condition had on their wellbeing and on those close to them. The service ran a patient and staff cancer support groups to support patients suffering with cancer. We saw they were made up of cancer survivors who supported patients individually and attended social evenings to discuss issues around cancer care. The service also ran a skincare and makeup workshop for these patients. The service held regular fundraising events for the support groups and charities it worked with.

We spoke to a patient who told us that staff were constantly reassuring them during a procedure that made them anxious. They described how the staff made sure that patient was positioned on their favourable side so they communicate during the procedure as they were deaf in one ear. They spoke to how they shared jokes with the staff which put them at ease throughout. Staff members contacted them following discharge to ask how they were recovering which was greatly appreciated by the patient and his wife.

Patients described how they still felt cared for even when they had been discharged with regular follow up calls from familiar members of staff.

Patients on the oncology ward had complimentary access to reflexology services who could provide patients with massages, emotional support and relaxation techniques. We spoke to patients with complex clinical needs who had used the service and they told us that it helped them to relax and manage pain when being treated for cancer. We saw an example of the reflexologist providing emotional support over the phone to a patient who was isolated because of their condition. The patient told us that the support was greatly appreciated as they could not receive visitors.

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. People who use services and those close to them were active partners in their care.

Staff made sure patients and those close to them understood their care and treatment. Patients would be contacted before attending the hospital to ensure that they followed the correct pre-procedure advice and to check if they required further information and had further needs to be met. For example, one patient told us that a cancer support nurse would contact them regularly before attending the hospital for complex cancer treatment. The patient told us that this was 'extremely helpful' for physically and emotionally preparing for life altering treatment.

Patient family members were allowed to stay with the patients for the day of procedures or were allowed to visit patients on the ward with minimal visiting restrictions. In patient feedback from October 2022 to April 2023 we saw 100% of patients said that doctors showed understanding when assessing the patient's treatment and gave them sufficient time with their consultant to ask questions and understand their care.

Staff talked with patients, families and carers in a way they could understand, using communication aids where necessary. Hearing loops were available for those who were hard of hearing.

Patients and their families could give feedback on the service and their treatment and staff supported them to do this. We saw an example of feedback from the family of a long term patient who died in the service where they said they would have liked a space to allow them to stay overnight when the patient was at end of life. The service created a new room on the oncology and transplant ward to accommodate this which contained an end of life care box. This contained support leaflets on bereavement, LED candles and light entertainment amongst other support items. When we spoke to staff of all levels about this, they remembered details of the patient vividly who this was dedicated to and could describe the interactions they had with the patient and their family even though it had been a year since they had died.



Medical care (Including older people's care)

Staff supported patients to make advanced decisions about their care. We saw completed 'Do not attempt resuscitation' forms completed on patient records that showed the patient's and family members input into the decision.

Staff supported patients to make informed decisions about their care. Patients we spoke to told us they were well informed by staff members and consultants about next steps in their care. For example, one patient described to us what was expected to happen over the next five days which covered the procedure scheduled to be done and the post-procedure care.

Patients consistently gave positive feedback about the service. All patients we spoke highly of the service and told us if they had complaints, they were minor and resolved in a timely manner. This was reflected in patient survey data where the service routinely scored 100% in multiple sections of patient feedback including the overall experience of the nursing care and that they had confidence in the doctors and nurses to treat them.

They told us family members could stay with patients in the catheterisation laboratories if patients needed the support during the procedure.

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.

Is the service responsive?



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

Service planning and delivery to meet the needs of the local people.

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

The service provided inpatient care and day case procedures for adults who required a variety of treatments. Managers planned and organised services so they met the changing needs of the local population. Appointments for care were planned to suit patient's needs. Patients told us they could get appointments which suited them.

The service ensured that patients would be contacted at least 48 hours prior to the procedures to ensure that they had all the relevant information and were correctly prepared. This reduced the instance of cancelled procedures which benefited both the service and the patient, especially those who would travel far distances. The service had processes that ensured that patients who did not attend appointments were contacted and rescheduled.

Facilities and premises were appropriate for the services being delivered. Procedure rooms could be used for patients who were infectious as the service was able to alter the air flow to stop air leaving the room. Patients who received dialysis were able to access Wi-Fi and watch television whilst receiving treatment.



Medical care (Including older people's care)

The service worked closely with hospitals in the local area in the delivery of their stem cell transplant procedures. Patients stem cells were extracted, stored and delivered by the local NHS hospitals and delivered to London Bridge hospital when required for the patient. The service had processes to manage delays or if the patient was unwell enough for treatment. The service had plans to be able to extract and store the stem cells on site.

Staff could access emergency mental health support 24 hours a day seven days a week for patients with mental health problems. They could contact on call psychiatrists to support them through regularly updated contact lists that were distributed to staff.

The service had systems to help care for patients in need of additional support or specialist intervention.

The service relieved pressure on other departments when they could treat patients in a day. We saw the endoscopy ward cleaned medical equipment for other areas of the hospital and for sister hospitals in the area in case of cleaning equipment failure.

The service worked closely with cancer charities. We saw information from the national cancer charities available on cancer wards in various languages such as Portuguese, Arabic and Urdu. The service had members of staff who organised support on behalf of patients for these charities.

Meeting people's individual needs

The service was inclusive and tailored to meet the patients' individual needs and preferences. 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. We were shown numerous examples of the hospital tailoring their services to meet the needs of patients. For example, we spoke to a patient who was on dialysis and a heavy smoker and required frequent breaks. The service incorporated this into his appointments and offered smoking cessation patches to aid withdrawals whilst receiving dialysis. Furthermore, a patient told us that service leaders had rearranged a cardiac procedure for the same day as their dialysis appointment so that they receive all the care they needed in one day as opposed to visiting again at a later date. Additionally, dialysis staff would check if the patient had any upcoming appointments for blood tests in other departments and used the opportunity of the dialysis to draw the blood then. This meant patients did not have to return to the service for the blood test. A patient told us they appreciated this as it meant 'one less needle' for them. Staff also told us of an example where they set up a patient's dialysis in a separate side room to allow the patient to work whilst receiving treatment.

One patient told us that a sling commode and hoist was always ready for them when they visited the service.

A patient told us how the service had organised a dialysis machine to be moved to the critical care unit to start treatment promptly as they were too weak to move. Once they had recovered, they were moved back to the dialysis unit as an outpatient.

Another patient told us that the service had organised to deliver a transfusion for them late at night as they preferred to have it done then as opposed to early in the morning.



Medical care (Including older people's care)

We saw staff had access to services and tools that helped them meet the needs of those with sensory loss and communication difficulties and could make reasonable adjustments for patients to access the service. 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.

Although the service rarely treated patients on the medical wards with learning disabilities and dementia, staff could describe how they made sure patients living with learning disabilities and dementia, received the necessary care to meet all their needs. The staff described how they would use patient passports to support the patient throughout their stay. 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. Although we did not speak to any patients or family members of patients who had learning difficulties, the services policy described that these patients should be accompanied at all times and that the service would provide a member of staff to monitor the patient throughout the journey if family members or other carers were not available.

The dialysis department offered a holiday service where patients travelling to London on dialysis could arrange for ongoing treatment, in order to continue their dialysis treatment whilst abroad.

There was a chaperone service available to patients. We saw posters reminding patients about the service. These posters had also been translated into other languages.

Patients were given a choice of food and drink to meet their cultural and religious preferences. We saw examples of the chef creating custom dishes for long stay patients and others who requested off-menu items. For example, one long stay patient on the oncology ward requested a dish from their home county which was cooked by the chef with advice from the dietician. The service offered menus that were suitable for patients with allergies, vegetarians, vegans, religious preferences and those who required a specific diet. For example, we saw menus catered for patients with kidney issues that were designed to be low in salt.

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. Access to the chaplaincy service was clearly displayed around the service.

The dialysis department celebrated world kidney day in March 2023 where they provided 'kidney friendly' cakes and treats for patients and the staff.

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. We saw cancer charity information links displayed on the oncology ward in various languages such as Urdu, Portuguese and Arabic.

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 medical procedures and inpatient services at The London Bridge Hospital. Admission could also be facilitated at short notice to meet patient's 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.



Medical care (Including older people's care)

Managers and staff worked to make sure patients did not stay longer than they needed to. The median length of stay for inpatients from May 2022 to May 2023 was 2 days. The average length of stay of 4.82 days. However the service had long term patients on the wards with complex clinical needs who had stays of up to 284 days which skewed the average length of stay data. Patients we spoke to told us that service was 'efficient' and did not stay longer than anticipated. The service told us that patients could stay longer than expected if the clinical needs of the patients required it.

The service did not monitor how often patients moved within the service as moves were rare. Reasons for patients being moved were if they required specialist intervention, if the patient was moving to or from the critical care unit or if the patient requested to move for personal reasons.

The service supported patients when they moved between services. For example, when patients were moved from the oncology ward to the radiotherapy unit, they were escorted by a nurse who carried a grab bag containing emergency equipment in case of patient deterioration.

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.

When patients cancelled their treatment at the last minute, managers made sure they were rearranged as soon as possible at the next convenient time for the patient. Patients told us they were always able to get appointments that suited them.

Managers and staff started planning each patient's discharge as early as possible. Patients were informed of the estimated date of discharge when they were admitted for treatment and kept updated if this changed. Staff planned patients discharge carefully. We spoke to the palliative care lead nurse who told us they worked closely with social services in the local area when planning discharges for patients who were approaching end of life.

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 clearly displayed information about how to raise a concern in patient areas which included leaflets and posters. Patients, relatives and carers knew how to complain or raise concerns. All patients we spoke to were comfortable raising concerns on the ward with staff but also told us they had nothing to complain about. Patients who had used the service before had told us they could give feedback about their care through feedback forms given to them on discharge.

Staff understood the policy on complaints and knew how to handle them. The policy was clear and up to date and easily accessible to staff. Further information on handling complaints was displayed in staff areas on wards we visited. The service could refer complaints that could not be resolved to the Independent Healthcare Sector Complaints Adjudication Service (ISCAS).

Complaints were investigated on the wards and units by the ward managers. All actions and learning as a result of a complaint were monitored at the weekly complaints, litigations, incidents and patient experience (CLIP) meetings where they were then shared with staff at team meetings and displayed on the wards and units.



Medical care (Including older people's care)

The service had received 167 complaints from May 2022 to April 2023 where 3 of them were referred for external review at ISCAS. From the data provided by the service, it was difficult to determine exact numbers of complaints that referred to medical care but we could see that it was generally a low number. Across the hospital, the general themes of complaints were transparency of fees, consultant care and communication with secretaries.

Staff knew how to acknowledge complaints and patients received feedback from managers after the investigation into their complaint. The service displayed the hospital complaints flowchart in staff areas.

The service audited the complaints process twice yearly and scored 100% in the last audit in February 2023. The audit looked at whether complaints were acknowledged, responded or referred within timeframes set out as per policy.

Staff could give examples of how they used patient feedback to improve daily practice. For example, staff told us that they used initials of patient's names and full doctor's names on signs outside each patient room to identify patients instead of using full patient names. Patients had previously fed back they preferred to not have their names displayed on the doors.

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. There was an embedded system of leadership development and succession planning.

There was a clear management structure with defined lines of responsibility and accountability. The executive team was led by a chief executive officer with support from a chief operating officer, a medical director, a chief nurse, a chief HR officer and a chief finance officer. Many of the leaders had worked for the service HCA International Limited for many years before being promoted to executive team leaders.

Leaders at all levels showed a high level of experience, motivation and capability to deliver sustainable care. They had a firm understanding of the challenges they faced at department and hospital level such as priority for the hospital to introduce a new electronic patient record system.

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. We observed positive interactions between senior leaders and ward staff on inspection. Staff told us that they could request one to ones with the chief executive if they wished. Staff at all levels described how satisfied they were working in the service under the leadership team.

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.



Medical care (Including older people's care)

Staff were encouraged to develop skills by attending training sessions and accessing courses which would support them in the development and progression in the service. From 2022, we saw that 110 staff members had been supported into new roles across the whole hospital.

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.

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 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 hospital had clear strategic growth drivers for each of the services it provided. In medical care there were clear growth drivers for each of the oncology, cardiac, renal and digestive diseases specialities. For example in digestive diseases the service looked to increase the number of endoscopy theatres and dedicated endoscopy recovery rooms. They looked to grow pathways into the service with collaboration with local businesses and doctors.

The service had a clear roadmap for targets and investments for the next 3 years which included refurbishment and upgrades of the current hospital wards and procedure rooms.

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.

Staff told us they were well supported by leaders in learning and caring for themselves. They had access to a staff wellbeing hub, employee assistance programme and various wellbeing apps. They had further access to nominated mental health first aiders.

The service had recently been awarded a recognised national platinum award that recognised the service's effort in people management. They were considered to be high performing in leading and inspiring people, people living the values of the service, empowering and involving people amongst others. This was reflected in conversations we had with staff who also told us they were proud to work for the service and be part of any achievements.



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Ward staff told us they felt recognised by managers and consultants who knew them by name. They told us that they had opportunities to develop their skills. For example, health care assistants were upskilled in Transcatheter Aortic Valve Replacement (TAVI) preparation which allowed them to be further involved in procedures. They were able to assist doctors with this preparation which allowed nurses to be released and help others on the ward.

Staff we spoke with were knowledgeable, enthusiastic and spoke with pride about their work. When we asked if there was anything that could be better, they suggested the wider team (outside of consultants) could be better supported so they could respond faster to new and developing technology.

Staff told us they were treated as individuals and were empowered to safely care for patients. We saw freedom to speak up posters on the walls of the areas we visited. 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. They told us there was a culture of openness and honesty and they felt they could raise concerns without fear of blame. For example, nursing staff had raised concerns to senior leaders about the attitude and behaviour of a consultant towards ward staff.

The service promoted equality and diversity in the daily work. 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 a diverse talent pipeline; and exceptional healthcare that recognises and values patients as unique and individual. The service had a held a 'around the world' initiative to celebrate diversity in the workplace where colleagues were invited to pin on a map where they were from and share details of the culture on postcards with other colleagues.

Governance

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

The service had clearly defined governance system to monitor performance and safety of the service. Staff were all clear about their roles and responsibilities and knew how to escalate concerns.

The executive leaders of the hospital were responsible for the overall performance of the service who were informed by a variety of sub-committees such as IPC, patient experience and clinical audit and effectiveness. We reviewed minutes from these committees and saw they discussed relevant risks, were well attended and had updates on ongoing actions. Each committee was sponsored by a member of the board who share the information at more senior meetings.

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 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 medical advisory committee (MAC) met quarterly and reviewed clinical quality and governance matters including risks, incidents, new services, patient experience and recruitment. A lead for each medical specialty was represented on



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the (MAC) to consider applications for practising privileges, which were reviewed regularly along with scope and volume. Systems were in place to ensure there were no conflict of interests for consultants who had practising privileges or employment in other hospitals, such as a check on rotas to make sure consultants were not providing cover for more than one site at a time.

Staff and leaders at all levels told us they felt the governance the service provided gave them assurance that they were providing high quality and safe care. For example, consultants told us they felt reassured by the services decisions to not perform risky and unevidenced procedures that had been requested by patients.

Staff were kept informed of learning and changes from committees through meeting minutes, displays of key information on hot boards on the ward and unit areas. The service displayed hot boards in each area which displayed information on governance. It highlighted departmental risks, incident themes and learning from other areas of the hospital.

The hospital held a service level agreement with a local NHS trust for the provision of dialysis services which included but was not limited to information governance and data sharing, clinical governance responsibilities and information on clinical pathways. There was daily communication between the NHS trust and the service to ensure continuity of patient care. The service produced patient reports every two weeks that were sent to the trust and monthly MDTs were held between the clinical teams from both sites.

Management of risk, issues and performance

Leaders and teams used systems to manage performance effectively. They identified and escalated relevant risks and issues quickly and identified actions to reduce their impact. They had plans to cope with unexpected events.

There was a clear approach to audit and performance management at the service. The audit programme was thorough and had clearly laid out timescales for audits to be repeated to ensure compliance. Leaders also identified risks from patient and staff feedback, risk assessments and safety alerts.

Leaders in the medical service were able to describe risks associated with their department. Risks were recorded, discussed and mitigations put in place at regular departmental meetings. Risks that scored highly were escalated to the hospital wide risk register which was overseen by the executive leaders. The top 3 risks in the hospital were potential contamination of water supplies with pseudomonas bacteria due to aging plumbing, national medicines shortages and how to manage them and management of medical devices and the logistics of ensuring all devices were serviced in line with manufacturer recommendations. We saw the risks were assessed regularly and had nominated individuals for oversight of individual risks. Mitigations were also put in place and regularly updated. For example, the service had a team that monitored the frequency of flushing water taps and testing for contamination of pseudomonas around the hospital. They removed sinks that were used infrequently and had become a potential source of contamination.

All wards displayed health and safety boards which showed information of the health and safety team and committee. It also displayed information about managing risks related to the department including information on the water safety group which was responsible for managing the risk of pseudomonas in the water supplies. Also displayed was information on post fall assessments and management, risk assessments, learning from incidents, infection control messages and reminders for staff to remain hydrated.

The service had clear plans for emergency incidents such as power loss or fire which described the roles and responsibilities of staff and numbers of local emergency contacts. Staff on the wards were able to describe what to do in these instances.



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We saw the service had conducted simulations of patient deterioration to identify areas which could be improved in an emergency. We saw at the last simulation in medical care the service passed the simulation, with minor improvements that were discussed and shared with staff.

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 submitted to external organisations as required.

Staff had access to patients' health records and the results of investigations and tests in a timely manner through paper and electronic systems. The hospital was planning to transfer over to a fully electronic patient records system in the late 2024. 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.

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.

Staff commented that the intranet system was user friendly and showed us they could easily find policies on the hospital intranet and access various systems without issue. They could also access guidance, training and information on procedures.

The service submitted statutory notifications to the CQC as required by legislation.

Engagement

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

The service engaged with staff at all levels. The service requested feedback from consultants after each Medical Advisory Committee (MAC) meeting and actioned it. For example, the service had recently shortened the length of the presentation delivered at the meeting to allow more time to discuss clinical issues between the staff as requested by consultants. Leaders told us this had been well received.

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.



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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. 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.

The service had made improvements as a result of patient feedback from the patient experience committee. Improvements included new menus, reviewing minor repairs in patient rooms and once a month spot checks of public areas to ensure that they were not in need of repair.

We were told that London Bridge Hospital had continuously achieved the highest staff engagement score in HCA International Limited. This score was calculated using an average score of responses to the question “how happy are you working at the organisation” and “would you recommend the organisation as a great place to work”. The latest staff survey results released in May 2023 showed that medical services had an engagement score of 76 which meant staff agreed with the above statements. There had been significant improvements in the catheterisation laboratories and endoscopy unit since the previous results where the catheterisation laboratories score had increased from 78 to 89 out of 100 and the endoscopy unit had increased from 62 to 79. There was a high participation score of 89% in the medical division which indicated the scores were a true reflection of the departments.

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.

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 was participating in a multi-centre, observation study for stem cell transplants for multiple sclerosis. Staff members from the oncology department had also published international research into the effects of treatment ‘Dara-RVd’ on stem cell extraction and engraftment in patients with Multiple Sclerosis.

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

The hospital had direct links with the Sarah Cannon Research Institute, a research branch of the hospital's provider that offered clinical trials in new therapies, where they could refer patients if deemed appropriate through a relevant MDT. This allowed access to new anti-cancer therapies not currently available outside of the NHS.

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

Clinicians working at the hospital had produced 23 research papers that had been submitted and published in national journals.



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

The service had recently hosted an international renal conference in June 2023 with speakers from a variety of countries which discussed the latest evidence based practice in relation to kidney health. This was made available for staff to use as a learning and development opportunity. For example, nurses told us they used this for their yearly continuing professional development. It was made available to them online and in person.