

ASI London B Limited

One Welbeck Surgery

Inspection report

1 Welbeck Street
London
W1G 0AR
Tel: 02036532004
www.onewelbeck.com

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

Ratings

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

Summary of findings

Overall summary

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

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

However:

- Not all staff were clear about all of the principles of safe medicines management and not all clinical staff were following all infection prevention and control procedures.

Summary of findings

Our judgements about each of the main services

Service

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

Rating

Good



Summary of each main service

Medical care is a small proportion of hospital activity, and only included endoscopies. The main service was surgery. Where arrangements were the same, we have reported findings in the surgery section. We rated this service as good because it was safe, effective, caring, responsive and well-led.

Surgery

Good



We rated surgery as good see summary above for details.

Summary of findings

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Summary of this inspection

Background to One Welbeck Surgery

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

The service had two theatres and nine individual patient rooms and only cared for adults and provided only day case surgery and endoscopies. The service accepted referrals from independent doctors and accepted self-paying patients and those who had private medical insurance. They provided a range of day case surgical specialities including orthopaedic, ear, nose and throat, women's health and general surgery. They also provided an endoscopy service; this has been reported under Medical Care.

How we carried out this inspection

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

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

Outstanding practice

We found the following outstanding practice:

- The service had developed a bespoke smartphone application, that patients could choose to use to streamline their communication with the team.
- The service had developed additional patient reported outcome measures, for areas that were not yet collected nationally, to review their performance.
- The service had a clear procedure for bringing in new techniques or technologies that prioritised the safety of patients.

Areas for improvement

Action a provider **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 ensure that daily checklists are completed.
- The service should ensure that staff are aware of and follow all medicines management policies.
- The service should ensure all staff follow all infection control policies.






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	Good	Good	Good	Good
Surgery	Good	Good	Good	Good	Good	Good
Overall	Good	Good	Good	Good	Good	Good

Medical care (Including older people's care)

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

Are Medical care (Including older people's care) safe?

Good 

For mandatory training, safeguarding, nurse staffing, records, assessing and responding to patient risk, medicines and incidents, please see surgery.

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.

The specialist equipment for endoscopies was supplied by another service within the same building. There was on site decontamination facilities which followed national guidance to clean all equipment thoroughly.

The service had clear procedures to be followed in theatre to ensure clean equipment was kept separated from used equipment being taken for cleaning. These procedures included timescales, within the national good practice timeframes, for the service to return used kit for cleaning.

Environment and equipment

The service had access to adequate equipment to keep people safe.

Equipment for endoscopy procedures was supplied under a service level agreement from a specialist endoscopy service within the same building. Service managers told us they did not have a problem obtaining clean equipment in a timely manner for endoscopies.

The service level agreement specified that all specialist equipment provided must be adequately serviced before it was loaned to 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.

The service had enough medical staff to keep patients safe and only surgeons who regularly completed endoscopy procedures were permitted to carry them out.

Good 

Medical care (Including older people's care)

The bookings team knew to only book endoscopy procedures when appropriate medical staff were available to complete them.

Are Medical care (Including older people's care) effective?

Good 

For evidence-based care and treatment, pain relief, competent staff, multidisciplinary working, seven-day services, health promotion and consent, Mental Capacity Act and Deprivation of Liberty Safeguards please see surgery.

Nutrition and hydration

Staff gave patients enough food and drink to meet their needs and provided specialist advice about fasting or bowel preparation.

We were told staff gave patients advice to support them with their bowel preparation, including fasting advice. This was tailored to the procedure to be carried out and took into account patient specific needs.

Staff made sure patients had enough to eat and drink following their endoscopies.

Patient outcomes

Staff monitored the effectiveness of care and treatment.

The service audited the performance of individual surgeons completing endoscopies. Outcomes for patients were positive, consistent and met expectations. Individual endoscopist performance was monitored and discussed at regular specialist group meetings.

Are Medical care (Including older people's care) caring?

Good 

Please see Surgery.

Are Medical care (Including older people's care) responsive?

Good 

For service planning and delivery to meet the needs of the local people, meeting people's individual needs and learning from complaints and concerns please see surgery.

Access and flow

People could access the service when they needed it and received the right care at a time that suited them.

Medical care (Including older people's care)

The service did not have any waiting lists for patients to book their endoscopies. We were told appointments were booked in line with patient preference and surgeon availability. Appointments were often booked 6-12 months in advance as patients were on surveillance regimes.

Are Medical care (Including older people's care) well-led?

Good 

For leadership, vision and strategy, culture, information management, engagement and learning, continuous improvement and innovation please see surgery, management of risks issues and performance.






Governance

There were governance processes to support the smaller service.

The service's clinicians were invited to attend the endoscopy user group meeting, with the service they had a service level agreement for provision of equipment. This was to allow for a meaningful conversation, with a service that completed a much higher number of endoscopies on a regular basis.

The endoscopy user group meeting had a set agenda and covered a range of topics, including learning from incidents, aftercare of patients and providing patients with results.

Surgery

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

Are Surgery safe?

Good 

Mandatory training

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

Staff received and kept up-to-date with their mandatory training. Following inspection, we were told 98.9% of staff had completed their mandatory training.

The mandatory training was comprehensive and met the needs of patients and staff. This training encompassed general subjects including manual handling, information governance and recognising and responding to symptoms of sepsis.

Managers monitored mandatory training. The training system created automatic alerts for staff when they needed to update their training.

Safeguarding

Staff understood how to protect patients from abuse. 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, including female genital mutilation. Training was supported by a policy which was clear about the levels of training staff needed to achieve.

Staff we spoke to were able to describe signs of abuse and who to report it to. In the staff break room there was a poster with the contact details for reporting safeguarding, internally and externally.

Cleanliness, infection control and hygiene

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

Patients and carers were COVID-19 tested in the building reception before being allowed into the service area.

Surgery

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

The service generally performed well for cleanliness in their audits. Staff used records to identify how well the service prevented infections. The service scored 100% in the latest department cleaning audit.

Staff mostly followed infection control principles and used personal protective equipment (PPE) correctly. The service audited their compliance with good hand hygiene principles and found that outside of the theatres they were not always cleaning their hands at every identified necessary point. A hand hygiene champion had been appointed to challenge poor hand hygiene shortly before inspection. However, we observed that not all members of staff were following all bare below the elbow principles and had nail varnish on.

Staff cleaned equipment after patient contact and labelled equipment to show when it was last cleaned

The service had its own decontamination suite to sterilise equipment used in theatres.

We observed staff working to prevent surgical site infections by wearing appropriate surgical clothing and following hand washing procedures in theatres. Staff were trained to identify and treat surgical site infections if they were to arise.

The service regularly tested their water quality and monitored this in line with the national guidance.

Environment and equipment

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

The service had nine individual patient rooms to ensure patients had privacy at all times.

The service did not have a stage one recovery bay instead patients were safely cared for post operatively initially in theatre and then in their individual patient rooms with one to one nursing. A stage one recovery bay is used to care for patients immediately after surgery while waking up from general anaesthesia.

Patients could reach call bells and we observed staff respond quickly when called. The daily checklist included checking the call bells worked, however this was not always completed.

The service checked fridge temperatures as part of their daily checklist. However, this was not always completed.

The design of the environment followed national guidance. The air pressure was safely managed in theatres to ensure contaminated air did not flow into them and increase the risk of infection.

The service had enough suitable equipment to help them to safely care for patients and staff carried out safety checks of specialist equipment. The service had contracts with manufacturers and a local NHS trust to maintain equipment.

The resuscitation equipment was readily available, and records showed it was checked as per policy.

Staff mostly disposed of clinical waste safely.

Surgery

The service had suitable facilities to meet the needs of patients' families. The patient rooms were large enough to accommodate a relative or carer. At the time of the inspection this was discouraged, due to the COVID-19 restrictions, but if a patient needed support there was space for their relative or carer to chaperone.

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 to identify deteriorating patients and knew to escalate their care if required. The service had an agreement with a local private hospital where unwell patients could be sent if they needed overnight care.

Staff completed risk assessments for each patient pre-admission and on arrival. The centre had strict inclusion criteria to ensure they only accepted patients they could safely care for.

We observed the theatre staff completing the safer surgery checklist. The service audited the completion of the checklists.

Staff told us they knew about specific risk issues including sepsis and venous thromboembolism and took action to minimise these risks, when necessary.

Patients were connected to portable monitoring equipment to monitor their vital signs, such as blood pressure and heart rate. This followed patients from their private rooms to the theatre and then back to private rooms after surgery. The equipment sent real time information the vital signs to the nurse's station where staff could monitor patients while allowing them privacy.

The service provided information packs to patients after surgery detailing who to contact if any issue were to arise after surgery.

Staff had access to a resident medical officer for support. However, at the time of inspection, the role was vacant. The service managed this risk by ensuring anaesthetists stayed until patients were discharged so there was always medical cover.

The service had a contract with a local private hospital for receiving blood and blood products in an emergency. The service had recently undergone a scenario training exercise to ensure staff knew what to do if blood was required in an emergency.

Staffing

The service had enough staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment.

The service had enough nursing and support staff to keep patients safe.

Managers calculated number of nurses and healthcare assistants needed for each shift. Managers limited their use of bank and agency staff and requested staff familiar with the service.

The number of nurses and healthcare assistants matched the planned numbers.

Surgery

The service had low vacancy and sickness rates and only used bank or agency staff when required. The service was actively recruiting to fill a few vacant roles.

Managers made sure all staff including 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.

The service had enough medical staff to keep patients safe. All surgeries were completed by a consultant surgeon with an anaesthetist. Following surgery medical support was usually provided by a resident medical officer. However, when we inspected there was no resident medical officer employed by the service. There was a contingency plan that anaesthetists would stay until patients were discharged from the service, so there was always medical cover. The new resident medical officer was due to take up their role the week following the inspection.

The medical staff matched the planned number. Surgical bookings were made in-line with surgeon availability. Bookings teams worked with surgeons' personal assistants to ensure this.

Managers told us they made sure medical staff had a full induction to the service before they started work. New medical staff were given an induction and tour of the centre prior to starting to ensure familiarity with environment and procedures.

The service employed consultants under a practicing privileges agreement. The granting of practising privileges is an established process whereby a medical practitioner is granted permission to work with an independent hospital. The service ensured that clinicians working under practicing privileges were regularly practicing at the centre. If clinicians were not practicing, they were removed to ensure that only staff that were familiar with the service were working there.

Records

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

Patient notes were comprehensive, and all staff could access them easily. The portable monitoring equipment that followed the patient through the service automatically updated patient records.

Patient records were a combination of electronic and paper records. All information written on paper was digitised and added to the electronic record shortly after the patient left site to keep one complete record of their treatment.

Patients were given a paper information pack at discharge containing the discharge letter for the GP, information about their procedure and who to contact if they had any concerns.

Medicines

The service used systems and processes to safely prescribe, administer, record and store medicines. However, the service did not always dispose of medicines safely.

We observed staff follow systems and processes to prescribe and administer medicines safely throughout their stay in the service. Consultants and anaesthetists provided advice to patients about their medicines.

Surgery

Staff completed medicines records accurately and kept them up-to-date and double-checked prescribing with consultants, when necessary.

Most staff stored and managed all medicines and prescribing documents safely. Cupboards containing medicines and prescription pads were kept locked. However not all staff we spoke to were familiar with maintaining controlled drug records.

Staff did not always dispose of excess medicines in line with national guidance. We found a container with destroyed controlled drugs left unattended and not disposed in a medicines bin.

Staff learned from safety alerts and incidents to improve practice. Alerts were monitored by managers who alerted staff, when required.

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. Managers ensured that actions from patient safety alerts were implemented and monitored.

Staff knew how and when to report concerns, incidents and near misses on the online reporting system. The service manager regularly reviewed the incidents to try and identify themes but told us there were not any.

The service had no never events or serious incidents.

Staff understood the duty of candour. They were open and transparent and gave patients and families a full explanation if and when things went wrong.

Staff met to discuss the feedback and identify improvements to patient care. Meeting minutes detailed incidents being discussed and changes being explained.

The service manager met with other service managers in the building regularly to discuss incidents and share learning.

There was evidence that changes had been made as a result of feedback. We saw evidence of these changes on display in the break room.

Managers knew to debrief and support staff if any serious incident occurred.

Are Surgery effective?

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.

Surgery

Staff followed up-to-date policies to plan and deliver high quality care according to best practice and national guidance. Policies were held on the service's online system and staff were required to read them annually, there was an electronic signature so managers knew when policies had been read.

The service had a procedure to introduce new techniques or technologies. Any new ways of working had to be approved by the medical director and the service completed dry runs, without any patients present, before patients were treated. This ensured the service had the chance to identify any steps that were missing and gave staff an opportunity to familiarise themselves with the procedure.

If a new technology was bought into the service a representative from the manufacturer was required to be present the first time it was used. This ensured there was extra expertise on hand, in case the team had questions but did not cause delays to the treatment while support was sought.

Compliance with policy was regularly audited for example adherence with the World Health Organisation (WHO) safer surgery checklist, hand hygiene and admission paperwork were all audited every month. Audits were scheduled on a calendar, with regular repeats planned.

Nutrition and hydration

Staff followed national guidelines to make sure patients fasting before surgery were not without food for long periods. Following surgery staff gave patients enough food and drink to meet their needs.

Following their surgery staff made sure patients had a range of food and drink to meet any dietary restrictions.

Patients were given tailored fasting advice prior to any procedures that required them to fast. Staff told us they took into account patients with dietary restrictions or needs, such as diabetes and ensured they received advice that was tailored for their needs.

Patients waiting to have surgery were not left nil by mouth for long periods.

Pain relief

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

Staff assessed patients' pain using a recognised tool and gave pain relief in line with individual needs and best practice.

Staff prescribed, administered and recorded pain relief accurately and patients received pain relief soon after requesting it. We observed recovery nurses liaising with the patient's doctors to ensure patients pain relief needs were met when they experienced pain after surgery.

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 participated in relevant national clinical audits including patient reported outcome measures collected nationally. In addition to the pre-existing national patient reported outcomes measured the service had started collecting follow up data from patients treated for atrial fibrillation. The staff involved in starting this were planning to publish their data, once they had enough to be meaningful.

Surgery

Outcomes for patients were positive, consistent and met expectations, such as national standards. The service had no concerns about their post-surgical infection rates, readmission to theatre or outcomes data.

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

Managers used information from the audits to improve care and treatment. Audit results were discussed every two months at regular quality meetings, to identify any areas for improvement. When required, actions were identified and shared.

As the service was a standalone day surgery service it was rare that patients were seen again there if there were complications. The service had good working relationships with local private hospitals and NHS hospitals to monitor any readmissions. In addition to this, staff completed a follow up call shortly after surgery to check on the patient. This was another mechanism to identify any patients that might need extra clinical input before their formal follow up appointment.

Managers shared and made sure staff understood information from the audits and audit results were discussed regularly at staff meetings. For example, the service scored 100% on their surgical site infections policy and were always following their guidelines.

Competent staff

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

Staff were experienced, qualified and had the right skills and knowledge to meet the needs of patients. This was checked as part of pre-employment checks.

To apply, and be accepted for practicing privileges, surgeons had to provide a list of procedures they were competent to complete. This formed the scope of their practice, they were not allowed to deviate from this or add to it, without approval from the medical executive committee. The bookings team had access to surgeon's scope of practice and checked each procedure was on their approved list.

Managers gave all new staff a full induction tailored to their role before they started work, this included consultants, anaesthetists and bank and agency staff.

If training needs were identified for an entire staff group the manager arranged for training to be carried out for the whole team. For example, operating department practitioners who cared for sedated patients received training from manufacturer representatives to ensure they were confident to use the equipment required.

Managers supported staff to develop through yearly, constructive appraisals of their work. Staff told us they were useful appraisals and gave them a chance to identify any training they would benefit from. At the time of the inspection 100% of eligible staff had completed their appraisal within 12 months.

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

Managers made sure staff attended team meetings or had access to full notes when they could not attend.

Surgery

Managers told us they identified poor staff performance promptly and supported staff to improve. This included both clinical outcomes and staff conduct with other team members and with patients.

Multidisciplinary working

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

Staff worked across health care disciplines and with other agencies when required to care for patients.

The service employed resident medical officers (RMOs) to support the with care of patients after surgery, these RMOs worked closely with the surgeons and also supported other services within the building. medical officers were in close communication with the surgeons if a patient deteriorated to make decisions about their ongoing care.

The bookings team had close working relationships with the clinicians and their assistants to ensure patients were booked in at the correct time, in order to minimise any delays or cancellations.

Seven-day services

Key services were available to support timely patient care, there were processes in place to direct patients to access support outside of the service's opening hours.

The service was open Monday to Friday from 8AM to 6PM. If a patient needed urgent support outside of these working hours they were advised to attend their local NHS emergency department. If patients needed non-urgent support they were provided email addresses and telephone numbers of their care team who would provide advice as soon as possible.

Health promotion

Due to the nature of the care provided the potential for staff to give advice to patients about living healthier lives was minimal. However, the service did have some posters and leaflets in the waiting room for example one about having regular mammograms.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

Staff supported patients to make informed decisions about their care and treatment. They followed national guidance to gain patients' consent. They knew how to identify patients who lacked capacity to make their own decisions or were experiencing mental ill health.

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

When patients could not give consent, staff referred them to a larger private hospital locally. The service was a standalone day surgery unit and they recognised they were not able to provide the level of care to patients without the capacity to consent required.

Staff gained consent from patients for their care and treatment in line with legislation and guidance and made sure patients consented to treatment based on all the information available. Patients described having lengthy conversations with consultants about their treatment options.

Surgery

The service had a comprehensive informed consent policy. This policy included guidance to support staff to appropriately consent patients and to record discussions when virtual consultations were held.

Are Surgery caring?

Good 

Compassionate care

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

Staff were discreet and responsive when caring for patients. Staff took time to interact with patients and those close to them in a respectful and considerate way. Following surgery all patients were cared for on a one to one nursing ratio to ensure all their care needs were met.

Patients said staff treated them well and with kindness. All patients we spoke with enthusiastically told us how well cared for they were, how kind staff were and how all their needs had been met.

Staff followed policy to keep patient care and treatment confidential. Staff only spoke to patients about their care in their individual patient rooms, this ensured conversations were not overheard. While patients were on site their notes were stored in folders marked with their room number and not their name, to further preserve patient's privacy.

Staff understood and respected the personal, cultural, social and religious needs of patients and how they may relate to care needs and received training to support them to achieve this.

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.

Staff cared for all patients in individual rooms, therefore if a patient was anxious or distressed they had privacy.

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. Shortly prior to inspection all staff had participated in a course to help them become more confident in caring for transgender patients, and to ensure their communication was inclusive of all patients they cared for.

Understanding and involvement of patients and those close to them

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

Staff made sure patients and those close to them understood their care and treatment. Although most patients did not bring a relative or carer with them, due to the COVID-19 restrictions, they were encouraged to participate in all pre-surgical conversations and to collect patients so they knew the discharge advice.

Surgery

Staff talked with patients, families and carers in a way they could understand and gave patients a chance to ask any questions they had. All patients told us they were clear about their treatment options and why they needed treatment.

Patients and their families could give feedback on the service and their treatment and staff supported them to do this. The feedback was consistently positive, across both public reviews on search engines and private feedback, gathered from the application all patients could download.

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

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

Are Surgery responsive?

Good 

Service delivery to meet the needs of local people

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

Managers planned and organised services so they met the needs of their patients. The service cared for patients from across the country, as patients chose to seek out some surgeons due to their expertise. Patients were able to have all preassessment consultations over the phone, or via video conference to ensure they could minimise their travel.

The service had a dedicated smartphone application to support care for patients who preferred to use technology. Patients were able to complete preassessment forms and follow up paperwork and feedback all in one place. Patients told us this suited them and made their care easier.

Facilities and premises were appropriate for the services being delivered. The service had nine individual patient rooms, all with their own bathrooms and their theatres were appropriate and had the expected equipment, for further information see safe.

Managers monitored and took action to minimise missed appointments. The service had a low rate of patients not attending, less than one percent. For the few patients who did not attend managers ensured they were contacted.

Meeting people's individual needs

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

Surgery

Staff made sure patients living with mental health problems, learning disabilities and dementia, received the necessary care to meet all their needs. The service allowed patients with additional care needs to have a relative or carer with them and all patients received one to one nursing care to ensure their care needs were met.

Managers made sure staff, and patients, loved ones and carers could get help from interpreters or signers when needed this was arranged by the bookings team. All interpreters were required to complete a COVID-19 test before being allowed in the service, to keep all patients and staff safe.

The service had a hearing loop, to support patients who were hard of hearing to communicate.

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

Access and flow

People could access the service when they needed it and received the right care promptly. The service did not have a waiting list for treatment and patients were able to access care quickly.

Managers monitored waiting times and made sure patients could access services when needed.

Managers and staff worked to make sure patients did not stay longer than they needed to. The service audited late theatre starts and worked to minimise any unnecessary delays. We were told there were slight delays sometimes due to patients requiring a COVID-19 test on the day of surgery, however these delays were outside the control of the surgical service as the test centre was not run by them.

Managers worked to keep the number of cancelled operations to a minimum. The most common reason for a surgery to be cancelled was because a patient changed their mind and cancelled, or postponed, the surgery. The number of patient initiated cancellations was reducing over the year.

Some surgeries were cancelled as patients tested positive for COVID-19. The service rebooked the operation as soon as possible and followed the Royal College of Anaesthetist's advice of a minimum of eight weeks between testing positive for COVID-19 and having elective surgery. If the intervention was to investigate a possible cancer this time scale was reduced to as soon as possible, as per guidance.

Managers and staff worked to make sure that they started discharge planning as early as possible. Patients were made aware of discharge arrangements and recommendations before arriving for surgery. At the time of discharge, they were given written information, which was reiterated to their relative or carer as the patient may still be slightly confused following anaesthetic.

Learning from complaints and concerns

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

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

Surgery

Staff understood the policy on complaints and knew how to handle them and told us they knew to report anything that was raised verbally to them on their electronic reporting system.

Managers investigated complaints and tried to identify themes. In the past year there had been five formal complaints and there were no identifiable themes linking them.

Patients received feedback from managers after the investigation into their complaint. Managers worked through a clear policy to investigate complaints, with time frames for steps to be completed and had escalation criteria to request further support.

Staff could give examples of how they used patient feedback to improve daily practice. For example, the inclusive communication training mentioned above was arranged following a concern raised by a transgender patient.

The service manager attended a weekly meeting with other service managers in their building to share learning from complaints and concerns more widely. It was recognised that learning could be applied across different services to reduce similar incidents happening.

Are Surgery well-led?

Good 

Leadership

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

The service manager was an experienced surgery department manager, and had previously managed surgery departments in the NHS. They were aware of the referral criteria and ensured they only accepted patients with needs they could accommodate.

All staff we spoke with told us their manager was open and approachable and supported them if they had a query or concern.

There was succession planning in place in the service, if the manager was unavailable there were identified deputy staff who were able to fulfil their duties until their return.

Vision and Strategy

The service was refining its vision for what it wanted to achieve and were developing a strategy to turn it into action and were involving all relevant stakeholders.

The service opened to patients in May 2020 and had been working to keep services safely running during the pandemic, and was in the process of developing their vision or strategy. They had a mission statement of “beyond better” to inspire staff to deliver the best care they could.

At the time of the inspection there were regular meetings to develop their formal vision and strategy, these included clinical staff and considered ways to ensure the service’s vision and strategy priorities aligned with their staff’s views.

Surgery

The wider corporate provider was also developing their strategy and a brand for staff to be aligned to known as “the Welbeck way”. This would apply to all staff, both clinical and non-clinical and was aimed at supporting them in refining their customer service.

Alongside developing their vision and strategy the service was finalising their values. These had been drafted and reviewed by staff at a recent meeting for comment. We were told they were being amended, following staff comments ahead of being finalised.

Culture

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

All staff we spoke with told us they were happy to work for the service and that they felt well supported by their managers and respected by their peers and other members of the team. All staff told us they had good working relationships and were able to freely communicate and ask questions or raise concerns about patient care.

Medical staff we spoke with told us they were appreciative of the support they, and their patients, received from both clinical and non-clinical staff and that they had an open and honest relationship with the service manager, if they did have any concerns.

Staff were given opportunities to develop and were supported to undertake training, when identified, as necessary.

Staff all told us they were happy to speak out and raise concerns if they were worried about something. They told us more senior members of the team were receptive to hearing their concerns.

Patients we spoke with told us they were happy with their care and treatment and felt that staff were open and honest with them. They told us that if they had a concern they would not hesitate to speak with a member of staff about it.

The service did not run formal staff surveys, instead asking staff for feedback in regular one to ones, annual appraisals or staff meetings. We were told if a member of staff wanted to raise a concern anonymously there was a whistleblowing policy and champion and also a freedom to speak up guardian that staff could approach, who did not work for the service, but in the wider corporate body. The contact details for these people were on display in the staff room.

All policies we read had an equality impact assessment completed to ensure the policy did not disadvantage any patients with protected characteristics.

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 and other local services.

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

Surgery

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

There was a local quality assessment and performance improvement committee that met every two months. The service manager attended this and discussed multiple areas of quality including updates to policies, incidents, improvement projects and audit results.

There was a medical executive committee that was responsible for the management of the clinicians working for the service. The medical executive committee reviewed any applications for practising privileges, and requests to introduce a new technology or technique and any concerns that had been raised about clinicians. The committee was chaired by the medical director and had representation from each of the surgical specialities to provide input and support.

The surgeons regularly attended discipline specific group meetings, to discuss their services, any developments and ideas for growth.

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

Management of risk, issues and performance

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

The service held a risk register, which included a thorough list of risks. Each risk had a review date, mitigating actions and a responsible person. They were regularly discussed at the quality assessment and performance improvement committee meetings.

The service had plans to manage unexpected events and had regularly serviced backup generators, in case of a power failure to ensure all theatre equipment continued working in an emergency. In addition to this the service ran regular practise emergency scenarios with staff to ensure everybody was prepared for events that happened rarely but were very time sensitive, such as major haemorrhage.

The service recognised there was a risk when introducing new techniques or technologies to such a small team. To reduce this risk the service required surgeons who were introducing a new technique to do a practise run in theatres, without a patient present. This gave all staff the opportunity to learn their roles and to ensure they had all necessary equipment to hand.

Clinician performance was managed by the medical director of the service. They told us they looked not only at individual clinician performance and patient outcomes but also individual consultant's conduct in their role, and whether any concerns had been identified about their behaviour towards other staff. There were communication channels with the NHS trusts the clinicians were employed and if concerns arose they were shared.

Other clinical staff performance was also challenged, we reviewed meeting minutes detailing a discussion resetting staff understanding of their expectations.

Surgery

Financial pressures were regularly discussed at operational meetings to ensure finances were not compromising the quality of patient care.

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.

The service's information systems were reviewed and maintained by the wider corporate brand they sat under and met requirements.

Staff underwent information governance training and had a named person to contact if they were concerned about any breaches.

Information was submitted to the Private Healthcare Information Network, as required by the Competitions Markets Authority (CMA).

The service regularly audited their clinical performance and engaged with staff and patients to review and improve the service.

Engagement

Leaders and staff actively and openly engaged to plan and manage services. They collaborated with partner organisations to help improve services for patients.

The service ensured patients had multiple platforms to give feedback, to try and get as much feedback as possible. Patients were able to do this electronically either online or using a bespoke smartphone application. If patients were unable to access the internet they were able to also provide feedback on paper forms.

In addition to generic patient feedback on the service they also participated in the national patient reported outcomes measures. They were starting new areas of data collection, above those collected nationally, to try and understand patient's views on their performance.

Feedback was requested from staff at regular staff meetings and in their one to ones. Staff told us they were comfortable to comment on future plans or changes to the service and meeting minutes demonstrated this to be the case.

The service worked well with the other clinical services under their corporate umbrella. We saw evidence of discussions and shared learning between the services in the meeting minutes we reviewed.

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.

The service had clear procedures all staff needed to follow to implement new technologies and techniques. Surgeons we spoke with told us about some of the new innovations that were due to be introduced and explained the procedures were not overly restrictive, but supported safe practice.

Surgery

The cardiac team described introducing new outcome measurements, over and above the national standard for patients treated for atrial fibrillation. The team were collating results with a view to publish in the future, once they had enough data.

The service had developed a bespoke smartphone application, that patients could choose to use to streamline their communication with the team.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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