The London Welbeck Hospital

Quality Report

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This report describes our judgement of the quality of care at this location. It is based on a combination of what we found when we inspected and a review of all information available to CQC including information given to us from patients, the public and other organisations

Overall summary

The London Welbeck Hospital is operated by Welbeck Health Care Limited. It is normally open from Monday to Friday 7am until 8pm but has arrangements to accommodate overnight patients. The hospital has 14 beds. Facilities include two operating theatres, a ward, a minor operations theatre and two consulting rooms for pre and post-operative checks.

The hospital provides cosmetic surgery procedures including abdominoplasty, breast augmentation and reduction and rhinoplasty.

We carried out an announced inspection on 23 November 2016. The hospital was previously inspected in October 2014 and we found the hospital had taken some action to address the concerns we found during that inspection.

To get to the heart of patients' experiences of care and treatment, we ask the same five 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.

We do not currently have a legal duty to rate cosmetic surgery services or the regulated activities they provide but we highlight good practice and issues that service providers need to improve.

We found the following areas of good practice:

- We saw good infection prevention and control (IPC) practices with housekeeping and clinic staff ensuring all areas of the hospital were clean and tidy. Staffs personal IPC practices were carried out to the highest standard.
- Staff were overwhelmingly positive about the local and senior leadership teams and felt they were listened to when they had concerns or suggestions for change.
- There was a service level agreement with both a local NHS and local independent hospital for those patients requiring level 2 and 3 critical care. This allowed patients a choice of NHS or private care if they became unwell.

Summary of findings

However, we also found the following issues that the hospital needs to improve:

- We found that only scrub nurses and some healthcare assistants had signed competency booklets. No other staff had signed competencies and senior staff could not be assured that all staff had the correct skills to carry out procedures.
- Staff in theatres were drawing up anaesthetic drugs in advance of anaesthetists being present in theatre. Although there were hospital prescriptions for these drugs they were not in line with best practice.
- Patient observation charts that we reviewed were not always completed fully and could put patients at risk of not being escalated for review by the relevant clinicians.
- An audit in June 2016 had highlighted poor compliance in documenting post-operative consultant visits but we could not view an action plan for this.
- Compliance with mandatory training including basic life support was variable across staff groups.

Following this inspection, we told the provider that it should make other improvements, even though a regulation had not been breached, to help the service improve. These can be found at the end of the report.

Deputy Chief Inspector of Hospitals

Professor Edward Baker

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Surgery		• Staff knew how to report incidents and there was evidence of learning and steps taken to prevent reoccurrence of incidents. Staff understood the duty of candour and we saw good evidence of adherence to the duty of candour regulation. • Staff were trained in safeguarding adults to a level appropriate to their job role. • The hospital reported patient outcomes in accordance with Private Health information and National Breast Registry. Care was delivered in line with relevant national guidelines such as National Institute for Health and Care Excellence and the Royal College of Surgeons. • The hospital had a local audit programme and where issues were raised action plans for change were completed and change implemented. • There were adequate numbers of both nursing and medical staff across the hospital. • Patients had effective and timely pain relief. • Both nursing and medical staff felt supported with supervision and revalidation and were given opportunities for further study. • There was good multidisciplinary team (MDT) working both within the hospital and with other local NHS and private hospitals. • Staff across the service were friendly, caring and professional, and patients were treated with dignity. • Patient flow from admissions, through theatres and onto to surgery wards was satisfactory and bed availability was not an issue. • We found a strong and supportive local and senior management team, with well-established members of staff across surgery services. Staff were proud and positive about working for the hospital. • There were comprehensive governance and risk management processes in place that fed back to both clinical and non-clinical staff to ensure an embedded learning culture.

Summary of findings

- Both patients and staff were given opportunities to provide feedback to the hospital. Where feedback was less than excellent the hospital managers would look at ways to improve care and working and provide solutions and improvements.

However:

- Medical and nursing records were generally well completed and stores safely. However, patient observation charts that we reviewed were not always completed fully and may have meant patients were not escalated for review by medical staff.
- An audit in June 2016 had highlighted poor compliance in documenting post-operative consultant visits but we could not view an action plan for this.
- Some theatre staff were drawing up anaesthetic drugs prior to the anaesthetist being present. This was not in line with best practice guidance.
- Compliance with mandatory training including basic life support was variable.

Summary of findings

Contents

The London Welbeck Hospital

Services we looked at:
Surgery

Summary of this inspection

Background to The London Welbeck Hospital

The London Welbeck Hospital is operated by Welbeck Health Care Limited. The hospital opened in 1986. It is a private hospital in central London. The hospital primarily serves the communities of the London area. It also accepts patient referrals from outside this area.

The hospital provides cosmetic surgery procedures to both male and female patients over 18 years old and under the age of 65, however consultants can operate on patients over the age of 65 at the surgeon's discretion.

It is registered to provide diagnostic and screening, surgical procedures and treatment of disease, disorder and injury.

We inspected the service under a sample in the wave of pilot of independent healthcare in October 2014. We found the hospital must ensure that there were arrangements for the care of level one patients and consider the risks of drawing up anaesthetic drugs before the theatre list commenced. The hospital had taken some action in response to our findings but more work was needed.

The hospital has had a registered manager in post since October 2012.

Our inspection team

The team that inspected the service comprised a CQC lead inspector and two specialist advisors with expertise in surgery and theatres. The inspection team was overseen by Margaret McGlynn, Inspection Manager.

Why we carried out this inspection

We undertook a comprehensive inspection of the hospital as part of our of our planned inspection programme of acute independent hospitals.

Information about The London Welbeck Hospital

The hospital has one ward with 14 beds for both male and female occupancy. There are two theatres, a recovery area and a minor operations room. There are two consulting rooms for pre-operative consultation or post-operative follow up. It has an onsite pathology laboratory. It is registered to provide the following regulated activities:

- Diagnostic and screening procedures
- Surgical procedures
- Treatment of disease, disorder, or injury

During the inspection, we visited the ward, theatres and the consulting rooms. We spoke with 14 members of staff including; registered nurses, health care assistants, reception staff, medical staff, operating department practitioners, and senior managers. We spoke with four patients. During our inspection, we reviewed 10 sets of patient records.

There were no special reviews or investigations of the hospital ongoing by the CQC at any time during the 12 months before this inspection. The hospital has been

Summary of this inspection

inspected once before in October 2014 which found that there were two "must-do" and several "should-do" areas for improvement. Some action has been taken but, more work is required.

Activity (July 2015 to June 2016)

- In the reporting period July 2015 to June 2016 there were 1595 inpatient and day case episodes of care recorded at The Hospital; of these 100% were other funded.
- 42% of other funded patients stayed overnight at the hospital during the same reporting period.

  Fifty two surgeons and anaesthetists worked at the hospital under practising privileges. Two regular resident medical officers (RMOs) worked on a two week on, two week off rota which worked 24 hours a day. The hospital employed five registered nurses as well as having its own bank staff. The accountable officer for controlled drugs (CDs) was the registered manager.

  The track record on safety showed that there were no never events and clinical incidents numbered 11 low harm and no serious injuries. There were 29 non-clinical incidents.

  There were no incidences of any hospital acquired infections noted in the year prior to our inspection.

  There were 10 complaints in the reporting period June 2015 to July 2016.

Services provided at the hospital under service level agreement:

- Decontamination of sterile equipment
- Medical Gases
- Human resources
- Laundry
- Partial pathology services
- Pest control
- Waste disposals

Summary of this inspection

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?

We do not currently have a legal duty to rate cosmetic surgery service.

- The hospital had a good incident reporting culture. This was completed via a paper system and learning was fed back via the management team and local leaders.
- The ward and theatres were visibly very clean and well maintained. There were effective infection prevention and control (IPC) practices.
- Medicines on the ward were stored and administered safely.
- Nurse staffing levels were suitable to meet the needs of patients. Medical staff provided regular patient reviews and were employed by the hospital. Consultants were employed by practising privileges and were on the GMC specialist cosmetic surgery register.
- Staff knew how to safeguard patients against abuse and had training to an appropriate level for their role.
- There was a major incident policy which staff understood and knew how to access.

However:

- Medical and nursing records were generally well completed and stored safely. However, patient observation charts that we reviewed were not always completed fully and may have meant patients were not escalated for review by medical staff. An audit had found poor compliance in documenting post-operative consultant visit but there was no evidence of an action plan to address this.
- However, some theatre staff were drawing up anaesthetic drugs prior to the anaesthetist being present. This was not in line with best practice guidance.
- Compliance with mandatory training, including basic life support was variable.

Are services effective?

We do not currently have a legal duty to rate cosmetic surgery service.

- Care was underpinned by evidence based practice including guidelines from National Institute of Health and Clinical Excellence (NICE), Royal College of Surgeons and British Association of Aesthetic and Plastic Surgeons.

Summary of this inspection

- The service collected information on patient outcomes and provided information to national audits such as Private Health Information Network (PHIN) and the National Breast registry. There was also a range of local audits in place to drive improvement.
- Patient pain was managed well with input from anaesthetics if required. Patients received analgesia in a timely manner.
- Staff received appraisals through their managers and some medical staff had access to the Responsible Officer within the hospital to have their appraisal completed. Nurses and doctors were supported to complete revalidation.
- We saw good examples of multidisciplinary working between staff within the hospital and also externally with several service level agreements. These agreements were in place with local hospitals and services such as infection control and pharmacy.
- Consent was completed with both the surgeon and anaesthetist present. We saw that all consent forms were fully completed and patients were given a copy of their consent form.

However:

- We were not assured that managers knew that all nursing and health care assistants were competent to complete all aspects of their role.

Are services caring?

We do not currently have a legal duty to rate cosmetic surgery service.

- Patients were positive about the care they had received at the hospital. We saw staff were caring and protected patients' dignity.
- Patients felt they were partners in their care and were well informed of all details they needed throughout the surgical journey.
- We saw staff provided emotional support for anxious patients and helped ease their concerns and worries.

Are services responsive?

We do not currently have a legal duty to rate cosmetic surgery service.

- There were no surgical cancellations in the year prior to inspection and no waiting times for patients to be seen at the hospital.

Summary of this inspection

- Theatre overruns were monitored but did not happen often. They were normally due to staff arriving late or a previous case overrunning.
- There was a translation service available for those patients whose first language was not English. There were facilities for those patients living with a disability.
- There were low numbers of complaints and these were investigated within the time frame set out in the hospital policy. Feedback was disseminated through the hospital manager.

Are services well-led?

We do not currently have a legal duty to rate cosmetic surgery services.

- There was a vision and values that staff had helped to develop and were aware of. Staff told us that they worked to achieve these at all times.
- A leadership structure was evident from senior management to local leadership, and staff were overwhelmingly positive about both local and senior management.
- Staff told us that there was an open and honest culture and they felt able to discuss their concerns and suggestions for change and these were listened to.
- There was a clear governance structure including an integrated governance committee, management board and medical advisory committee.
- The hospital asked both staff and patients for feedback and suggestions were actioned where possible.

Surgery

Safe	
Effective	
Caring	
Responsive	
Well-led	

Are surgery services safe?

Some aspects of safety need to be strengthened.

Incidents

- There were 11 clinical incidents and 29 non clinical incidents reported from July 2015 to June 2016. We saw themes included the anaesthetic machine not working and staff injury.
- Incidents were recorded on paper forms which were easily accessible to staff. They were kept by the hospital manager or put in to the patient's file if necessary. All incidents were reviewed and investigated by the theatre or ward manager. If the incident resulted in serious harm or injury the hospital manager would be informed and investigate. Themes were identified via a log that was kept in all clinical areas.
- The hospital manager and owner explained that they had recently looked at having an online reporting system within the hospital and had discussed this at the Medical Advisory Committee (MAC) meeting. Due to their low levels of incidents this was not a current possibility but further investigation was being carried out.
- There was a policy on adverse incident reporting with examples of incidents and near misses that staff should report. There were clear guidelines on the process of reporting an incident including informing the hospital manager and ensuring the safety of any person involved.Staff told us the types of things they would report and told us there was a no blame culture when reporting incidents.
- Incidents and investigation outcomes were discussed at the MAC, management board meeting and integrated governance meetings. There were no formal theatre or ward meetings to discuss incidents; however, the incident log with actions was visible for all staff to review on the staff notice board in each area. The hospital manager had daily walk rounds and updated staff on any new incidents and learning from these.
- Some staff told us of specific learning from incidents and explained that they had been asked to write reflections on practice following an incident. They told us this had been a beneficial learning experience that they had shared with colleagues. We saw that a new local anaesthetic prescription sheet had been developed and had to be filled out and signed by the anaesthetist to ensure patients were not given the wrong dose of local anaesthetic following an incident. One staff member told us that discharge paperwork labelling had been changed following a patient receiving the wrong information.
- Duty of Candour and its importance when reporting incidents was reiterated at the Medical Advisory Committee meeting and staff had been given a summary of their responsibilities in regard to duty of candour. Ward and theatre staff told us that they would always be open and honest with patients in case of an incident. Theatre staff gave an example of time there was an incident in theatre and how this was fed back to the patient. We reviewed three duty of candour letters sent to patients whilst on inspection which contained the outcome of the investigation and an apology.
- There was one incident of a surgical site infection between June 2015 and July 2015 which had been fully investigated at the time of inspection.

Clinical Quality Dashboard or equivalent

- Independent health providers do not have to use safety thermometer data to monitor areas such as falls,

pressure sores or venous thromboembolism (VTE). However, information provided to us prior to inspection showed that there were no incidents of VTE and 100% compliance with VTE risk recording.

Cleanliness, infection control and hygiene

- Areas we visited were visibly clean, tidy and uncluttered. We saw cleaning schedules completed daily by domestic staff. Domestic staff told us they had colour coded and disposable cleaning instruments. The domestic supervisor did weekly walk rounds to ensure all areas were cleaned to the highest standard.
- The hospital had infection and prevention control (IPC) policies on MRSA screening, hand washing, aseptic technique and decontamination of equipment. There was a ward based IPC link nurse who was assisted by an external IPC lead nurse for which there was a service level agreement in place which was updated yearly.
- There had been no incidents of any hospital acquired infections between June 2015 and July 2016. Patients had MRSA screening completed as part of pre-operative assessments from the referral clinics or consultant. No patient could be operated on in the hospital without a negative MRSA screen. If a patient had a MRSA screen done pre-operatively that was positive they had to get MRSA eradication therapy and produce a negative MRSA screen prior to surgery as per hospital policy.
- Between September 2015 and September 2016 100% of staff had completed mandatory training in IPC which was completed on a face to face course by the external IPC nurse.
- We reviewed hand washing audits completed in July 2016 which showed 95% compliance. On inspection we observed that staff used hand gel and washed their hands appropriately. Staff used personal protective equipment (PPE) as required.
- We saw a mattress audit was carried out by the IPC nurse and this showed 100% compliance with IPC standards. Previously this had indicated poor compliance and a full set of new mattresses had been ordered and were in use.
- An audit of staff carrying out aseptic technique was carried out in April 2016 which showed 100% compliance for the IPC standards including the use of sterile dressing packs, gloves and wound dressings.
- An action plan from August 2016 following an IPC audit showed that a patient bathroom had been de-cluttered, a new vacuum cleaner ordered and a new changing room for staff had been implemented to ensure the hospital was meeting IPC requirements.
- A lot of theatre instruments were single use and the hospital had a service level agreement with a local NHS trust for the decontamination of sterile theatre equipment. Staff said this worked well and there had not been any problems with sending and returning sterile equipment.
- Patients were given an IPC leaflet on discharge informing them of what would happen if they had an infection, details of the hospitals IPC team and how to contact them if a patient wished to.
- There was a full risk assessment completed for IPC with legal and company requirements and standards, current controls and the risk propriety with all controls in place. All risks with controls in place were marked as low risk.
- There was an infection prevention and control committee that formed part of the integrated governance committee, which met every three months. It prepared the yearly IPC programme of audits and teaching and ensured any issues were raised with the board. We saw that the MRSA screening programme was discussed at the April and November 2015 meetings.

Environment and equipment

- There were two resuscitation trolleys, one on the lower floor and one on the upper floor of the ward and one in theatre which were all checked daily and we saw check logs whilst on inspection. There was a difficult airway trolley available in theatre which was checked on a weekly basis.
- Both theatres had laminar flow ventilation which was best practice for ventilation within operating theatres. There was one minor operations theatre which was seldom used but was visibly clean and uncluttered.
- Equipment in theatres was easily accessible and staff checked dates and sterility prior to use. We saw evidence of maintenance logs for five pieces of equipment and staff told us there were records for all other pieces of equipment. Safety testing of equipment was marked with stickers on most of the equipment we saw.

- The ward equipment and environment was audited weekly and we reviewed the details of these audits whilst on inspection. Where there was non-compliance the managers of the respective areas would ensure that staff were aware of the changes that were required and that these were carried out prior to the next audit.
- Stock was ordered and delivered on a weekly basis and staff could write their stock requests in a ward book. All orders that arrived were recorded in the same book.
- There was an onsite maintenance team who would assist in fixing any broken or damaged equipment in a timely manner and staff told us how they would refer damaged equipment to the team.
- There was evidence that a laser used in theatres was appropriately risk assessed with goggles available for staff to use and fire risk assessments completed. There was a laser protection advisor who attended from an external body and a laser protection supervisor within the hospital. There was a policy for the laser use in case staff were unsure of guidelines surrounding its use.

Medicines

- A medicines management policy was available and included instructions on the administration, storage, ordering and disposal of medications. Staff told us this could be easily accessed via the intranet or paper format.
- The accountable officer for controlled drugs (CDs) was the registered manager.
- Medicines including CDs were ordered as required and delivery of the medicines had to be signed and dated with the member of staff who received them. Staff told us they had no issues accessing medications. There was a service level agreement with two local pharmacists for medication provision and advice for those medicines not stored on site.
- Take home medications for patients such as pain relief and oral antibiotics were kept on the ward in a locked cupboard. Labels were printed and attached to the medication boxes by the RMO once prescribed. The labels had detailed information about how and when to take the medications. Prescription pads were not used.
- When staff closed the hospital the medicines keys were kept in a locked safe within a locked room to ensure medicines were kept safe.
- There was a policy specific to controlled drugs management. This included delivery and receipt of CDs and how to manage any discrepancies in a CD count. Staff we spoke to knew how to manage a CD discrepancy but told us this had never happened. We saw daily checks of the CD registers in all areas were completed.
- We reviewed four medications charts and all had allergies recorded, signatures were legible and medications had been given as prescribed.
- Where medicines were kept in a fridge these were within the correct temperature range of between 2-8 degrees celsius and we reviewed a daily log that confirmed this.
- An audit carried out in November 2015 by an external pharmacist, under a service level agreement, showed several areas of medicines management that needed to be improved. Areas involved poor recording of fridge temperatures and labelling of discharge medication being completed in advance. Both of these areas had been rectified and we saw this on inspection.
- A local NHS consultant provided microbiology and antibiotic use advice if required via a service level agreement (SLA). Staff told us that consultants had different protocols on antibiotic use and if a patient required intravenous medicines on the ward the RMO was competent to administer them.
- Whilst on inspection we observed that operating department practitioners were drawing up anaesthetic drugs to be used by the anaesthetist. Staff told us that this was normal practice in the hospital. However, The Royal College of Anaesthetists (RCOA) recommends that drugs should be drawn up and labelled by the anaesthetist who will administer them. We saw a prescription in place for use which the anaesthetist could sign for drugs to be drawn up but this remained outside best practice guidelines. This was found on the previous inspection in 2014 and although the hospital had taken some action, it was still not in line with best practice and there was no evidence that a risk assessment had been carried out.

Records

Surgery

- In the three months prior to inspection no patients were seen and cared for in the hospital without their records being available.
- Records were kept in paper format and kept onsite. They were overseen by two members of staff. Records were kept in locked rooms and could be traced via a paper system. Staff told us no notes were ever taken off site by consultants.
- Staff completed information governance (IG) training as part of their mandatory training. We saw that new IG policies were discussed at the September 2016 MAC meeting and were awaiting board approval before being published.
- There was a monthly records audit completed by the Resident Medical Officer (RMO) and one by nursing staff. In June 2016 the RMO audit highlighted poor compliance in, four out of the five sets of notes reviewed, documenting of pre- discharge visits by consultants. The nursing notes audit from August 2016 showed compliance in most sets of the eight patients notes audited. The hospital manager told us that in 2017 they were due to undertake another large notes audit.
- There were set care pathways for monitoring patients undergoing certain procedures such as abdominoplasty, breast augmentation and a special pre-admission checklist for use by the RMO. These pathways included documentation of medications, past medical history and any concerns staff had.
- We reviewed 19 sets of records across the hospital and all patient details were recorded in each record including patient identifiers, care pathways and risk assessments. Notes were legible, signed and dated by the relevant clinician.

Safeguarding

- The safeguarding lead for the hospital was the registered manager who was trained to level three adult and child safeguarding.
- There was a safeguarding adults policy which detailed the steps to take to report a safeguarding incident and had contact details for the local authority in case a referral was required.
- Ninety seven percent of staff were trained to level two safeguarding adults and children between September 2015 and September 2016. Staff we spoke to told us how they would report a safeguarding concern and details of the local authority if required.
- There had been no safeguarding referrals to the CQC in the year prior to inspection.
- The hospital manager told us that they attended the local authority safeguarding meetings on a quarterly basis to keep up to date with changes in safeguarding in the area

Mandatory training

- Staff completed a range of mandatory training courses including safeguarding, health and safety, manual handling and fire safety. There were varying levels of compliance in each area from 74% in Basic Life Support to 100% in IPC. However, whilst on inspection, we were told that staff who completed their mandatory training within their regular hospital were not contained in the numbers provided to us. This was corroborated with information we saw in their HR files. The hospital was putting together a new spreadsheet that would incorporate both records of training.
- The RMO completed the mandatory training provided by the hospital and was up to date with all aspects of training at the time of inspection.

Assessing and responding to patient risk

- The hospital had pre-admission guidelines which staff were aware of. Patients not suitable for surgery at the hospital included those with severe cardiac and lung disease, unstable diabetes, blood disease and stroke.
- The hospital did not have critical care facilities to accommodate a patient who may have anaesthesia difficulties and this would be assessed at the pre-admission screening. The hospital would only take patients who required anaesthetic of ASA 1 or 2. An ASA score assesses a patient's physical fitness for surgery.
- The RMO used a pre-admission checklist the day prior to the patient admission and on arrival of the patient to screen patients who may not be suitable for admission.

The assessment included tests for obesity, blood tests and an ECG if required. Where necessary the RMO told us they would contact the anaesthetist or consultant if any answers raised concerns.

- There was a policy detailing how staff should transfer a deteriorating patient requiring higher level care to an appropriate hospital. It explained that if a patient was in cardiorespiratory arrest an ambulance must be called immediately. It had contact details for local NHS trusts that patients could be transferred to in an emergency. There was also critical care available via local independent hospitals.
- There were no unplanned transfers in the period July 2015 to June 2016.We reviewed three patient observation charts. The hospital used a National Early Warning Score patient observation chart in line with NICE guidelines CG50. We saw that two of the three charts had not been fully completed. One chart showed a patient had scored a three for their blood pressure and the doctor had not been contacted. When we asked the staff member to explain what had happened they told us that the patient had been to the toilet, had been asked to get back into bed and they had rechecked the observations again and noted that patient was then scoring a zero. The other chart had no score charted but all observations were noted to be in normal range. Staff we spoke to could tell how they would escalate a patient if this was required.
- The five steps to safer surgery including the WHO checklist was used in the hospital. We observed sign in, time out and sign out all completed during a patients operation. Staff told us and we saw that there was a team brief and de-brief completed at the beginning and end of each theatre session. We reviewed 15 sets of records all with fully completed safer surgery checklists. Audits for August to October 2016 showed that there was 100% compliance with the five steps to safer surgery checklist.
- The RMO was on site 24 hours per day seven days per week and had training in advanced life support. They were available at all times to review deteriorating patients. Consultants and anaesthetists were expected, as part of their practising privileges, to be within a one hour commute to the hospital and contactable via phone if their patients were in the hospital. Staff told us they had not had any problems contacting medical staff in the year prior to inspection.
- The hospital manager told us that those patients requiring psychological input prior to surgery would be carefully selected. They would involve the patient's GP if consent was given and if the patient had a notable psychiatric history they would not fall within the admission criteria.
- The hospital had visible protocols for obtaining blood in the situation that a patient needed a blood transfusion. They had a service level agreement with another local independent hospital (that was located very close) that blood would be ordered and couriered to the London Welbeck Hospital. There were two blood champion nurses and staff underwent training at the local independent hospital on how to give blood. However, as no staff had ever had to give blood within the hospital they could not have their competencies signed off. The RMO and anaesthetists had completed competencies in giving blood and could give this if required.

Nursing and support staffing

- The hospital provided staffing levels of one registered nurse to four patients. This was in line with the Royal College of Nursing Safer Staffing Guidelines.
- There were two full time nurses employed on the ward and three in theatre. A healthcare assistant supported ward staff and was employed by the hospital bank staff. Bank staff were employed in the same way as substantive staff and many had been full time at the hospital for several years.
- Bank staff were added to the rota four weeks in advance but were aware they could be cancelled at short notice. The numbers of staff were adjusted to ensure that patients needs were met. Staff told us they always had adequate numbers of staff both on the wards and in theatre.
- The safer nursing care tool was used alongside the association of peri-operative practitioner guidelines to staff theatres. Two scrub practitioners and one anaesthetic assistant, a circulating staff member and one recovery nurse per patient were present for each session.

- The hospital provided information which showed there had been no sickness and no staff vacancies from July 2015 to June 2016.

Medical staffing

- There were two RMOs who worked two weeks on, two weeks off in rotation and covered the hospital 24 hours a day.
- RMO responsibilities included assessing patients for admission, admitting patients to the ward, medicines management, completing discharge paperwork and following up any post-operative instructions. The RMO was very rarely disturbed overnight and when this occurred it was noted and the hospital manager made aware to assess if other arrangements were required.
- Consultants and anaesthetists were granted practising privileges if they met the hospital's criteria. They had to be recommended by the medical advisory committee and we saw minutes of the meeting in September 2016 which granted two surgeons full admitting rights and one surgeon specific admitting rights.
- Consultants were expected to be available by telephone 24 hours a day if they had patients within the hospital and within a one hour commute to the hospital to attend if required.
- The RMO told us there was very rarely an RMO to RMO handover as the hospital was shut at weekends. If they did require a handover this would be done on a Monday morning. We were told by the RMO that they would assess all the notes post-operatively for any instructions and had details of all the consultants should they require assistance on any aspect of patient care.

Emergency awareness and training

- The hospital had a business continuity plan which told staff what to do in case of an emergency such a flood or fire. They told us of one occasion they put this into action when there was a power cut in theatre, even though there was generator power, the list was cancelled for patient safety.

Are surgery services effective?

Some aspects of effectiveness need to be further developed.

Evidence-based care and treatment

- We saw that policies and procedures were in date with guidance from National Institute of Health and Care Excellence (NICE), Department of Health (DoH), Royal College of Surgeons and the World Health Organisation (WHO). Staff were able to access these in both paper format and online. Staff had access to computers in all clinical areas.
- Policies and procedures were ratified in the MAC meeting and by the board. The most recent MAC minutes in September 2016 showed that a recent policies on data security and information governance had been reviewed.
- Since our last inspection care pathways had been updated to include national guidelines. Pathways for abdominoplasty's and breast augmentation followed NICE guidelines, and RCN peri-operative fasting guidelines.
- The audits carried out for infection control followed guidelines from the Infection Prevention Society guidelines.

. **Pain relief**

- Whilst on inspection we saw patients had appropriate pain relief prescribed and were offered pain relief by staff and patients told us that they felt their pain was well managed.
- We saw that nurses documented pain scores as part of the patient observations. This was scored between one and three with one being no pain and three the worst pain the patient had experienced. We saw that after analgesia had been administered pain scores were reassessed.
- Patients had access to information on their post-operative analgesia. The hospital provided ibuprofen, codeine and paracetamol as take home medications following surgery. Side effects and cautions in use were discussed. Patients were encouraged to ask for more information about their analgesia if they had had questions.

Nutrition and hydration

- We saw that patients were asked to be nil by mouth for between four to six hours pre-surgery and this was in line with best practise guidelines.

- Nausea and vomiting was managed post-operatively by the anaesthetist and RMO and we saw that patients had been given anti sickness medications as required as per their prescription chart.

Patient outcomes

- The Hospital had provided information in September 2016 to the Private Healthcare Information Network (PHIN) as legally required by the Competition Markets Authority (CMA) and they were awaiting results to be published.
- The hospital had started to provide information to the National Breast Registry which was set up to ensure proper registration of all breast implants nationwide to allow for traceability in case of complication or issues with the implants.
- There were two unplanned readmissions and 10 unplanned returns to theatre between January 2016 and June 2016. There were no cancelled procedures. Medical staff told us the most common reason for return to theatre was due to a haematoma post procedure.
- The registered manager and head of the MAC explained that they were assessing ways to collect information for Q-PROMS which would assess the patient reported outcomes for cosmetic surgery but had not yet started this.
- There was a series of local audits including infection prevention and control, both medical and nursing notes, health and safety and medicines management. Where there was non-compliance with these action plans were put into place and changes made to practice.
- Consultants were required to feed back their patient outcomes as part of their membership to the British Association of Aesthetic Plastic Surgeons (BAAPS). This was not shared with the provider unless there was a complaint or concern about their practise.

Competent staff

- We saw that nursing staff were given the opportunity to complete further study such as infection prevention and control conferences and master's degrees. One member of staff we spoke to told us that they were undergoing further training as a healthcare assistant and this had been beneficial to their role. The registered manager told us staff would provide a formal expression of interest to study and each case would be considered individually.
- In theatres, scrub nurses completed a signed competency sheet to show they could carry out certain aspects of their role. Some theatre nurses had completed tracheostomy training. Some health care assistants had completed a care certificate on starting at the hospital. No other nursing staff had completed signed competency documents. We were not assured that managers knew that staff were competent to complete all aspects of their role.
- Three nurses had recently completed revalidation. Revalidation was introduced in 2016 by the Nursing and Midwifery Council to allow nurses to maintain professional registration. The registered manager was assisting staff to complete this as required.
- Medical staff were granted practising privileges once the MAC had assessed their applications. This included a CV, evidence of medical and surgical qualifications, evidence of specialist cosmetic surgery register registration, references, appraisal and revalidation data, GMC number and evidence of indemnity insurance. This was reviewed yearly and we reviewed four consultant's files all with the relevant and up to date paperwork.
- The hospital had a designated body of surgeons who received their appraisal through the Responsible officer within the hospital. The registered manager was trained to provide medical appraisals to ensure that all staff had the opportunity to complete a yearly appraisal. All medical staff had their appraisals completed at the time of inspection.
- Surgeons who wished to bring first assistants to theatre had to speak to the chair of the MAC. The first assistant would have to provide a copy of their CV, immunisation status and evidence of their interest or experience in cosmetic surgery. As part of practising privileges surgeons had to agree and sign that they would follow this process prior to bringing first assistants to the operating theatre.

- We reviewed the RMOs competency file and saw that all training was up to date including advanced life support (ALS) and advanced paediatric life support (APLS). We saw that there were references, evidence of appraisal and revalidation and GMC registration.
- Both inpatient and theatre staff had an appraisal compliance rate of 90% from July 2015 to June 2016 and 85% of staff had an appraisal complete up to the time of inspection. Staff we spoke to told us this had been a beneficial process allowing them to highlight good practice and obtain feedback on areas of improvement.

Multidisciplinary working

- We saw that there were service level agreements with local NHS trusts and larger independent hospitals so patients could be transferred if they were unwell or required further intervention in a high dependency setting.
- The hospital manager attended several external meetings including safeguarding with the local authority, a local hospital regarding blood transfusion and blood products and liaised with both the local NHS and independent hospitals about the transfer of unwell patients. They attended meetings with the clinics that carried out pre-admission consultations to ensure they were clear about the hospital's protocols and procedures.
- All staff told us that there were strong working relationships between clinical and non-clinical groups and we saw good examples of team working throughout our inspection. Staff told us they felt part of a "family" and everyone helped each other to provide high quality care.

Seven-day services

- Services at the hospital were normally provided Monday to Friday 7am to 8pm however there was provision for overnight and weekend stays if required and bank staff were on standby in case they were required.
- The RMO was available 24 hours per day seven days per week and consultants had to be available by phone and be within a one hour travelling time to the hospital if their patients were staying in the hospital. Staff told us they had never had any problem contacting a consultant.
- Out of hours there was an emergency theatre team on call which included a surgeon, anaesthetist, theatre nurses and ODPs who were all within a 45 minute radius of the hospital to cover unforeseen circumstances.

Access to information

- All policies and protocols were available to staff on the computer and in a hard copy kept on the ward and in theatre. Staff showed us how they would obtain these as required.
- We saw that patients were given details of their breast implants which they could store and a copy was also put into patient notes for reference if ever required.
- Notes were available to staff for each patient and were kept on site and tracked by administration staff. Staff told us there was never a problem with obtaining notes for patients.
- Staff told us that if patients consented they could inform their GP about their surgery and all discharge letters stated that patients should provide a copy to their GP for continuity of care.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- The valid and informed consent policy was available and had been reviewed in August 2015. It explained staff must be aware of patient capacity to consent to their treatment, consent must be taken and information given to the patient discussing the risks of the procedure and consent should not be taken at the time of the procedure taking place.
- Patients were given a two week cooling off period after they consented to treatment.
- Staff told us that if they had concerns over a patient's capacity to consent to treatment they would ask the consultant to review the patient immediately. They explained the principles of the Mental Capacity Act 2005 including acting in the patient's best interests.
- We saw that patients were given a copy of their consent form discussing the risks and benefits of the procedure on discharge in a discharge package of information. Patients confirmed that they had been told that they would receive this on discharge.

Surgery

- We saw good practice that both the consultant and anaesthetist would consent the patients for both the operation and the anaesthetic itself. We reviewed 15 consent forms all of which were fully completed for both surgical and anaesthetic consent and risks of both sections of the operation.

Are surgery services caring?

Compassionate care

- The hospital had a patient survey which showed between 93% and 100% of patients were likely to recommend the hospital to family and friends between July 2016 and October 2016.
- We spoke to four patients whilst on inspection and all told us they were treated with dignity and respect and each stage of their stay in the hospital. They told us that staff spent time with them and put them at ease.
- Patients told us that staff were attentive and we observed that call bells were answered in a timely manner.
- In theatre patients were covered appropriately and their modesty protected. Staff were kind and respectful to patients whilst they were under anaesthetic.
- Patients told us that staff were "calm and relaxed" and "all staff were really helpful".
- Interactions we saw between staff and patients were compassionate, empathetic and respectful and one patient described the staff as "very caring".

Understanding and involvement of patients and those close to them

- Patients told us that they were given time to ask questions and were given treatment options to best suit them. They told us that they felt involved in deciding the best treatment and were included in planning their discharge.
- We saw and patients told us that they were given a full overview of the risks and benefits surgery may present before making a final choice to go ahead with their procedure.
- There was information for each type of surgery available to patients pre-operatively and they were given this at clinic appointments prior to their arrival for surgery.
- All patients that we spoke to said they were fully informed of the fees that would be incurred during their stay and the possibility of extra fees. We saw that fees for minor procedures such as facial filler injections were visible on entry to the hospital.

Emotional support

- Patients were positive about the emotional support they received from staff especially around anxiety pre-and post-surgery. We saw that staff were empathetic towards patients and spent time alleviating patients concerns and anxieties.

Are surgery services responsive?

Service planning and delivery to meet the needs of local people

- The hospital resides in central London and cares for both a local, national and international population and can accommodate patients' families to stay if necessary.
- Staff are flexible with ensuring patients can stay an extra night at the hospital if they require or wish to following surgery. Staff are on standby to work both weekends and night shifts if required to meet patient need and safe staffing levels.
- There are two consultation rooms for patients to see medical staff for pre and post-operative consultation if they feel this is necessary to they receive continuity of care within the hospital.

Access and flow

- Patients could be seen at the London Welbeck Hospital or clinics in which consultants with practising privileges worked. The clinics were bound by service level agreement to use the admission criteria, risk assessment and pre-operative assessments when considering admitting patients at the London Welbeck Hospital.
- We saw that several patients had requested to come to the hospital in London from across the UK and this had been accommodated including an overnight stay if required which could be in either the hospital or a hotel.

- Patients were normally admitted as day cases but where an overnight stay was required patients were given information on this prior to admission. If a patient was unhappy to return home then staff would attempt to accommodate this and had staff on standby to work nights and weekends.
- Patients would arrive at the hospital by approximately 7.30am and be taken to their room. They would be seen by the RMO, Consultant and anaesthetist and assessed by the nurse with a baseline set of observations, orientated to the hospital and asked to choose a meal for post-surgery if they wished.
- Discharge was discussed pre-operatively to ensure patients had suitable transport to get home and someone to care for them once at home. Where a patient lived a distance from the hospital but required follow up hotel options were provided to allow them to stay close to the hospital.
- There were no cancellations of operations for non-clinical reasons from July 2015 to June 2016. Patients we spoke to told us they had not experienced any delays in booking a suitable time for their operations.
- We saw that theatre run times were monitored and between January and June 2016 the main issues with theatre finishing late was late staff or patients cases running late.
- Patients could return to the London Welbeck Hospital to have dressings renewed or stitches and drains removed if they required. This was done in a hospital bedroom by the Consultant or nurse. Alternatively, they were discharged back to the referring clinic or their GP.

Meeting people's individual needs

- There were toilet facilities for those living with a disability on the ground floor of the hospital. There was a portable ramp that could be used for those patients who had issues with their mobility to get into the reception area and around the ground floor of the hospital.
- Translation services were available through a telephone service. Staff told us that they would use these services for patients who did not speak English and needed to be consented. Some staff told us they would use a patient's family member for translation in situations other than consent.
- Patients could order food prior to their surgery which would be ready post-surgery as required. Patients could not be discharged without having something to eat and drink. Meals could be produced for special diets including cultural menus and intolerances.

Learning from complaints and concerns

- There have been 10 complaints from July 2015 to June 2016. Most were in relation to nursing care.
- Patients were provided with ways to raise a concern or complaint as part of a patient information pack found in the patient bedrooms. It included contact details for the hospital manager.
- All formal complaints were investigated and managed by the registered manager. Staff told us they would try to resolve any problems at a local level in the first instance. If the complaint became formal a nominated member of the board would undertake an independent and objective review. All complaints were discussed at the MAC meeting, integrated governance committee and management board.
- There was a two day response period and a further 20 days to formally investigate the complaint. All complaints had been responded to in this time frame.
- We saw that one complaint had involved poor communication and the staff involved had been asked to write a reflection on their practise to see if they could change the way they would handle a similar situation differently. Other staff told us about this complaint and the ward manager had spoken to staff about this particular incident and reminded them of behavioural standards expected of them.

Are surgery services well-led?

Vision and strategy for this this core service

- The hospital vision was written at the top of the board minutes as "Service excellence in cosmetic surgery" Both senior managers and junior staff told us that their

vision was to be the "best cosmetic surgery hospital" and to continue to provide high quality care and treatment to patients both nationally and internationally.

- Staff and managers told us that the vision and values were developed with input from all of the staff throughout the hospital to encourage people to be more accountable to the vision of becoming the best.
- Staff told us they did not engage in aggressive marketing to obtain business but instead relied on word of mouth from both surgeons and patients to ensure they did not portray a financial as opposed to patient focussed experience.

Governance, risk management and quality measurement

- There was a governance structure within the hospital. Wards and theatres did not have formal minuted meetings to discuss incidents, complaints and issues within the hospital. Instead they had a notice board which contained incident and complaints logs and learning from these and staff were expected to read these. The hospital manager completed a daily walk round of both the ward and theatres to inform staff of any concerns or positive feedback that had occurred. Staff were aware of incident and complaint themes and could refer to the paper log of incidents and complaints which was kept in clinical areas. Staff told us they could contact their line managers or the hospital manager to escalate any concerns.
- There was a quarterly integrated governance meeting which involved the ward and theatre managers, domestic staff, bookings manager, health and safety lead and IT staff. We saw minutes from April, July and November 2016 which included discussions on action plans from audits, health and safety reports and discussed the patient experience and complaints. We saw that incidents and patient safety were discussed and plans for improvement agreed.
- The MAC met quarterly and discussed areas including incidents, complaints, patient satisfaction and health and safety. They reviewed any new applications for consultants who wished to gain practising privileges and those consultants whose privileges should be removed. Minutes of these meetings were emailed to consultants who were not able to attend.
- The management board had oversight of the hospital and met quarterly and included the board chairman, hospital director and manager, Responsible Officer, head of booking and the MAC chair. During inspection we spoke to the board chairman who was a non-clinical member. We saw that discussion mirrored that of the MAC meeting and any discussions and decisions from the MAC were fed up for ratification at the board. Other discussions included the ROs report and implementation of new policies and procedures.
- Between governance meetings the hospital manager could organise meetings with any member of staff to discuss concerns, changes to practise or policy or any other business and meetings could be brought forward if required.
- The hospital had a risk register which contained items including scrub nurses working outside their role without the appropriate training. This had been discussed at the MAC and integrated governance meetings. We saw that a letter had been sent to each scrub nurse and consultant clarifying the role of the theatre scrub nurse and surgical first assistance to avoid confusion.
- Intermittent faults recorded with the anaesthetic machine were documented as a risk and this was being upgraded and on trial at the time of the announced inspection. The hospital owner explained that if staff found it was appropriate they would purchase the machine and this risk could be removed from the register.
- The risk register was discussed at the management board, integrated governance and MAC committee meetings. Discussions around staff taking ownership of risks in their areas were discussed with the overall aim being effective risk management. All risks had to be escalated to both the MAC and the board prior to being added to the risk register.

Leadership / culture of service

- The Hospital Director, also the owner of the hospital, was supported by a Deputy Manager and the management board which included a chairman, deputy chairman and board secretary. The hospital manager

oversaw the non-clinical and clinical staff and the MAC. There was a ward and theatre manager at a local level who would assist the hospital manager in case of annual leave or sickness.

- The MAC chair and Responsible Officer had overall responsibility in managing the medical workforce and granting and removing practising privileges.
- Staff spoke very highly of both the hospital manager and director. All staff we spoke to told us they felt part of a "family" and there was an open door policy for access to all senior staff. They told us they were visible on a daily basis and sometimes the hospital manager would work shifts including night. Staff felt confident to raise concerns or challenge poor behaviour if required. Many staff told us they felt "proud" to be part of the hospital and the team.
- Medical staff we spoke to reported a strong and open working relationship with the management. They told us they felt that they could challenge practise and would be challenged if required. They said there was open and honest communication throughout the staff body on reporting incidents and learning from these and there was no evidence of a blame culture.

Public and staff engagement (local and service level if this is the main core service)

- Patients were encouraged to complete a patient experience survey on their discharge. Where there were comments of a negative or concerning nature the hospital manager would contact these patients to gain further feedback on issues they had experienced.
- Staff told us that they felt involved in the running of the hospital through assisting with audits, helping to form the vision and values of the hospital and meeting with senior management on a daily basis. Where they had provided ideas for change these had been listened to and implemented, for example, getting new mattresses for the hospital beds or trialling a new anaesthetic machine.

Innovation, improvement and sustainability

- There had been several changes in practice since our last inspection. Staff had a better understanding of level one care for patients, the role of the scrub nurse and first assistant in theatre, their safeguarding responsibilities and patients were receiving their consent forms once they had been signed.

Outstanding practice and areas for improvement

Areas for improvement

Action the provider SHOULD take to improve

- The provider should ensure that staff have signed competencies completed and available for review as required.
- The provider should ensure that clinical staff complete NEWS charts in full to ensure that patients are not at risk of deteriorating and not being escalated for further review.
- The provider should continue with plans to undertake an audit of patient records and develop an action plan to address any problems.
- The provider should ensure that in line with best practice theatre staff are not drawing up drugs for anaesthesia.
- The provider should ensure that all staff complete mandatory training.
- The provider should to continue to work to collect information about patient outcomes.