

Welbeck Healthcare Limited

The London Welbeck Hospital

Inspection report

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

Ratings

Overall rating for this location		Good	
Are services safe?	Requires Improvement		
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

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 controlled infection risk well.
- Staff assessed risks to patients, acted on them and kept good care records. They managed medicines well. The service managed safety incidents well and learned lessons from them.
- Staff provided good care and treatment, gave patients enough to eat and drink, and gave them pain relief when they needed it. Managers monitored the effectiveness of the service and made sure staff were competent. Staff worked well together for the benefit of patients.
- Staff treated patients with compassion and kindness, respected their privacy and dignity, and took account of their individual needs.
- The service took account of patients' individual needs, and made it easy for people to give feedback. People could access the service when they needed it.
- Leaders ran services well using reliable information systems and supported staff to develop their skills. Staff felt respected, supported and valued and were clear about their roles and accountabilities.

However:

- We checked the equipment on the resuscitation trolley next to theatres and found that atropine in the anaphylaxis box on the was out of date and had expired in January 2022. There were also two blades in the tracheostomy kit which were out of date and had expired in February and March 2022 and a pair of gloves with the kit which were out of date and had expired in February 2021. The weekly checklist had been ticked as checked and complete even though these items were out of date.
- Not all staff were able to identify who the safeguarding lead was in the hospital.
- Not all staff had a full understanding and knowledge of the duty of candour.
- The service's staff survey response rates were low.

Summary of findings

Our judgements about each of the main services

Service

Surgery

Rating

Good



Summary of each main service

The London Welbeck Hospital is operated by Welbeck Healthcare Limited. It is a non-acute hospital providing elective cosmetic surgery procedures and is open 24 hours a day, seven days a week. The hospital has 14 beds and overnight facilities are also available. The hospital provides services to adults over the age of 18 years. There is a core team of permanent staff including the registered manager, three resident medical officers, ward and theatre managers and nursing staff, operating department practitioners, healthcare care assistants and administrative team members. Surgeons and anaesthetists working at the hospital use the hospital facilities under practising privileges.

The provider has three operating theatres, two consulting rooms and a ward.

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

We rated the service good overall. We rated safe as requires improvement and good for effective, caring, responsive and well led.

Summary of findings

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Summary of this inspection

Background to The London Welbeck Hospital

The London Welbeck Hospital is operated by Welbeck Healthcare Limited. It is a non-acute hospital providing elective cosmetic surgery procedures and is open 24 hours a day, seven days a week. The hospital has 14 beds and overnight facilities are also available. The hospital provides services to adults over the age of 18 years. There is a core team of permanent staff including the registered manager, three resident medical officers, ward and theatre managers and nursing staff, operating department practitioners, healthcare care assistants and administrative team members. Surgeons and anaesthetists working at the hospital use the hospital facilities under practising privileges.

The provider has three operating theatres, two consulting rooms and a ward.

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

The provider is registered for the following regulated activities:

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

We carried out an unannounced inspection on 19 April 2022. The hospital was previously inspected in November 2016 however it was not rated at the time as we did not have the authority to rate the type of service.

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? Throughout the inspection, we took account of what people told us and how the provider understood and complied with the Mental Capacity Act 2005.

How we carried out this inspection

We carried out an unannounced comprehensive inspection on 19 April 2022 using our comprehensive methodology.

The inspection team comprised a lead CQC inspector, a CQC policy officer who was shadowing the team and a specialist advisor. The inspection team was overseen by Nicola Wise, Head of Hospital Inspection for London.

During this inspection, the inspection team spoke with the registered manager, the director of the hospital, nurses, consultants, anaesthetists, healthcare assistants, domestic staff, administrative staff and patients.

We reviewed 11 patient records, personnel files and the hospital's policies.

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>.

Summary of this inspection

Areas for improvement

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

Action the service MUST take to improve:

- The service must ensure that expiry dates on equipment and medicines on the resuscitation trolleys are checked and monitored. (Regulation 12(2) e and g)

Action the service SHOULD take to improve:

- The service should ensure that all staff are aware of who the safeguarding lead is.
- The service should ensure all staff have a full understanding and knowledge of the duty of candour.
- The service should consider improving their staff survey response rate.






Our findings

Overview of ratings

Our ratings for this location are:

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

Surgery

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

Are Surgery safe?

Requires Improvement 

We rated it as requires improvement.

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. At the time of our inspection mandatory training compliance levels were 100%. Consultants and anaesthetists with practising privileges were required to provide evidence to the hospital that they had completed their training at their main place of work. We saw that their mandatory training compliance was monitored through a tracker which alerted the hospital when any training was due. The head of administration then followed this up with staff members and they would not be allowed to book theatre time/procedures until the modules had been completed. Consultants and anaesthetists also had the option to complete the hospital's mandatory training schedule. Resident medical officers' (RMO) also completed the hospital's mandatory training modules. At the time of our inspection, compliance levels were 100%.

Mandatory training was comprehensive and met the needs of patients and staff. Modules included basic life support, immediate life support, infection, prevention and control, health and safety, clinical skills including sepsis, safeguarding adults and children, duty of candour, mental capacity act and deprivation of liberty safeguarding, care of the deteriorating patient and manual handling.

Managers monitored mandatory training and alerted staff when they needed to update their training. The hospital organised training days dedicated to the completion of mandatory training modules. On these days, no clinical activity would take place and staff would attend the hospital purely to complete their mandatory training modules. We saw a schedule of the training days which were planned to ensure that 100% compliance could be maintained throughout the year.

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. However not all staff knew who the safeguarding lead was.

Surgery

All staff received training specific for their role on how to recognise and report abuse. There had been no safeguarding referrals made during the reporting period.

Staff were trained to level 2 and 3 in both children and adult safeguarding and compliance was 100% at the time of our inspection. The registered manager was the safeguarding lead. Staff knew how to identify adults and children at risk of, or suffering, significant harm. They knew who to inform if they had concerns, however not all staff we spoke to knew who the safeguarding lead was.

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

We reviewed the hospital's safeguarding adults and safeguarding children policies which were in date. The policies detailed individual responsibilities and processes for reporting and escalation of concerns.

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

Staff also told us they had taken part in the preventing radicalisation of vulnerable people programme (PREVENT).

The provider told us they would always double check that patients were over the age of 18 years by ensuring at the pre-admission stage, they complete identification verification by checking the patient's NHS number and passport.

Cleanliness, infection control and hygiene

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

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

The service performed well for cleanliness. The service had an infection, prevention and control (IPC) policy which staff signed to say they had read and understood the document. The service had an IPC lead and IPC champions within the hospital who carried out IPC audits.

There was a six-monthly general infection, prevention and control audit which looked at areas such as management of infections, hand hygiene, clinical practice, environment, waste management, linen and sharps bins. The pass mark was 85% and results in the reporting period were consistently at 100%. The provider also conducted monthly observational hand hygiene audits. The pass mark was 90% and the service was consistently achieving 100%. Any actions or improvements were noted at the bottom of the audit. The service conducted annual mattress audits to ensure they were in good condition and replacements made where needed. The service also conducted clinical practice audits which looked at surgical site infections, care of peripheral vascular devices, antimicrobial prescribing, urinary catheterisation. These audits were paused during the pandemic but had restarted since the service started seeing patients. Results of audits were shared with teams at the integrated clinical governance and risk management meetings which took place on a quarterly basis. We viewed the recent minutes from February 2022 which showed discussion around the infection control action plan where staff were reminded of infection control standards, updated protocols for COVID-19 testing for staff and continuation of the use of masks, personal protective equipment and an enhanced cleaning schedule.

Surgery

The service also employed an external provider to conduct an infection, prevention and control audit on a quarterly basis to provide additional assurance and action plans to ensure the service was following good practice in all areas of the hospital.

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

Staff worked effectively to prevent, identify and treat surgical site infections. There had been two surgical site infections in the last year. We saw that a full investigation and root cause analysis had been conducted in relation to these. The service had access to a consultant microbiologist who was accessible 24 hours a day, seven days a week. The consultant microbiologist helped with investigations of surgical site infections in addition to providing advice on the service's antibiotic policy and methicillin-resistant staphylococcus aureus (MRSA) or methicillin-susceptible Staphylococcus aureus (MSSA) infections.

Wards and theatres were visibly clean and free of clutter. Hand sanitisers were available in all areas including at the point of entry to patient rooms on the wards.

Staff followed infection control principles including the use of personal protective equipment (PPE). Throughout our inspection all staff were observed to be 'bare below the elbow' and adhered to infection control procedures, such as hand washing and using hand sanitisers when entering and exiting wards. There was easy access to personal protective equipment (PPE), such as aprons and gloves. We witnessed staff using PPE effectively. Patients we spoke with were satisfied with the level of cleanliness of their patient rooms.

We inspected a sample of patient rooms and en-suite bathrooms and found them to be visibly clean.

We inspected various items of equipment including blood pressure cuffs and bed tables and found a good level of cleanliness.

We spoke with the housekeeping staff who had a good knowledge around the Control of Substances Hazardous to Health (COSHH) and were able to show the daily cleaning checklists for all areas of the hospital. We reviewed the daily cleaning checklists for areas of the hospital and saw that they had been fully completed with no gaps. We observed housekeepers working throughout the day following cleaning protocols and schedules.

Most of the 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 told us that this worked well and they did not encounter any issues with the service.

All patients were swabbed for methicillin-resistant staphylococcus aureus (MRSA) during their pre-operative assessment. Staff would inform the IPC lead and consultant microbiologist when there was an infected patient in the hospital and the information would be highlighted in the patient's notes.

The last reported case of MRSA was in January 2022. We saw that this case was associated with the surgical site infection and had been investigated fully. There were no reported cases of MSSA or C. Difficile in the reporting period.

Environment and equipment

The design, maintenance and use of facilities, premises and equipment kept people safe. However, we found some items on a resuscitation trolley next to theatres that were out of date.

Surgery

Surgical patients were cared for on the first and second floor of the building. All patients were cared for in private single rooms with en-suite facilities. All patient rooms had a call bell next to the bed and emergency buzzers in the main patient bedroom area as well as the en-suite bathroom. Due to the layout of the building, patient rooms were not always close to one another, the doors were closed to ensure privacy and therefore could not easily be monitored by staff. The management team had recognised this as a potential risk if a patient were to deteriorate and in response, had created extra nursing stations nearer to the rooms so that staff could access the rooms quicker. In addition, the service ensured there was always one nurse to four patients at any one time with nursing staff allocated on each floor so they could quickly attend to patients. Following a procedure, all patients would be monitored by staff every 30 minutes for two hours following surgery and would not be discharged until four hours post-procedure so staff could ensure they were stable and it was safe for the patient to go home.

Theatres were based on the lower ground floor consisted of three operating theatres. All theatres had laminar flow. Laminar flow theatres aim to reduce the number of infective organisms in the theatre air by generating a continuous flow of bacteria free air.

There was a patient transfer lift from theatre to wards.

Medicines cupboards were locked to prevent unauthorised entry. Linen cupboards and storage rooms were appropriately stocked and tidy.

Emergency trolleys including a difficult airway trolley were available on wards and in theatres.

We checked the emergency trolley in the operating department/recovery area and found that they were secured with a plastic snap lock, so it was clear if someone had accessed the resuscitation equipment. Equipment in emergency trolleys were checked daily and weekly by a registered nurse on wards or operating department practitioner for the trolley in the operating department.

Resuscitation trolley check sheets listed equipment which was ticked as checked and signed by the allocated staff member to confirm checks had been made. However, when we checked the equipment on the trolley, we found that atropine in the anaphylaxis box on the resus trolley next to theatres was out of date and had expired in January 2022. This was a risk because in the event of a cardiac arrest, a patient may not be treated effectively with out of date atropine. There were also two blades in the tracheostomy kit which were out of date and had expired in February and March 2022 and a pair of gloves with the kit which were out of date and had expired in February 2021. This was an infection control risk if the metal blades had degraded and if the gloves snapped when in use. The weekly checklist had been ticked as checked and complete even though these items were out of date. We were therefore not assured the checking process was fully embedded and effectively completed. When we raised this with staff, they replaced the atropine and equipment immediately. Following the inspection, the registered manager told us that they were now going to add a second member of staff to check equipment on the trolley in the operating department and three monthly spot checks were going to be undertaken by the theatre clinical lead.

We saw evidence that equipment had been serviced and calibrated regularly. We checked various items of equipment such as defibrillators, diathermic machine, glucometer and blood pressure monitors and found they had been safety tested. We saw that safety checks had been completed and logged for anaesthetic machines.

We checked consumable equipment cupboards and found that all items we sampled were in date and packaging was intact, indicating it was sterile and safe for use in patient care.

Surgery

Lasers were used in theatres for some procedures. We saw that the use of lasers was appropriately risk assessed. Goggles were available for staff to use and there was an external laser protection advisor and a laser protection supervisor within the hospital.

Waste management was handled appropriately, with different colour coding for general waste, and clinical waste. All clinical bins were seen to be operated with lids and were not overfilled. Waste management and removal including those for contaminated and hazardous waste was in line with national standards. We inspected sharps bins and found them to be correctly labelled and not filled above the maximum fill line.

Equipment faults could be reported by staff and the service had an onsite engineer who could attend to any issues.

Assessing and responding to patient risk

Staff completed and updated risk assessments for each patient and removed or minimised risks. Staff identified and quickly acted upon patients at risk of deterioration. The service made sure patients knew who to contact to discuss complications or concerns.

Staff we spoke with were aware of escalation protocols for deteriorating patients and the use of national early warning scores (NEWS2). We checked patients' NEWS2 charts and found them to be correctly filled in. NEWS2 was audited as part of the nursing records audit. The audits were completed monthly on a random sample of ten patient records. We viewed the last four audits which showed consistently that the records were being completed in full. Any issues were discussed with individual staff members.

The use of the World Health Organisation (WHO) five steps to safer surgery checklist was embedded in practice and we saw that staff used this in theatres. The latest audits as from January 2022 to March 2022 showed 100% compliance for WHO checklist completion.

Staff we spoke with said they had received training in sepsis and the sepsis six care bundle which consists of three tests and three treatments for the management of patients with presumed or actual sepsis. There was a notice board on the ward with information on escalation, contact numbers and flowcharts for staff to follow for suspected sepsis.

Patients were assessed by the resident medical officer (RMO) prior to their surgery. The service followed National Institute for Health and Care Excellence (NICE) recommendations for pre-operative tests. The service risk assessed patients against their own pre-admission criteria as they were a non-acute facility managing a low risk category of patient (categorised as ASA 1 which is a healthy patient and ASA 2 which is a patient with mild systemic disease such as diabetes). If the patient was categorised as ASA 2, the service's RMO looked at the patient notes before admission and if anything was picked up in presurgical assessments (such as medical risks, clinical pathology), the provider declined the patient. The RMO would also escalate any concerns with the consultant.

The service did not treat high risk patients and had strict pre-admission criteria and did not accept bariatric patients with a body mass index (BMI) of 35 (32 during the pandemic) or greater and patients with complex co-morbidities. The service had reopened in July 2020 following the height of the pandemic and had been supporting the NHS prior to this by providing their theatre facilities for skin cancer surgery.

Surgery

We reviewed the pre-admission checklist which included the patient's COVID-19 status, if they had diabetes whether they had been admitted to hospital in the last year, completion of psychological assessment or letter from GP, HIV status, if they were a smoker, whether they had refrained from smoking for two weeks before the procedure, venous thromboembolism (VTE) risk, MRSA and MSSA swabs, familial cancer, asthma, pregnancy status, epilepsy and if they had been seizure free for a year. Patient notes we reviewed showed that this checklist had been followed.

Consultants who worked at clinics in London used the hospital's theatre facilities to undertake cosmetic surgical procedures. Consultations and preoperative assessments were undertaken by the consultant at their individual clinics and the record of this was double checked by the resident medical officer at the London Welbeck Hospital alongside the provider's own admission criteria. Psychological assessments were done on an individual basis at the point of consultation and the service held various templates which consultants used. While some patients received psychological assessments from consultants, the detail of this varied and so to further strengthen the assessment of a patient, the hospital was in the process of implementing a detailed psychological assessment tool to be undertaken for all patients accessing the hospital and were planning to put the use of this tool as a condition for a consultants' practising privileges at the hospital.

We saw evidence in patient notes that risk assessments had been completed. For example, notes showed that patients were assessed for venous thromboembolism (VTE) risk on admission and 24 hours after admission in patient documentation. VTE risk assessments were completed for all patients by nurses and VTE audits for the reporting period showed 100% compliance.

Patients received a discharge information letter when they were discharged from the hospital. The letter included information such as symptoms to look out for and a 24-hour telephone number to the wards if they had any concerns or needed advice post-discharge.

All nursing staff had completed immediate life support training, all healthcare assistants had completed basic life support training and resident medical officers (RMO) had completed advanced life support training. There was an arrangement with another independent health provider in cases of major or significant blood loss. There was a pathway, policies and procedure in place with staff specifically trained and signed off to maintain competencies in the case of major or significant blood loss.

If a patient deteriorated, nursing staff would escalate for support from the resident medical officer who was on site 24 hours a day, seven days a week. The provider would call 999 to arrange for transfer to a local NHS hospital depending on the severity of the patient deterioration. We reviewed adult medical emergency policy which explained the protocol for managing a deteriorating patient. The hospital also had a service level agreement with a local independent health hospital's critical care unit to care for patients who required level 2 or level 3 critical care.

In the reporting period, the hospital had two unplanned transfers to another hospital and had utilised their adult medical emergency protocol. The registered manager told us staff knew how to use the protocol and the service had received good feedback from paramedic staff. Staff also received a briefing following the transfers to share learning.

Consultants were required to be contactable by telephone and available to attend their patient at all times in the event of an emergency. At the point of booking, anaesthetists and consultants informed the hospital of who would be covering them if they were not able to attend to their patient. Cover would be provided by a staff member who had practising privileges with the provider. Anaesthetists and consultants were able to attend to a patient within 30 minutes of being called.

Surgery

The service had a back-up generator if there was a power outage during a procedure. As the service provided elective surgeries only, the business continuity plan outlined that in cases such as a power outage, the service would close and no surgeries would take place until the issue had been fixed.

Nurse and support 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. Managers regularly reviewed and adjusted staffing levels and skill mix, and gave bank, agency and locum staff a full induction.

The hospital used a nursing staffing tool to determine staffing levels. Managers accurately calculated and reviewed the number and grade of nurses and healthcare assistants needed for each shift in accordance with national guidance. The hospital always ensured there was one nurse to four patients.

Staff in theatres and the ward reported generally good levels of staffing although they reported that the service had recently had to increase agency staff usage due to the pandemic and staff needing to self-isolate. Staff sickness and turnover rates were low. Sickness rates in the reporting period was less than one percent. At the time of inspection, there was a vacancy for a ward nurse, scrub nurse and a healthcare assistant. Managers limited their use of agency staff and requested staff familiar with the service. All agency staff had a full induction, received an induction pack and were initially allocated to work with and be supported by substantive staff members.

The service undertook elective surgeries and was able to plan staffing accordingly. During our inspection we saw that there were enough staff allocated to theatres, recovery and the ward.

There was an information board on the ward and in the operating department which detailed the staffing level for the day, the nurse in charge, the resident medical officer, anaesthetists, consultants and the types of procedures that had been planned for the day.

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. There was always a resident medical officer (RMO) on duty 24 hours a day, seven days a week. The RMO was responsible for assessing patients for admission, admitting patients to the ward and completing discharge paperwork. There were three resident medical officers who worked at the hospital to ensure there was always an RMO to cover leave and sickness. All medical staff working at the London Welbeck Hospital had practising privileges with the hospital.

There were 48 active anaesthetists and 68 active surgeons who worked at the hospital under practising privileges.

Once they had their practising privileges approved, all medical staff received an induction to ensure they were familiar with the facilities at the hospital. Before starting work at the hospital, all medical staff met with the registered manager and head of administration to discuss practising privileges paperwork and governance expectations in relation to the practising privileges policy. The staff member would then receive a tour of the hospital and introductions from the theatre manager. The consultant would be required to fill in a preference card in readiness for practice. The card detailed the type of procedure the consultant undertook, the equipment they needed, glove sizes and other notes or comments such as consultant preferences for example having the scrub nurse on the left of the surgeon and the first assistant on the right of the surgeon.

Surgery

Consultants and anaesthetists worked under the London Welbeck Hospital's practising privileges agreements. Under practising privileges, a medical practitioner is granted permission to work within an independent hospital. Practising privileges were granted to consultants by the medical advisory committee. Consultants with practising privileges engaged with the medical appraisal system and mandatory training either through the NHS, the London Welbeck hospital or another independent service. The London Welbeck Hospital monitored annual compliance and followed up with staff when updates were required.

The provider's practising privileges criteria required surgeons to be on the specialist register and hold an NHS consultant post. The hospital removed practising privileges from consultants if there was non-compliance with documentation or under-utilisation at the hospital. In the reporting period, four medical practitioners were removed from the service's practising privileges list; two were due to retirement and two were because the staff members rarely attended the hospital.

Anaesthetists and consultants were responsible for their patients throughout their stay in the hospital. Consultant surgeons were required to be contactable by telephone and be able to attend to their patient within 30 minutes at all times or ensure there was suitable cover to attend to patients in the event of an emergency.

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. Staff recorded all cosmetic implants on the Breast and Cosmetic Implant Registry (BCIR).

Patient notes were comprehensive and staff could access them easily. Records were paper based and kept in a locked records room.

We reviewed 11 sets of patients records and found that they were comprehensive and detailed. Records contained information from the patient's initial consultation to referral to the London Welbeck Hospital for their procedures. We saw evidence of psychological evaluation and letters from the general practitioner (GP) obtained by the referring consultant.

Pre-operative assessments were checked by the resident medical officer to ensure patients were eligible for the procedure they were booked for and all risks had been assessed. Records were comprehensive and included the patient's medical history, medication they took, allergies, fasting, whether an interpreter was required, consent documentation, discharge summary instructions. Patients were also required to sign that they had understood the risks of venous thromboembolism.

We saw in patient records that risk assessments had been completed such as a venous thromboembolism risk assessment, fluid balance charts were completed, operation notes were legible, comprehensive and explained the procedure that was undertaken with postoperative plans clearly documented. A tool was used to ensure safe amounts of anaesthetic was being used. The amount of anaesthetic needed and given were recorded and signed by both the consultant and anaesthetist. We also saw that a COVID-19 questionnaire had been given to patients.

Records noted patients' additional needs such as if a patient required additional support for example if they were visually impaired or had mobility needs. National early warning system (NEWS2) observations were completed. Cosmetic surgery care pathways and nursing evaluation sheets were detailed and there was evidence that these were reviewed daily. The service used pain scoring and nausea scoring tools. We saw that there were stickers on records in order to be able to trace medical devices used. All cosmetic implants were recorded on the Breast and Cosmetic Implant Registry.

Surgery

We saw evidence in patient records and our observations in theatres that staff completed the safety checks undertaken during surgery.

Medical records were audited on a monthly basis and monitored the quality of the records and documentation. Audits showed that records were consistently compliant in all areas such as consent form documentation, record of a pre-discharge visit from the surgeon and detail of medication prescribed and given to the patient to take home.

Medicines

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

Suitable arrangements were in place for the ordering, dispensing, prescribing, recording and handling of medicines.

All staff undertook medicines management training as part of their mandatory training.

Medicines were stored safely in locked cupboards and fridges at nursing stations and theatres. Checks for expired medicines were completed as well as the daily temperature checks of the fridge used to store medicines. The fridge temperature logs that we checked were all within acceptable range. There was a drug expiry checklist on the walls of theatres.

Nursing staff were aware of the policies on the administration of controlled drugs (CDs) (medicine that is controlled under the 'Misuse of Drugs Act' (2001). CDs were stored in line with required legislation and recorded in a controlled drugs register. The register containing details of the contents of the CD cupboard was stored within the cupboard and identified the expected stock of medicine. Two members of staff checked and signed the CD stock levels twice a day. We checked a sample of CD stock levels and found them to be accurate and the medicine in date. The keys for the CD cupboard were held by the nurse in charge.

Medicines used in patients' procedures were clearly listed in the patient records. Patient records showed that the allergies were clearly documented when medicines were prescribed. Patients with allergies wore red wrist bands to ensure staff could easily identify that the patient had an allergy.

Medicines to take away (TTA) were listed within patient notes and stored securely until the patient was discharged. Prescription pads were kept in a locked cupboard to prevent unauthorised access.

There was a protocol in place for the safe use of local anaesthesia. In the case of liposuction performed under tumescent local anaesthesia there was the necessary medicine readily available to use in the event of toxicity. The service had staff with the appropriate training to monitor the patient for signs and symptoms of toxicity. There was always an anaesthetist and operation department practitioner (ODP) with the training to interpret and monitor and respond to a deterioration.

At our last inspection we observed ODPs drawing up anaesthetic drugs before the anaesthetist was in the room which was against best practice. At this inspection, we observed that this no longer happened.

Oxygen cylinders were stored securely and were in date.

Patient notes showed that the service comprehensive and explained the procedure that was undertaken with postoperative plans clearly documented. A tool was used to ensure safe amounts of anaesthetic was being used the amount of anaesthetic needed and given were recorded and signed by both the consultant and anaesthetist.

Surgery

The provider had a service level agreement with an external pharmacist for advice on medicines.

The service undertook controlled drugs audits as part of monthly medicines management audits. Results were consistently at 100%. In addition, the service had a yearly medicines audit conducted by an external company. We reviewed the latest report and saw that the service had carried out the recommendations from the report for example introducing pain management audits.

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 what incidents to report and how to report them. Incidents were reported on paper forms which were submitted to the theatre or ward manager who investigated the incident with the registered manager. We saw examples where staff had raised concerns and reported incidents in line with the service's policy. In the last year there were 12 incidents which reflected less than one percent of the total admissions at the hospital. Three were graded as high, two were graded as moderate and seven were graded as low. We viewed the investigations for the incidents and found them to be detailed with action plans in place.

Staff received feedback from investigation of incidents, both internal and external to the service. Learning from incidents and patient safety alert updates were discussed at quarterly integrated clinical governance and risk management meetings. The provider encouraged incident reporting and had a phrase: 'See it, report it and together we will sort it' and the registered manager produced a poster detailing feedback from incidents reported and actions arising from the incidents. Theatre and ward staff had informal meetings monthly where incidents and learning would be discussed and shared and actions following incidents was displayed on the wall of the operating department and ward area. We saw a recent poster which detailed that the service had bought new equipment in response to incident reporting from staff.

There was evidence that changes had been made as a result of feedback from staff. For example we spoke to a staff member who had requested machines which monitored the depth of anaesthetic to improve patient safety and we saw that these machines had been brought in by the service.

Managers investigated incidents thoroughly and produced a root cause analysis report. All reports had corresponding action plans in place where action needed had been identified. Patients and their families were involved in these investigations. Managers debriefed and supported staff after any serious incident. We saw that incidents were investigated in detail and a tool was used which looked at the situational factors, organisational factors, local working conditions and communication and culture related to the incident. A summary was then written up with the most contributory factors with any action plans implemented.

For additional sharing of learning purposes, the registered manager had linked with the national reporting and learning system to report patient safety incidents.

Staff understanding of the duty of candour was variable. While they understood the need to be open and transparent, and to give patients and families a full explanation if and when things went wrong, staff were unable to describe the apology element of the duty of candour.

Surgery

Are Surgery effective?

Good 

We rated it as good.

Evidence-based care and treatment

The service provided care and treatment based on national guidance and evidence-based practice. Managers checked to make sure staff followed guidance. The service met cosmetic surgery standards published by the Royal College of Surgeons.

Staff followed up-to-date policies to plan and deliver high quality care according to best practice and national guidance. The service delivered care in line with national clinical guidance. Staff had access to policies and procedures based on national guidance. Policies were available on the hospital internal computer systems and in paper form.

We reviewed a sample of hospital policies including policies for safeguarding adults, pre-operative assessment, medical records management, consent, chaperone policy, adult medical emergency policy, sepsis, resuscitation, controlled drugs, practising privileges and duty of candour which were all in date and appropriately referenced national guidance and best practice such as that recommended by the National Institute for Health and Care Excellence (NICE) and the Royal College of Physicians.

Policies were reviewed by the registered manager and any changes and updates were reviewed and approved by the medical advisory committee. Staff were informed of changes at twice monthly departmental meeting and also received emails alerting them to changes that had been made to policies.

The provider was a member of the independent care providers network and the registered manager ensured any updates were shared with the relevant teams. The service also monitored updates from BAAPS (British Association of Aesthetic Plastic Surgeons).

The service monitored data such as: infection control, returns to theatre, incidents, complaints, patient safety, health and safety, medical records which were all audited quarterly.

There were noticeboards throughout the hospital for staff informing them of new guidelines, updates and policies as well as health and safety messages, incidents reported, patient feedback and wellbeing notices for staff.

The service used evidence based 'care bundles'. A care bundle is a set of evidenced based interventions that, when used together, can improve patient outcomes. For example, we saw that staff used the sepsis six care bundle which consists of three treatments and three tests for the management of patients with presumed or actual sepsis.

We saw that there was a formal annual clinical audit schedule in place to evidence performance monitoring, quality measures or patient outcomes. The audit schedule detailed the frequency at which the audits should be undertaken and included audits for infection prevention, medicines management, medical practitioners performance, WHO five steps to safer surgery, nursing records, and medical records. Managers monitored and discussed results at integrated clinical governance and risk management meetings.

Surgery

Nutrition and hydration

Staff followed national guidelines to make sure patients fasting before surgery were not without food for long periods.

There were appropriate processes in place to ensure patients' nutrition and hydration needs were met on the ward.

We saw that catering staff were made aware of patients' dietary requirements. Food menus catered for different patient groups including those with specific dietary requirements such as allergies and intolerances. Nurses could bring patients toast and drinks throughout the day from the kitchen to patients who requested this. Patients staying the night told us they could also request for special meals to be delivered to them.

Fasting instructions were given to patients at the pre-operative assessment stage and patients told us that staff checked with them that they understood the instructions.

We reviewed fully completed fluid charts which were used to monitor patients particularly after a surgical procedure.

Pain relief

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

Staff gave pain relief in line with individual needs and best practice. They assessed patients' pain using a standardised pain assessment tool to measure patients' pain. Patients were asked to describe their pain with a score of zero (no pain) to ten with corresponding smiley face symbols so patients could indicate how they were feeling if they were unable to speak. Patients told us they received pain relief soon after requesting it.

We saw from patient records we reviewed that staff prescribed, administered and recorded pain relief accurately.

Patients were reminded upon discharge that they could call the ward at any time if they were experiencing pain or had any questions following their procedure.

Pain management was not audited however the service did ask patients about adequacy of pain medication in their patient satisfaction surveys. Although there were no issues reported in relation to pain management from the surveys, the service told us that after a recent update of their medicines management policy, as part of good practice, they were about to start undertaking a pain management audit and had received a pain management tool from their external link pharmacist.

Patient outcomes

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

The hospital audited patient outcomes and reported on these at integrated clinical governance and risk management meetings and at the medical advisory committee.

To monitor quality of care and outcomes, the provider looked at consultants' key performance indicators every three months. We viewed minutes of the last clinical governance meeting which showed discussion around key performance indicators such as unplanned readmissions, unplanned returns to theatre, unplanned transfers out of the service, healthcare associated infections and significant incidents.

Surgery

In the last year, the service saw 1853 patients. 1041 (56.2%) patients attended for day case procedures and 812 (43.8%) were inpatient attendances. In the reporting period there was 22 returns to theatre which was 1% of the total number of patients treated.

Patients were also given surveys to complete including post discharge and this was collated and submitted to the private healthcare information network (PHIN). PHIN is an independent patient information network that works to empower patients to make informed choices about their care provider. Details on surgeons involved were also submitted quarterly to PHIN.

The service participated in patient reported outcome measures (Q-PROMs) for cosmetic surgery. Patient reported outcome measures assesses the quality of care from the patient perspective. Patients undergoing cosmetic surgery are asked to complete questionnaires before and after their operations to assess improvement in health and health-related quality of life and how this has been changed by the surgical intervention as perceived by the patients themselves. Questions asked to patients who had undergone procedures such as abdominoplasty, breast augmentation, rhinoplasty showed that most patients answered that results from procedures were 'excellent' and for the question 'how do you look now compared to before you had the procedure', most patients answered 'a lot better'.

Adherence to and understanding of NICE guidelines was embedded and evidenced through the use of audits to benchmark practice. The service was able to demonstrate that it participated in national clinical audits such as patient reported outcome measures (Q-PROMS) and the national breast and implant register.

Outcome data including patient reported outcome measures (Q-PROMS) was reviewed by the registered manager and results were discussed at integrated clinical governance and risk management meetings and medical advisory committee meetings.

The registered manager also monitored consultants' key performance indicators every three months. The consultant would be required to submit to the registered manager a document which listed the number of operations/procedures complete for the year to date, the number of unplanned readmissions, the number of unplanned returns to theatre, the number of unplanned transfers to other hospitals, adverse clinical incidents, diagnosed post-operative deep vein thrombosis, surgical site infection rates, the number of formal patient complaints, the number of serious events. Any concerns would be escalated to the medical advisory committee where the outcomes would be discussed.

The hospital reported surgical site infections. In the last 12 months, the surgical site infection rate was less than 1% (2 cases). There had been a full root cause analysis with input from the microbiologist and discussion held at the medical advisory committee.

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 at the quarterly integrated clinical governance and risk management meetings where staff from all departments attended. Any immediate issues were raised within individual departments' informal team meetings as and when required.

Competent staff

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

Surgery

Staff were experienced, qualified and had the right skills and knowledge to meet the needs of patients. New staff received a comprehensive induction and all staff had to complete competency booklets which were signed off by senior members of staff once a competency had been achieved. We reviewed the competency booklets for all staff including healthcare assistants and saw that 24 tasks and skills were assessed and signed off by managers.

Staff told us that their training needs were met, and managers were always willing to support their development. Information from integrated clinical governance and risk management meetings were shared with staff via email. Theatres and wards held their own informal meeting twice a month and there were larger team meetings which were held in conjunction with the teaching day where staff refreshed their mandatory training.

At the time of our inspection, 79% of staff had had their appraisal (41 staff members).

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

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

A number of staff had taken on roles as link nurses in various specialities. For example, the service had IPC nurses and champions.

Medical staff were granted practising privileges by the medical advisory committee who assessed their applications. In order to be granted practising privileges, medical staff were required to submit their CV, with evidence of their surgical qualifications, appraisal and revalidation data, GMC number and evidence of indemnity insurance. All medical staff had to undergo a medical appraisal annually. The provider held a policy that described the medical appraisals process. The head of administration was responsible for ensuring that the database of medical staff was up to date and that they had had their medical appraisals. The head of administration then provided quarterly reports of medical appraisal compliance to the medical advisory committee. There was a responsible officer responsible for all of the medical practitioners and ensured their appraisals were up to date to meet the requirements of the practising privileges agreement.

All consultants under practising privileges received an induction pack which included details on what was required of them to practise at the London Welbeck Hospital. The registered manager also monitored consultants' key performance indicators every three months. The consultant would be required to submit to the registered manager a document which listed the number of operations/procedures complete for the year to date, the number of unplanned readmissions, the number of unplanned returns to theatre, the number of unplanned transfers to other hospitals, adverse clinical incidents and complaints.

If a surgeon wished to bring first assistants to theatre, they had to speak with the chair of the medical advisory committee and the first assistant would be required to submit their CV and qualifications.

Multidisciplinary working

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

Staff held regular and effective multidisciplinary meetings to discuss patients and improve their care.

Surgery

The provider had service level agreements with an independent healthcare provider to transfer patients for critical care provision. They also had an agreement with a local NHS hospital with regards to blood transfusion and blood products.

During the height of the pandemic the service provided equipment and also supported the NHS by providing their theatre facilities for skin cancer surgery.

Due to the nature of the service where patients came from many different sources, multidisciplinary meetings focused on improving the procedures and how to safely deliver them rather than discussions about individual patients. For example, the service organised further training for staff around transgender awareness to further support the patient groups the hospital served.

Staff spoke of a good relationships with anaesthetists and surgeons. We saw good team working between clinical and non-clinical groups.

Seven-day services

Patients could contact the service seven days a week for advice and support after their surgery.

The London Welbeck Hospital was open 24 hours a day, seven days a week. On discharge, patients were given a telephone number to call at anytime of the day if they had any concerns or questions. This was a direct line to the ward and would be picked up by the nurse in charge who could also receive advice from the resident medical officer on duty who was available 24 hours a day, seven days a week. Patients also had the details of the consultant whom they could call if they had questions prior to their post-surgery follow up appointment.

We were told that out of hours surgery was very rare and any returns to theatre were usually booked for the following morning before the booked lists for the day. There was an out of hours theatre team consisting of a surgeon, anaesthetist, theatre nurses and operating department practitioners who could attend the hospital within 30 minutes.

Health promotion

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

Staff assessed each patient's health at the pre-assessment stage and provided support for any individual needs to live a healthier lifestyle. Patients told us they received advice and support from consultants to lead healthier lives such as smoking cessation and a healthy diet which was encouraged prior to undergoing surgery.

Patients told us that ongoing care such as appointments with therapists were organised for them by their consultant.

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 and ensured that patients gave consent in a two-stage process with a cooling off period of at least 14 days between stages. They understood how to support patients.

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

Staff gained consent from patients for their care and treatment in line with legislation and guidance involving a two stage process with a cooling off period of 14 days where they could change their mind about their decision to undergo cosmetic surgery.

Surgery

Written consent including anaesthetic and surgical consent was sought from the patient. Written consent was also sought prior to surgery and on the day of surgery. The service also had a COVID-19 consent form which patients were required to sign. Depending on the procedure, consultants ensured that patients were reviewed by a psychiatrist prior to undergoing cosmetic surgery.

All records we reviewed showed that staff clearly recorded consent in patient records. We also observed consent being confirmed with patients in theatre prior to anaesthetisation.

Staff received training on the Mental Capacity Act (2005) as part of their mandatory training. Staff understood the relevant consent and decision-making requirements of legislation and guidance, including the Mental Health Act and Mental Capacity Act 2005 and they knew who to contact for advice.

Are Surgery caring?

Good 

We rated it as good.

Compassionate care

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

Staff were discreet and responsive when caring for patients. We saw staff took time to interact with patients in a respectful and considerate way. Patients we spoke to and feedback we reviewed consistently reported that staff treated them with kindness and compassion. We observed all staff in theatres, and wards to be caring and compassionate in their interactions with patients.

Staff we spoke with understood and respected the individual needs of each patient and showed understanding and a non-judgmental attitude when caring for patients.

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

We viewed comments from patient feedback forms which were overwhelmingly positive. Comments included: "Right from admission to discharge, I felt respected and supported. No question or request was too much"; "All of the staff are lovely, caring and supportive. I felt very well cared for here"; "The nurses were lovely, put me at ease straight away on admission. Very attentive throughout my stay and things were explained really well to me"; The nurses made me feel comfortable. Took their time with me and treated me with respect and dignity; "Continuously friendly and respectful. Had no issues using the correct name and pronouns on everything"; The whole experience has been fantastic. I have felt so well taken care of and put at ease. All staff have been lovely and welcoming, facilities are comfortable.

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 emotional support and advice when they needed it.

Surgery

Staff understood the emotional and social impact that a person's care, treatment or condition had on their wellbeing and on those close to them. Staff described to us how they had supported patients who became anxious in an open environment such as when they arrived in theatres.

Due to the COVID-19 pandemic, the hospital did not allow visitors however on a case by case basis the hospital allowed patients to be supported by a loved one as long as the person had undertaken testing to ensure they were COVID-19 negative and as long as they agreed to stay in the premises during the duration of the patient stay to minimise infection risks.

Staff were passionate about their work and focused on delivering patient centred care. We observed staff spending time speaking with a patient. Staff told us they could leave the patient's room door open if requested so they did not feel so isolated in their private room.

We spoke to a patient who told us that staff helped allay their fears of waking up from surgery without their glasses on and not being able to see clearly. Staff reassured them that they would make sure they would wake up from surgery with their glasses on. We then observed staff ensuring this happened.

Patients were given a direct line to the ward when they were discharged so they could call for advice and support at any time of the day.

Patient records showed that a patient's cultural and religious needs were documented.

Understanding and involvement of patients and those close to them **Staff supported patients to make decisions about their care and treatment.**

Staff involved patients in decisions about their care and treatment. Patients told us they felt comfortable asking doctors and nurses questions and felt involved in their treatment plans. Patients told us staff spent time explaining and were happy to repeat any details that they did not understand.

Patients told us that conversations about finances were done so with sensitivity at the beginning of the process and that they had all the information they needed before deciding to proceed.

The hospital gathered feedback from patients and undertook an annual patient survey. In 2021, of the 139 patient responses, 98% said they were involved as much as they wanted in decision around care and treatment, 98% found someone in the hospital to discuss any worries, 100% said they were given enough privacy when discussing treatment and 99% were told about medication side effects. 99% said they were told who to contact if they had worries post-discharge, 100% felt treated with respect and dignity. 96% of patients rated their experience as 'very good' and 96% of patients said they would recommend their consultant to friends and family. 100% of patients said they had confidence in the care given by their consultant.

Are Surgery responsive?

We rated it as good.

Surgery

Service delivery to meet the needs of the patient population

The service planned and provided care in a way that met the needs of their patient population.

Managers planned and organised the service so they met the needs of the patient population. As the clinic provided private elective cosmetic surgery, appointments were planned in advance at times to suit the patients. The service was open seven days a week for post-operative wound care appointments. Theatre lists were planned in advance.

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

Facilities and premises were appropriate for the services being delivered. There was a waiting area, where hot and cold drinks were available for patients.

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. There was a system for referring patients for psychological assessment before starting treatment, if necessary.

Staff understood and applied the policy on meeting the information and communication needs of patients with a disability or sensory loss. We saw examples where staff had supported a patient who was visually impaired. We saw theatre staff taking care of a patient's glasses and making sure they woke up from surgery with their glasses on as requested. Staff told us that the hospital had also arranged for a specific medicine to be ordered for a patient with epilepsy just in case they needed it.

The service was inclusive and took account of patients' individual needs and preferences. Patient records detailed a patient's additional needs, ethnicity and religion. Staff made reasonable adjustments to help patients access services. Patients were able to book surgery dates to suit their plans and commitments. Due to the COVID-19 pandemic, the hospital did not allow visitors. However, staff told us that if a patient required a carer or partner to stay with them to support them emotionally, special arrangements could be made on a case by case basis to ensure they could stay with the patient.

The service had adjusted hospital consent forms to accommodate for transgender patients when indicating whether they are male or female. Forms had also been updated to include whether a chaperone was requested and the name of the chaperone was inputted on the form.

Depending on the procedure, consultants ensured that patients were reviewed by a psychiatrist prior to undergoing cosmetic surgery or had a letter from their GP. We saw that this was recorded within patient notes.

The hospital was also in the process of implementing a psychological assessment tool to be undertaken for all patients accessing the hospital and were planning to put the use of this tool as a condition for a consultants' practising privileges at the hospital.

The service had access to a telephone interpreting service for patients who did not speak English as their first language. We saw some leaflets in the reception area of the hospital however they were only available in English.

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

Surgery

The service told us they did not see patients with dementia or learning disabilities. Staff told us they did not have access to communication aids to help patients become partners in their care and treatment but that if a patient did require additional support, they would make sure these were in place prior to their admission.

Upon discharge, patients were given a discharge information leaflet relevant to the procedure they had had which detailed a telephone number to call if they had any concerns, 24 hours a day, seven days a week. Calls would go straight to the ward where there would always be a nurse and resident medical officer on duty to offer advice and support. Patients also had the option of calling their individual consultants. Patient feedback forms were also given to patients. The leaflets were available in English but not in other languages.

There was wheelchair access within the hospital and a portable ramp could be used to access the entrance of the hospital into the reception area which was served by steps. Patient lifts were available in the building.

Access and flow

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

There was timely access for cosmetic surgery at the London Welbeck Hospital. In the reporting period there had been 75 cancellations; 14 had been cancelled on the day by the consultant due to clinical reasons and 61 had been cancelled by the referring source due to various reasons such as the patient testing positive for COVID-19 or the patient changing their mind about surgery. There had been two unplanned transfers to another hospital.

In the last year, the service saw 1853 patients. 1041 (56.2%) patients attended for day case procedures and 812 (43.8%) were inpatient attendances. All surgical procedures were elective which meant that workflow could be planned. Surgeons were allocated theatre times in advance to allow prior planning of theatre activity. Timings for the use of theatres was staggered and the third theatre was in use two to three times a week to accommodate for any unplanned returns to theatre. Theatre lists were discussed each morning in the nurses' office. Any changes were relayed to staff including the resident medical officer.

We followed the patient journey through theatres and found that patients were transferred from recovery to the ward appropriately and without delay. Staff reported that they did not experience access issues moving patients from theatres to recovery as capacity was never at 100%. Patients had a designated room on the ward which was reserved from admission so there were no delays moving patients back to the ward.

There were enough beds on the ward for patients who required an unexpected stay overnight, for example patients undergoing day case surgery.

Staff told us that the discharge process was effective and medicines to take away were prepared before discharge so a patient did not need to wait for this upon discharge. Discharge arrangements were discussed with the patient on admission to ensure they had suitable transport home after their procedure. Patients had the choice to be seen at the London Welbeck Hospital to have dressings removed or they could go to their referring clinic or GP.

Learning from complaints and concerns

The service treated concerns and complaints seriously, investigated them and shared lessons learned with all staff. The service included patients in the investigation of their complaint. The service had a system for referring unresolved complaints for independent review.

Surgery

We looked at the complaints log for the hospital. From January 2021 to April 2022, the service received three formal complaints. We reviewed all three complaints and saw that they were responded to in line with the provider's complaints policy. Complaints were investigated, learning was identified, and the hospital apologised to patients when something went wrong.

Complaints were overseen by the registered manager. We reviewed investigations of complaints which were comprehensive and detailed. The service had put in actions and learning from complaints. Managers shared feedback from complaints with staff and learning was used to improve the service. Staff could give examples of how they used patient feedback to improve daily practice.

Complaints were discussed at integrated clinical governance and risk management meetings, medical advisory committee meetings and board meetings.

There were a number of ways patients and families could send feedback including filling in feedback forms. Patients we spoke with were aware of how to make a complaint and told us they felt comfortable about speaking directly with staff if they wanted to complain.

Nurses said they tried to address concerns as they arose by speaking to patients directly and explaining how they would address their concerns.

The service clearly displayed information about how to raise a concern in patient areas and on their website. Patients were also provided with information on how to make a complaint to the Independent Healthcare Sector Complaints Adjudication Service (ISCAS) if they were not satisfied with the hospital's complaints process. From January 2021 to April 2022, one complaint was referred to ISCAS.

Are Surgery well-led?

Good 

We rated it as 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.

The senior management team consisted of the registered manager and hospital director. Day to day leadership was management by the senior management team on site which included the registered manager, theatre manager, ward manager and head of administration. The senior management team attended the integrated clinical governance and risk management meetings with all staff where incidents, complaints, mandatory training rates were discussed with the clinical teams.

All staff spoke highly of the ward and theatre leadership team as well as the hospital senior management team. Both nursing and medical staff spoke of good teamwork.

Staff told us they were supported by their managers to develop their skills and access development opportunities.

Surgery

All staff including domestic staff, commented on the friendliness and visibility of the senior management team in the hospital and that they felt able to approach them.

Leaders had a strong understanding of issues, challenges and priorities in their service. Consultants told us they felt listened to and encouraged by the leadership team.

Vision and Strategy

The service had a vision for what it wanted to achieve and a strategy to turn it into action.

The service's vision was "to be the number one cosmetic hospital in the UK where customers feel safe and know they will receive the best of care." The service's values were: "positively welcoming, clearly communicating, visibly reassuring, actively respectful, highly professional."

The service's strategy was to identify and act to meet emerging regulatory requirements and trends in cosmetic surgery. The registered manager told us that the hospital planned to develop a better IT system across the service including moving to electronic patient records to better assist staff to provide high quality care to patients.

Most staff were able to describe the vision of the service but not all were able to recall the values or strategy of the service.

Culture

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

Staff were passionate about their work and spoke of good teamwork in a patient-centred environment. We found an inclusive and constructive working culture within the hospital among both clinical and non-clinical staff.

We found an open and honest culture and staff told us they felt supported by their managers. They told us the senior management team were visible throughout the hospital. Staff including the housekeeping staff we spoke with told us that senior leaders were friendly and knew them by name.

Leaders promoted a positive culture that supported and valued staff, creating a sense of common purpose based on shared values. The registered manager was actively involved in the day to day management of services. Staff we spoke with told us they felt able to report concerns to their managers and spoke of an open-door policy.

Consultants we spoke with told us there was a supportive culture and they felt able to approach the senior management team. A consultant told us they had made a request for new equipment which they felt would further improve patient safety and this was taken on board by the senior team who swiftly acquired and brought the equipment into the hospital.

Staff gave us examples of times when they directly approached the registered manager to express concerns or requests that they had and how they had been supported and listened to.

Staff we spoke with were proud of working at the London Welbeck Hospital and spoke highly of the culture, referring to there being a family atmosphere within the hospital.

Surgery

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.

Governance structures were in place at the service. Staff we spoke with had a good awareness of governance arrangements and knew how to escalate their concerns. There were a number of meetings where staff could voice their concerns.

The medical advisory committee (MAC) met quarterly and reviewed clinical quality and governance matters including risks, incidents and practising privileges. The registered manager told us that the quarterly MAC meeting and board meetings were challenging and scrutinising of governance issues. The registered manager also met with the chair of the medical advisory committee every two weeks to discuss any governance issues and ensure there was oversight of issues in between the formal meetings. There was a responsible officer responsible for all of the medical practitioners and ensured their appraisals were up to date to meet the requirements of the practising privileges agreement. The chair of the medical advisory committee assessed applications for practising privileges and the applications would be discussed and agreed at the medical advisory committee meeting.

There were quarterly integrated clinical governance and risk management meetings which was attended by ward and theatre managers administrative staff, the registered manager and domestic staff. Minutes we review included feedback from audits, incidents, complaints and patient feedback.

Ward and theatre teams held informal meetings monthly to discuss incidents, audit results and safety alerts. There were also teaching days three to four times a year where the service closed to the public and the day was dedicated to ensure all staff could make sure they were up to date with their mandatory training.

Management of risk, issues and performance

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

There was a corporate risk register and a separate risk register for the ward and theatres which were maintained by the ward manager and theatre manager. Risks on the risk registers were reviewed regularly and discussed at the integrated clinical governance and risk management meetings as well as the medical advisory committee. Each risk was given a rating, review date and a set of control measures.

The issues and risks which managers identified were in line with what we found on inspection and there was alignment between these and the risks outlined on the risk register. For example, the service was aware of the risk presented from having individual patient rooms spread across two floors and due to the layout of the building, this could not be changed. To mitigate the risk a number of measures had been put in place such as there always being one nurse to four patients, a dedicated nursing team for each floor and nursing stations located closer to the rooms.

There was a formal audit plan in place for theatres and the ward which outlined the frequency of the audits and dates of the audits. Audit results were fed back at the integrated clinical governance and risk management meetings.

Surgery

Information Management

The service collected reliable data and analysed it. Staff could find the data they needed, in easily accessible formats, to understand performance, make decisions and improvements. The information systems were integrated and secure. Data or notifications were consistently submitted to external organisations as required.

Staff had access to patient's health records and the results of investigations and tests in a timely manner. The service had paper records which were well organised and stored securely in a locked room accessible only to staff with authorisation. The service had recently transferred all administrative human resources paperwork to a digital system and were considering the impact of doing this for patients medical records.

There were effective arrangements to ensure the confidentiality of patient identifiable data. Computer stations we saw were logged out when not in use.

The hospital had their own IT system which produced data reports on areas such as complaints, incidents, patient feedback.

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

Engagement

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

Patients were encouraged to share their views on the quality of the service through feedback questionnaire booklets which were given to patients on discharge.

Staff were engaged in the planning and delivery of the service. Staff told us that they felt able to suggest new ideas to their managers and that they were listened to. Staff told us they felt looked after and told us they were provided with lunch as well as snacks throughout the day and they were encouraged to take their breaks. We visited the staff break room which was spacious and accommodated the staff.

We visited the staff break room where we saw space for staff to relax, snacks and tea and coffee making facilities readily available. Staff told us that although during the pandemic, social events had been limited, the service did arrange Christmas parties and social gatherings. In addition, at the end of the year, all staff received a bonus and 'thank you' gift from the leadership team for their hard work.

We saw posters in the staff areas, reminding staff of the employee assistance programme which was a free, confidential helpline which staff could access 24 hours a day, seven days a week for advice related to work or any other other issues.

The hospital did undertake a staff survey which asked questions such as job expectations, harassment, bullying, culture of listening, colleague and manager support and workload. In the last staff survey, the service received responses which which were overall positive with high scores around goals and objectives and relationships with managers. However, we noted that the response rate was low with 16 responses from the 64 permanent staff at the hospital, (49 clinical and 15 administrative staff).

Learning, continuous improvement and innovation

All staff were committed to continually learning and improving services.

Surgery

Staff were committed to continuous learning. Staff told us they were supported by their managers to develop their skills and access development opportunities.

The hospital had recently transferred HR documentation to a digital system and was in the process of doing this for patient records.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Treatment of disease, disorder or injury Surgical procedures	<p>Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment</p> <p>Regulation 12: safe care and treatment</p> <p>(2) Without limiting paragraph (1), the things which a registered person must do to comply with that paragraph include--</p> <p>(e) ensuring that the equipment used by the service provider for providing care or treatment to a service user is safe for such use and is used in a safe way;</p> <p>(g) the proper and safe management of medicines;</p> <ul style="list-style-type: none">• We found that atropine in the anaphylaxis box on the resus trolley next to theatres was out of date and had expired in January 2022. There were also two blades in the tracheostomy kit which were out of date and had expired in February and March 2022 and a pair of gloves with the kit which were out of date and had expired in February 2021. The weekly checklist had been ticked as checked and complete even though these items were out of date.