Queen Anne Street Medical Centre Limited

Quality Report

18-22 Queen Anne Street
London
W1G 8HU
Tel: 0207 034 3301
Website: www.enquiries@qasmc.com

Date of inspection visit: 23 February 2017
Date of publication: 04/08/2017

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

Ratings

Overall rating for this location	Requires improvement
Are services safe?	Requires improvement
Are services effective?	Requires improvement
Are services caring?	Good
Are services responsive?	Good
Are services well-led?	Requires improvement

Summary of findings

Letter from the Chief Inspector of Hospitals

Queen Anne Street Medical Centre Limited is operated by Dr Brian Leaker. The service has one inpatient and four day care beds. Facilities include one operating theatre and recovery area, outpatient and diagnostic facilities.

The service provides a range of surgery to adults only. This is predominantly cosmetic in nature, although there are some general eye surgery and endoscopic procedures undertaken. They also provide private consultations and outpatient diagnostics, which include pulmonary function tests, colposcopy and cardiac function test. We inspected surgery and the outpatient department using our comprehensive inspection methodology, and included our outpatient findings within the surgical report. We carried out an announced inspection on 23 February 2017.

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.

The main service provided by this location is surgery.

Services we rate

We rated this hospital as requires improvement overall.

- Professional practice guidance was not always adhered to in the operating theatre. The clinic was not following The National Institute for Health and Care Excellence (NICE) guidelines CG65 Hypothermia, Prevention, and management. This was highlighted to the medical director and since the inspection; we have seen evidence of the appropriate course of action the service has taken with regard to hypothermia management.
- Within the operating theatre equipment used for managing a patient with a difficult airway was not logically stocked or fit for purpose. Some items of equipment were stored separately, which would reduce the response time, and checking of this equipment was not being routinely undertaken. Wall mounted patient use equipment storage boxes and trolleys were not sufficiently clean.
- The new safeguarding policy for children and adults did not refer to female genital mutilation (FGM).
- The arrangements for collecting reliable information on patient outcomes were limited. Further, the effectiveness of services provided was not subject to detailed audit against national guidance.
- The risk register did not have detailed information about the level of risk and mitigations. There were no risks related to outpatients on the risk register. Further, the governance arrangements were not sufficiently robust for managing risks.

However we found the following areas of good practice:

- Staff we spoke with understood how to report an incident. Feedback would be given through theatre team meeting and on a one to one basis.
- Staff had access to infection prevention and control policies and had received necessary training. There had been no reported incidents of hospital acquired infections for the period October 2015 to September 2016.
- We found there were sufficient number of appropriately skilled staff to care for patients that were receiving care and treatment.
- Staff in theatres followed the World Health Organisation's safety checklist and these were completed appropriately.

Summary of findings

- There was a designated safeguarding lead and there were appropriate numbers of staff trained in safeguarding. Staff we spoke with were able to give examples of what would constitute a safeguarding referral to be made.
- Patient care was consultant-led and there was 24-hour cover provided by a resident medical officer who was based on site.
- There were systems to check the competencies of consultants who had applied to work under practising privileges at the service. This process involved the application being reviewed and agreed by the medical advisory committee.
- Systems had been implemented to ensure staff received an annual appraisal.
- Consent was sought prior to treatment and surgical procedures.
- Staff were caring, compassionate, and treated patients with dignity and respect. Their privacy and dignity was maintained, and staff ensured patients were involved in how their care was delivered.
- Services were delivered in a way that met the needs of patients who attended the service. The service had clear admissions criteria, which meant they were able to exclude patients they were not able to provide care and treatment for.
- Managers were aware of the need to develop their service and to ensure the sustainability by responding to new markets.

Professor Edward Baker

Deputy Chief Inspector of Hospitals London

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Surgery	Requires improvement 	Surgery was the main activity of the hospital. We rated this service as requires improvement for safe, effective, and well-led but good for caring and responsive.

Summary of findings

Contents

Requires improvement

Queen Anne Street Medical Centre Limited

Services we looked at: Surgery and Outpatients

Summary of this inspection

Background to Queen Anne Street Medical Centre Limited

Queen Anne Street Medical Centre Limited (QAMC Ltd) is a private independent acute care hospital, operating under the same provider name. The service was established in 2005, and is located in central London, easily accessible via public transport.

The service primarily serves the communities of London and accepts patient referrals from outside this area, including from overseas.

QAMC Ltd provides specialist medical care offering a range of surgical surgery, outpatient consultations and diagnostics. In addition, there are separately registered services related to clinical trials, which do not come under the regulatory functions of the Care Quality Commission.

The service provides a range of general cosmetic surgery, such as; full facelift, brow lift, neck lift, breast surgery, including breast enlargement and reduction. Abdominal surgery included buttock augmentation. The service also provided genitalia procedures including; hymenoplasty, labiaplasty, and penoplasty. Other surgical procedures undertaken include eye surgery, liposuction and nose surgery.

Endoscopic procedures undertaken in the operating theatre include; bronchoscopy, hysteroscopy, and cystoscopy.

There are on-site consultation facilities and access to some diagnostics, including exercise electrocardiographs, pulmonary functions tests, ultrasound, and colposcopy.

The service was registered in January 2011 with the Care Quality Commission for the following regulated activities:

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

The hospital has a registered manager who is also the nominated individual. There is a designated controlled drugs accountable officer (CD AO).

The most recent inspection was carried out in September 2016 in response to concerns brought to the attention of the commission. Whilst we found no breaches in the regulations, we made a number of recommendations to address identified shortcomings.

Prior to this, a comprehensive inspection was undertaken on 16 May 2013, where the service was found to be meeting the required standards at the time.

We made an announced inspection visit to the service on 23 February 2017.

Our inspection team

The team that inspected the service comprised Stella Franklin, a CQC inspection manager, an inspector, and a specialist advisor with expertise in operating theatres and nursing. The inspection team was overseen by Nick Mulholland, Head of Hospital Inspection.

Information about Queen Anne Street Medical Centre Limited

The service is situated in a building which also provides separately registered activities, including those related to clinical trials. Services are arranged over five floors, with the lower basement used as storage. The main surgical areas are located on the ground floor.

The first floor contains consulting rooms including an ophthalmic suite, the QASMC Pharmacy, a four-bedded ward area that is used for diagnostics and non-invasive tests; a single bedded investigation area currently used

Summary of this inspection

for invasive investigations such as urodynamics and ultrasound investigations. The single bedded area may also be used as an overnight stay area if required as it contains en suite facilities.

The second floor houses the six bedded clinical trials unit with diagnostic facilities and lung function as well as the research laboratory.

The third floor contains consulting rooms and a cardio-pulmonary diagnostic suite. The hospital administration and Quality Assurance departments are located on the fourth floor.

The service has one operating theatre and a two-bed recovery area. Staffing of the theatre/surgical area is independent of the other services. The outpatient department was staffed according to pre-planned arrangements.

The service is registered to provide the following regulated activities:

- Diagnostic and screening procedures (10 January 2011)
- Surgical procedures (10 January 2011)
- Treatment of disease, disorder or injury (10 January 2011)

In addition to the surgical and outpatient services, Queen Anne Street Medical Centre Limited undertakes clinical trials. Designated areas within the location were set aside for this activity, which does not come under the responsibilities of the Care Quality Commission.

During the inspection, we visited the operating theatre and recovery area. We visited the consultation and diagnostic treatment areas, pharmacy and the overnight bed facility. We spoke with 14 staff including; registered nurses, health care assistants, reception staff, medical staff, operating department practitioners, and senior managers. We spoke with one patient. Although we provided the service with 'tell us about your care' comment cards, none of these were completed. During our inspection, we reviewed six 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 service had been inspected four times previously, and the most recent inspection took place in September 2016. The latter inspection was a focused visit carried out in response to concerns raised with the Care Quality Commission. Our findings following this inspection were that the service was meeting the standards of quality and safety we specifically assessed. However, there were some actions we asked the provider to take in order to make improvements.

Activity (January 2016 to September 2016)

- In the reporting period January 2016 to January 2017, there were 401 day case episodes of care recorded at the service. There were five in-patient stays in the same period.
- The number of patients who attended the outpatient department for the first time was 800, and those returning for a follow up was 451. The main category of outpatient attendances was for ophthalmic (35%) followed by aesthetic/cosmetics (20%), and health checks (15%). Urodynamics accounted for 10% of activity, and gynaecology 8%. Other outpatient activities accounted for 5% or less of throughput.

Surgical specialties include:

Gynaecology

Urology

Andrology (The medical specialty that deals with male health, particularly relating to the problems of the male reproductive system affecting male fertility and sexuality).

Endoscopy

Cosmetic

Ophthalmic

General surgical procedures

Surgical activity by type for the period October 2015 to September 2016:

- 49 Cataract removals.
- 40 Xen insertions.
- 32 Liposuctions.
- 31 Breast augmentations.
- 23 Labiaplasty

Summary of this inspection

- 12 Rhinoplasty
- 9 Hairline lowering.
- 7 Hymenoplasty.

15 surgeons, 11 anaesthetists, 13 physicians, and two radiologists worked at the service under practising privileges. A regular resident medical officer (RMO) worked on day shifts, covering the surgical services until all patients had been discharged. The surgical service employed 2.66 whole time equivalent (WTE) registered nurses, 1 WTE health care assistant and two receptionists, as well as having its own bank staff. The accountable officer for controlled drugs (CDs) was the general manager.

Track record on safety

- There had not been any never events in the period October 2015 to September 2016.
- There were 12 clinical incidents at the location, two of which occurred within surgery in the same reporting period.
- There was one non-clinical incident within surgery or inpatients.
- There were no serious injuries reported and no inpatient deaths in the period October 2015 to September 2016. It was confirmed there were no incidents in these categories subsequently.
- There had not been any serious injuries.
- There were no incidences of hospital acquired meticillin-resistant Staphylococcus Aureus (MRSA)
- There were no incidences of hospital acquired meticillin-sensitive Staphylococcus Aureus (MSSA).
- There were no incidences of hospital acquired Clostridium Difficile (c.diff).
- There were no incidences of hospital acquired E-Coli.
- There had been four complaints in the previous year up to the time of our inspection.

Services accredited by a national body:

- Clinical trials were regulated by the Medicines & Healthcare products Regulatory Agency (MHRA).

Services provided at the location under service level agreement:

- IT services
- Record keeping
- Clinical and or non-clinical waste removal
- Interpreting services
- Laser protection service (Currently lasers not in use)
- Laundry
- Maintenance of medical equipment
- Pathology and histology
- RMO provision

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?

Requires improvement

We rated safe as requires improvement.

- The contents of the difficult airway box needed to be reviewed in theatres, and regular checks should be undertaken on this equipment to ensure items are readily available.
- There was no protocol to demonstrate compliance with keeping patients warm (NICE guideline CG65). Such guidance relates to the prevention and management of hypothermia in adults having surgery.
- Cleanliness arrangements needed to improve in relation to storage facilities in theatre.
- The safeguarding policy did not include guidance on female genital mutilation (FGM).

However:

- Staff knew how to report an incident and would receive feedback through team meetings or on a one to one basis.
- Staff received the necessary training for infection prevention and control practices. Staff were able to access relevant policies. There were no reported incidents of hospital acquired infections between October 2015 to September 2016.
- The World Health Organisation's checklist was followed and completed in theatres.
- There was a designated safeguarding lead and an appropriate number of safeguarding trained staff.
- The hospital was visibly clean and tidy. Staff in all areas used appropriate hand hygiene techniques and complied with the hospital's policies and guidance on the use of personal protective equipment.
- The arrangements around medicine optimisation were safe.

Are services effective?

Requires improvement

We rated effective as requires improvement.

- Professional practice guidance was not always adhered to in the operating theatre.
- The current arrangements for collecting reliable information on patient outcomes were limited, and the effectiveness of some services provided was not subject to detailed audit and scrutiny.

However:

Summary of this inspection

- Staff used a recognised tool to monitor the patient's condition, and there were arrangements for responding to any changes in their well-being.
- The competency of surgical and medical staff was reviewed through the practising privilege approval system.
- Staff worked well together, and effectively to provide comprehensive care to patients. They had access to professional development and received an annual performance review.

Are services caring?

Good

We rated caring as good because:

- Staff recognised how important it was to identify and meet the individual needs of patients. They provided sensitive, caring and individualised personal care to patients, which acknowledged and respected their choices.
- Staff treated the patients with respect and ensured their dignity and privacy was maintained.
- Although there were variations of the number of respondents completing patient satisfaction feedback, between January and November 2016, patient satisfaction almost achieved 100%.

Are services responsive?

Good

We rated responsive as good because:

- Patients could access the service at their own convenience. Outpatient appointments were pre-arranged and surgery was elective in nature, arranged around the patient's preferences and availability of surgical teams.
- Risks were considered in determining the suitability of patients having surgical or outpatient treatment, particularly with regard to staff being able to support their needs.

However:

- Consultants did not always use an approved translator and relied on relatives, which is not best practice.

Are services well-led?

Requires improvement

We rated well-led as requires improvement.

- The governance arrangements and oversight of expected professional standards were not sufficiently robust. The

Summary of this inspection

management of risks and incident review processes needed to be strengthened. Incidents did not always have a risk score applied with regard to the level of severity, and the mitigating actions for risks listed had not always been clarified.

However;

- The service had appointed designated staff with responsibilities to focus on the quality and governance of the services, and progress was being made in this area.

Detailed findings from this inspection

Overview of ratings

Our ratings for this location are:

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

Requires improvement

Surgery

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

Are surgery services safe?

Requires improvement

We rated safe as requires improvement.

Incidents

- We reviewed the local policy for incident reporting and risk management, both of which set out the expectations of staff, processes to be followed, and the purpose of acting on incidents or risks, and who would conduct the incident review. We noted there were five different forms for staff to report incidents. The level of investigation to be undertaken was indicated as being determined by the severity of the incident's consequences. This ranged from a full root cause analysis of the incident to an immediate departmental action to correct the problem.
- Information provided to us indicated that risk management and incident reporting training was mandatory for all departmental managers, as they would be responsible for investigating incidents.
- We noted information contained within the incident policy outlined the reporting process and time frames for review. The governance reporting process was highlighted, which included sharing the information at the Health and Safety meeting, and how lessons learned would be shared.
- Information relating to incidents was made available to us for the reporting period October 2015 to September 2016. During this time, there have been 0 Never Events. Never events are serious patient safety incidents that should not happen if healthcare providers follow national guidance on how to prevent them. Each never event type has the potential to cause serious patient harm or death but neither need have happened for an incident to be a never event.
- There were clinical incidents at the location. Of these, clinical incidents had occurred within surgery. During this same period, there was non-clinical incident within surgery. The remaining clinical and non-clinical incidents occurred within other areas of the service, which did not come under this inspection.
- We found the incident reporting process had improved since our most recent inspection. Theatre staff we spoke with told us they reported incidents to the theatre manager and were able to complete an incident reporting form, which was kept, on the hospitals electronic computer. We saw an incident form completed on the electronic system and this had been completed and investigated through the correct channels.
- The theatre manager told us any feedback on incidents was shared through team meetings and on a one to one basis with the staff member. Due to the small size of the service, the theatre manager was in close contact with all theatre staff on a daily basis.
- Theatre staff told us there had been an improved sharing of learning from incidents since the new theatre manager started. All theatre staff told us they felt confident to report incidents.
- During our visit to the theatre area we were told about and saw incident reports were kept on the hospital 'J

drive', which all staff had access to. We viewed one incident form selected at random and followed it through to the matter having been rectified appropriately.

- There were no serious injuries reported and no inpatient deaths in the period October 2015 to September 2016. It was confirmed there were no serious injuries since September 2016, up to our inspection.
- We asked if there had been any serious incidents or never events in the period October 2016 to the current date and were told there had not been any.
- We noted in the health and safety performance data supplied to us prior to the inspection visit that there had been one clinical incident in October 2016 and two clinical incidents in both November and December 2016. We asked for the most recent information related to health and safety performance and were advised there had been three clinical near misses reported in November 2016, and one in December 2016.
- We asked to review one of the clinical incidents and noted this had been reported initially on paper, prior to uploading onto the electronic system. Details of the incident had been included, along with initial action taken, and the type of risk. However, we were not assured the process was a robust as it could be. For example, we noted a risk score had not been applied, although the record had provision for this. Root cause analysis had not been completed, although the management action indicated the measures to be taken to avoid similar situations occurring. Further, we were unsure how the service was able to determine the level of harm if a score was not applied to the incident. An incident which resulted in moderate harm would require duty of candour to be applied.
- Despite these gaps in the information, we saw evidence, which demonstrated the incident had been escalated appropriately through the Health and Safety Committee, and the Medical Advisory Committee (MAC). The incident had also been recorded on the clinical incident report register. This reflected the guidance within the incident policy, which set out the assurance processes, including any systems or procedures to be put in place for the future, or actions taken by the committee to ensure the incident could not reoccur.
- We noted from information provided to us the training related to duty of candour was provided yearly. Duty of candour relates to a legal duty to inform and apologise to patients if there have been mistakes in their care that may have led to significant harm. Training had been attended in February 2017.
- Theatre staff we spoke with during the inspection were able to explain the principles of the duty of candour and the finer details associated with it. We saw discussion took place on the duty of candour during the theatre team meeting of December 2016.
- Although there was no formal mortality and morbidity meeting, we were assured by the medical director who told us the Medical Advisory Committee (MAC) would review patient mortality and morbidity matters if the need arose, as part of the incident reporting process.

Clinical Quality Dashboard or equivalent (how does the service monitor safety and use results)

- Unlike NHS trusts, this service was not required to use the national safety thermometer for measuring, monitoring, and analysing common causes of harm to patients, such as falls, new pressure ulcers, catheter and urinary tract infections and venous-thromboembolism (VTE).
- The service collected information related to VTE assessments. However, the incident reporting process would enable the collection of data related to other safety outcomes, such as patient falls.

Cleanliness, infection control and hygiene

- Staff had access to infection prevention and control (IPC) policies and guidance. A lead IPC nurse provided additional support and guidance to staff, as well as overseeing practices.
- There was a designated IPC committee and we reviewed minutes of meetings, which confirmed the matters discussed.
- Infection control training was part of induction and mandatory training. Training in IPC had been completed in various months during 2016. This was as per the expectations outlined in the training policy.
- An independent infection control company had undertaken a six monthly IPC audit of the centre,

including theatres and pre-admission areas. They measured areas and gave a final compliance score. For July 2016 the compliance score for the whole centre was 94.6%.

- The areas in which patients received their consultations, treatment, and care appeared visibly clean and tidy. The operating theatre and associated areas were visibly clean. However, the Gratnell trolleys and storage boxes used to store clinical equipment were dirty on the interiors.
- Staff wore the appropriate scrub garments and had their hair tied back. Staff working inside the operating theatre wore theatre caps and masks during treatment.
- Personal protective equipment (PPE), including eye protection, gloves and aprons was available to staff in all clinical areas. This was in line with Health and Safety Executive (2013) Personal protective equipment (PPE): A brief guide.
- Staff were observed to be bare below elbow, which enabled them to wash their hands before and after each patient contact. We observed regular hand washing happened in practice.
- We observed the staff managed different types of waste in accordance with Department of Health (2013) HTM 07-01: Safe management of healthcare waste.
- We observed staff disposed of sharps, including needles and glass ampoules in accordance with safe practices outlined in the Health and Safety (Sharp Instruments in Healthcare) Regulations 2013. Guidance for employers and employees.
- We were informed by the medical director surgical site infection rates were collected as part of the 30-day follow up of patients. Subject to patients consent they were contacted by a nurse and asked a number of questions including those related to their wound and any problems they may have had, such as attendance at their GP because of a wound related matter.
- We were provided with data for the 30-day follow up and noted this indicated six unhealed wounds had been reported for one consultant, 22 for another, and two for a third. The information was limited in that it was not analysed further in order to establish themes or practice related matters. In all cases, we did not know if the unhealed wounds had been related to infection. Further, we were not assured the governance arrangements provided an effective means of reviewing such data.
- A service level agreement had been established with a local NHS provider for the decontamination of reusable medical devices, so their management met with national guidance. We were provided with a copy of the service level agreement for this and noted therein the arrangements made. We observed the on-site arrangements were suitable with regard to storage, set up and use. However, we noted used surgical equipment was boxed up and then placed in the staff coffee room for collection. We were concerned of the risk related to the possibility of unsecured lids.
- We questioned all theatre staff independently on the re use of single use disposable items, and they informed us the single use items were used appropriately.
- The scrub nurse was observed performing an efficient scrub in line with Association for Perioperative Practice (AFPP) guidelines, and theatre staff dress code was correct, again in line with AFPP guidelines.
- We observed there were accessible clinical hand washbasins and instructions for good hand washing principles were displayed above these in all clinical areas. Staff were noted to adhere to these whilst we were present. We observed staff also adhered to the dress code and were bare below elbow, which enabled good hand washing.
- Staff in the operating theatre were observed to follow good scrub technique when preparing the operating arrangements, both prior to setting up instruments and prior to surgical procedure.
- In the reporting period (October 2015 to September 2016) there were no incidents of hospital acquired meticillin-resistant Staphylococcus Aureus (MRSA). There were no incidents of hospital acquired meticillin-sensitive Staphylococcus Aureus (MSSA) during this same reporting period.
- There were no incidents of hospital acquired Clostridium difficile (C.diff) or hospital acquired E-Coli in the reporting period (October 2015 to September 2016).

- We spoke with the operations manager who showed documentation in relation to the checking of legionella. An independent company checks legionella at the centre on a monthly basis. Legionella was an item agenda on monthly IPC meetings.

Environment and equipment

- The recovery and theatre areas were visibly clean, well maintained, and free from clutter.
- The recovery room comprised of two beds, which could be separated by a curtain and were suitably spaced apart. There were a further two pre-assessment/ recovery rooms containing day beds.
- There was a separate staff room and changing facilities for staff.
- There was sluice area and separate stock cupboard and medicine cupboard. The theatre was spacious and had a separate scrub area.
- The theatre environment was suitably warm and a temperature was maintained at least to 21 degree centigrade.
- We reviewed information provided to us, which demonstrated there was a thorough system set up to monitor critical service contracts related to the environment, including theatre air handling, lifts, and water systems. Some equipment items were covered in this, such as call bells and IT.
- The consultation/outpatient areas were organised safely and enabled access to rooms for specific diagnostic tests and investigations. Clinical treatment rooms were sufficient in size and set up to promote safe practices.
- Some equipment within the consultation rooms was used for clinical trials patients and was not therefore checked by us. We were provided with the equipment list which documented every piece of equipment at the centre, the serial number, model and make and when a service was due on the equipment. Records showed all servicing of equipment was in date. We viewed service level agreements for the servicing and decontamination of equipment.
- A resuscitation grab bag was easily accessible in one of the consultation treatment rooms.
- There was an accessible resuscitation trolley in theatre, which was not opened by the inspectors. This was sited in an appropriate place. The trolley was stocked and had a checklist in line with current Resuscitation Council guidelines. The seal was checked daily and broken weekly when all drug dates were checked. We observed both these actions had been regularly documented.
- Theatre equipment, such as diathermy machine, the anaesthetic machine, and suction was in good order. The staff were taught by colleagues in their use but nothing formal was recorded with this regard. When questioned on basic diathermy safety, the staff were aware of good practice.
- We asked the agency operating department practitioner (ODP) what they included in their anaesthetic machine check. They were able to describe the checking process, which had been carried out that morning, and this was in line with Association of Anaesthetists of Great Britain and Ireland (AAGBI) guidelines. The Consultant Anaesthetist had also carried out a check.
- The anaesthetic machine was connected to back up in case of main power failure.
- A hoist was available if required, although this was kept in the basement. We saw it was serviced regularly.
- Single use patient equipment was readily available and used safely.
- There were disabled toilet facilities at the service and a wheelchair was accessible beside the lift.

Medicines

- The service had its own on-site pharmacy department, led by a pharmacist and supported by a pharmacy technician. We visited the pharmacy area and observed this to be well organised, safe with regard to storage controls, including temperature monitoring and restricted accessibility to keys.
- Staff we spoke with during the inspection said they had good support from the pharmacist.
- We saw the pharmacist checked the theatre controlled drugs (CD) book and saw the pharmacist entry in the CD book for 27 January 2016. All recordings were correct. Staff received further training from the pharmacist if there were trends or discrepancies.

- The pharmacist carried out CD audits for the theatre department. We saw two audits were undertaken in November and December 2016. The audits checked the compliance of management of CD in the theatre and pharmacy department. The audit findings were graded and the responsible person for taking actions was listed. Findings were discussed, for example, we saw a signature list for theatre staff who used the CD register book had been collated. This was to ensure easy identification of staff. The audit also discussed handling of drugs in theatre, and reconfirmed all actions had been taken and completed from the previous audit taken in September 2016.
- The theatre manager checked the CD book every evening at the end of a shift to check recordings and reconciliation.
- We noted there were relevant protocols, guidance, and systems for checking the appropriate use of medicines.
- Medicines used for the treatment and care of patients undergoing a surgical procedure were prescribed and prepared by the consultant anaesthetist. Emergency drugs were available on the anaesthetic trolley with labelled syringes but not drawn up.
- Spare oxygen cylinders were available, and these were full. We checked the medicines storage and management arrangements and found these were all safely organised.
- Patient allergies had been documented on their care plan and red allergy bands were used to alert staff. We observed staff checking these during the safety checks they carried out.

Records

- A records management and archiving policy was available to support staff in managing patient records and other confidential information in accordance with safe practice and data protection.
- We viewed six patient records. We saw pre-operative assessment forms had been completed which included information on venous thromboembolism (VTE). This form was introduced as a result of our findings from our previous inspection. We could see the form was now fully embedded within the service as part of the patient's pre-assessment and pre-operative checks. The information was clear and well documented.
- The patient records also included informed consent, theatre registration form, surgical safety checklist, intra-operative care checklist, and post-operative care in recovery. Nursing staff used a nationally recognised early warning scoring tool (NEWS) to ensure the safety and well-being of patients was assessed and responded to if the need arose. We saw the NEWS included observational checks and recording of the patient's physiological condition, such as heart rate, blood pressure and respirations. A discharge checklist that included the patient's vital signs was present in records we reviewed.
- We noticed intra-operatively the anaesthetist did not record the patient's core body temperature. We highlighted this to the medical director at the end of our inspection. We have since been sent confirmation and seen evidence that all anaesthetists have been asked to record the patients core body temperature monitoring as part of the routine anaesthetic monitoring procedures if procedures are of greater than 30mins duration or if other clinical circumstances dictate. We were also informed this would be a topic of discussion in the next MAC meeting. This course of action demonstrated the service was reactive and took quick action to remedy concerns.
- The patient notes also included a drug chart, and 30-day follow up questionnaire.
- We saw an integration of consultant information and assessment included in patient notes dependant on the treatment plan.
- A patient booking form included medical history and risk evaluation was required to be completed by the consultant. This was reviewed by the medical director or designated person prior to surgery.
- The service had applied and been accepted by the National Breast Implant Registry. The registry is designed to capture all breast implant surgery carried out both privately and on the NHS and allowed patients to be traced in the event of an implant recall.
- At the time of our inspection the service were not populating all the information on the implant register. The side of implant with consent details and patient information leaflets were not yet part of their

submission. We had a discussion with one surgeon and they informed us this was in the process of being done. All staff had their own log in details ready for it going live.

- There was an Implant Register in theatre. When cross checked, we noted five procedures, which had used implants from the operating register, were all correctly recorded.
- We were informed in the pre-inspection details the patient records were kept within QASMC premises at all times. The majority of patients seen at QASMC were short-term patients. Their records were created and maintained at QASMC. An archiving database was in use, and a master archivist was aware of the location of registered patient notes at all times.
- An audit of the completion of the national early warning score (NEWS) patient checklist included 10 patient records in November 2016. The outcome indicated 100% compliance.

Safeguarding

- The service had separate safeguarding policies for adults and children, which provided information for staff to follow.
- Although the service did not accept children, they had ensured all the contracted staff (100%) had received training with regard to safeguarding of vulnerable children and adults at the required level of their policy. Records we reviewed showed signatory attendance at training, which had been arranged by an external provider in October and November 2016. A bank nurse was still to complete the training at the time of our inspection.
- Level one (administrative staff), and level two (clinical and theatre staff) training was required to be completed every two year. The medical director and general manager were required to attend level three yearly.
- The medical director was the nominated individual for safeguarding and had level three training, as did the general manager.
- We spoke with a registered nurse, healthcare assistant (HCA) and the theatre manager about safeguarding. They all had a good understanding about this matter, and were clear about the procedure for escalating possible concerns.
- We received confirmation that training on child sexual exploitation and female genital mutilation (FGM) had been covered in safeguarding training. Staff demonstrated their knowledge by explaining how they would follow escalation of concerns as per the safeguarding procedure. However, FGM was not part of the children or adults safeguarding policy.

Mandatory training

- We saw from the service protocol related to training a number of safety related subjects formed part of mandatory training. This included by way of example; manual handling, health and safety, fire marshal, IPC, control of substances hazardous to health (COSHH) and controlled drugs (CD).
- Staff who we spoke with in theatres confirmed they had received training in health & safety, fire, manual handling, basic life support and intermediate life support. We saw certificates to confirm this.
- We reviewed information which identified the safety subjects completed in the induction programme, method of training and if outsourced. We noted 100% of clinical staff had completed the required training or they were due to undertake this in the next scheduled training sessions. For example, the deputy theatre manager was due to complete manual handling DVD and fire safety and security.
- The services annual audit programme included monitoring of mandatory training, for audit in July 2017 and a training records audit in December 2017.

Assessing and responding to patient risk (theatres, ward care and post-operative care)

- The admission criteria for surgery excluded individuals with an anaesthetic risk score above two, except if they were having a local anaesthetic.
- We were shown information which related to a standard operating procedure (SOP) for assessing the patients fitness for treatment. This set out staff responsibilities, the need to assess a patient prior to surgery, and the patient assessment in the day surgery area. Nursing staff were responsible for obtaining patient base line physiological measurements and a pregnancy test where relevant. We saw patients physiological assessments had been recorded in care plans and patient observation charts.

Requires improvement

Surgery

- A separate SOP related to the patient journey and included information about patient pre-operative assessment, consent for a number of measures, assessment of fitness for surgery, type of anaesthetic and intraoperative care. The latter included the management of any risks associated with surgery, and in particular prevention of deep vein thrombosis, (DVT).
- In the reporting period October 2015 to September 2016, the percentage of patients risk-assessed for venous thromboembolism (VTE) was 100%. There had not been any cases of hospital acquired venous thrombosis and pulmonary embolism in patients treated at the service.
- We saw staff used an early warning score system to monitor the patient's condition. This enabled them to identify any early deterioration and bring this to the attention of the consultant and/or resident medical officer (RMO).
- The World Health Organisation (WHO) checklist was launched in June 2009 and recommended by the National Patient Safety Agency (NPSA) for use in all NHS hospitals in England and Wales in 2010. Its use is now widely accepted as best practice as a tool to lower avoidable surgical mistakes, including independent hospital services. We observed the World Health Organisation's three steps to safer surgery was used by staff in theatres. These were also enhanced further by an additional two steps, which included a pre briefing step prior to surgery.
- There was no protocol to demonstrate compliance with keeping patients warm (NICE guideline CG65). Such guidance relates to the prevention and management of hypothermia in adults having surgery.
- The difficult intubation box we checked was lacking some of the emergency equipment, and some items, such as 'i-gel' was kept separately in the storeroom. The Association of Anaesthetists of Great Britain and Ireland (AAGBI) in their safety guideline – Checking Anaesthetic Equipment 2012 states, "equipment for the management of the anticipated or unexpected difficult airway must be available and checked regularly in accordance with departmental policies." At the time of inspection there was no checklist accompanying the difficult intubation box and it was not known if the contents were subject to routine checking. Although not validated by us, we were told action was taken to address the concerns regarding this equipment following our visit.
- Although there was no policy for major haemorrhage, (The AAGBI expect hospitals to have a major haemorrhage protocol in place), in the event of major haemorrhage the protocol outlined in the Management of Medical Emergencies (including Resuscitation) Policy would be adhered to. This included the replacement of fluid loss in order to stabilise the patient, prior to transfer out.
- There was a management of adult emergencies policy, which involved processes for staff to follow in the event of patient with sepsis. All medical and nursing staff had received training in relation to the policy and participated in emergency teaching scenarios, which covered the management of medical emergencies (including sepsis). Sepsis was also covered in scenarios taught at the life support refresher training courses attended by QASMC staff.
- For patients with sepsis the patient would be assessed, treated, and stabilised on site by the appropriate medical and nursing staff. Assessments by Physicians included history taking and physical examination, vital signs, as well as appropriate blood and urine investigations.
- There were on site capabilities for the management of medical emergencies (including resuscitation) with crash trolleys on all clinical floors, defibrillators, and oxygen equipment.
- The centre stocked a range of antibiotics that could be administered to patients intravenously for initiation of treatment of sepsis. IV fluids and oxygen were available for administration to patients.
- There were procedures in place to transfer critically ill patients and these were documented in the clinics management of adult emergencies policy. The medical director told us medical emergencies from the clinic were transferred to either the local NHS hospital or an independent hospital. We were told the latter had previously been arranged formally but as the medical director had admitting rights to a private hospital with

intensive care beds, the arrangement was no longer formalised. The medical director would take responsibility for making the necessary arrangements directly.

- The nominated individual was available for medical input if required, as were other physicians with admitting rights, and the RMO.
- We were told by the clinical staff and medical director patients having cosmetic surgery or gender re-assignment surgery had counselling or referral for psychological assessment arranged through the admitting consultant. This was not provided on site but externally.

Nursing and support staffing

- Staffing was arranged around planned activity. For example, when a patient who needed to stay overnight this was planned in advance, and the night shift was covered by the nurse with a sleep in resident medical officer (RMO). At short notice or when unplanned, the service had bank nursing staff or could request an agency nurse.
- Theatre staffing included: A whole time equivalent (WTE) theatre manager, one WTE scrub nurse, one recovery nurse who worked 30 hours per week, and one WTE healthcare assistant. In addition to these staff there were regular temporary bank staff, consisting of two scrub nurses and an anaesthetic/recovery nurse.
- There were no separate clinical staff for the recovery beds and overnight bed facility. Nursing staff worked across both areas, and although nursing staff were professionally trained, this did not include anything formal for the specific role of recovery of patients post operatively.
- On the day of our inspection there were no nursing or healthcare assistants working in the consultation/OPD area. We were informed the OPD clinics were booked by the consultants in advance, so staff knew which clinics they needed to provide staff for, and a member of staff was allocated in advance for clinical support or chaperoning purposes. Weekly activity of OPD clinics and theatre were discussed in the 'Week Ahead Meetings', minutes of which we saw confirmed this.
- In the event of an unplanned overnight stay, the theatre department would try and cover the night by utilising their regular QASMC full time or part time staff (Theatre nurses and Theatre HCAs). Bank staff were utilised, if the regular staff were not available to cover the night shift, and agency nurses were used as a last resort.
- Where a patient stayed overnight, the nurse and RMO relieved each other for breaks, unless there was an additional nurse on shift, in which case one nurse would relieve another nurse for a break.
- Although we were told no patient had needed to be taken back to theatre unexpectedly in the previous 10 years of practice at QASMC, arrangements could be made for staffing. For example, we were informed that if a patient had to return to theatre in the evening or night and the duration of the case meant staff could not return to duty the next morning, staffing for the next day would be covered by other members of regular staff who did not attend the case the evening/night before, complimented (if required) by bank or agency staff. In the very unlikely event that staffing levels were critically impaired following an evening or night return to theatre, cancellation or delay of the next day's operating list would be considered with no impact to patient outcomes as only elective surgery is carried out at QASMC.
- The use of bank and agency operating department practitioners (ODP) and health care assistants (HCA) in theatre departments was higher than the average of other independent acute hospitals we hold this type of data for in the same reporting period, except for October 2015 and February 2016.
- According to information provided prior to the inspection, there were no bank nurses working in the theatre department from October 2015 to September 2016. However, we were told temporary (bank) staff were used in anaesthetics and as scrub.
- Regular agency staff were also used in the theatre for anaesthetics, scrub and in recovery.
- We found the theatre staffing level arrangement during our visit were in line with those recommended by the Academy of Medical Royal Colleges' 'safe sedation practice for healthcare procedures October 2013', and the Association for Perioperative Practice (AfPP), in terms of numbers and skill mix.

- On the day of our visit, we found theatres had an establishment of four staff, which included one agency member of staff. The skill mix on the day was good, and enabled the safe delivery of treatment and care.
- We were told a new HCA had been appointed and was starting in March. Theatres also used a particular bank nurse one day a week for a surgical specialty.
- We observed handovers taking place between staff, including the RMO during the course of the day's activities. Information was provided in a clear and concise manner.

Medical staffing

- The number of RMOs employed by the provider was one for the surgical services. If there was a need for the RMO to stay overnight and sleep in, they were released earlier than usual the following day and another RMO was arranged through the agency.
- We spoke with the RMO who gave positive feedback on the service. Handovers were provided to other RMO clinical staff and consultant. New RMO's visited the service for one day before they started and received induction when they joined. Competency involved the signing of a checklist.
- The medical director explained they used a specific agency and usually had the RMO on a placement for a minimum of six months. The current RMO was said to be on an annual placement.
- For unplanned overnight stays, we were advised the RMO on shift may stay and cover the night shift. The medical director may also assist, and was available on-call nearby in an unplanned situation. Whilst QASMC employed a permanent RMO for a contracted 40 hours, additional RMOs were provided by the RMO agency at short notice for cover including overnight stay if required.
- Out of hours cover at weekend and nights was available through the medical director, with access to the admitting consultant arranged through themselves and their patient.
- Handovers took place between the RMO, clinical staff (and vice versa) and consultant to RMO, according to the duration of patient stay and individual needs.
- The new in-coming RMO usually attended the day before their official start to be familiarised.
- Agency medical staff received an induction, and a checklist was ticked and signed when completed.
- A doctor who is registered with a licence to practise is permitted to carry out certain activities. The QAMC required consultants to have admitting rights and practising privileges before they could use the services.
- A designated member of the administrative staff had a responsibility to keep the practising privileges of consultant surgeons, physicians and anaesthetists up to date. This included checking their professional registration, qualifications, insurance, disclosure and barring, and revalidation.
- Practising privileges were subject to the agreement of the medical director in conjunction with members of the revalidation committee and medical advisory committee. Both committees had a responsibility to review annually and advised on the suitability of the continued eligibility of medical practitioners to hold these privileges. This included a review of any information received from external bodies or internal complaints and incidents.
- Each consultant provided cover to their own patients, usually via 24-hour telephone contact to their nurse or doctor.
- There were arrangements for calling in the surgeon/ anaesthetist out of hours for unplanned surgery. Theatre staff and QASMC reception staff had contact details for all surgeons and anaesthetists who have practicing privileges.
- The surgeons and anaesthetists provide mobile telephone numbers including a 24 hour manned response for certain clinics. The surgeons were available for call out after they have performed a routine elective list.

Emergency awareness and training

- A management of adult emergencies policy was available to support the delivery of services. This included detailed instruction regarding patient resuscitation.
- An emergency team was available at all times to respond to an emergency when patients were in the

location. The configuration of the team was determined locally, although there was an expectation it would have no fewer than three members of the team at all times. Where there were less than four staff members in this team, rapid access to the local ambulance service for additional support was required.

- We saw there were algorithms for staff to follow in the event of adverse medical situations.
- Staff received resuscitation training both announced and unannounced simulation exercise by an external provider. We saw evidence of the report following such an exercise carried out in September 2016.
- Topics covered for mandatory training included, fire safety, and security. Staff we spoke with were confident of what they would do and the procedures to follow in the event of a fire. All fire exits within the theatre department were free from obstruction. Fire extinguishers were available throughout the service and the appropriate company had made regular checks of these.
- The back-up arrangements in the event of power failure was explained to the inspectors, and the contingency plan was seen, and was found to be comprehensive.
- The hospital had a triple phase electricity supply designed for industrial and commercial buildings.
- The critical electrical power requirements for theatre such as for the anaesthetic machine were supplied by a backup UPS system that automatically supplied sufficient power for at least 30 minutes following power failure for relevant emergency procedures to be completed. There was a separate back at UPS system for the operating lights in theatre. The operating theatre had two separate power rings in the electrical circuitry. This enabled critical machines to be plugged into the backup system only, whilst non-critical devices could be plugged into the separate circuit.

Are surgery services effective?

Requires improvement

We rated effective as requires improvement.

Evidence-based care and treatment

- We noted information which demonstrated adherence with some of the professional guidance available, including the; National Institute for Health and Care Excellence (NICE) CG50 Physiological observations. We saw patients physiological assessments had been recorded in care plans and patient observation charts.
- Staff used a physiological track and trigger system to identify at risk patients through a nationally recognised early warning system, known as NEWS.
- We noted there were response strategies for patients who were deteriorating, which included a policy for a medical emergency to guide staff.
- The service was not following the NICE guidelines CG65 Hypothermia, prevention, and management. Each patient should be assessed for their risk of inadvertent perioperative hypothermia and potential adverse consequences before transfer to theatre with their temperature taken in the hour before their allocated theatre time. Following this the patient's temperature should be measured and documented before induction of anaesthesia (if below 36 degrees induction of anaesthesia should not commence) and then every 30 minutes until the end of surgery.
- Although we did not have any information to suggest a patient had undergone surgery with an unacceptably low temperature, our specialist advisor considered it to be a critical incident if the patient arrived in theatre with a temperature below 36 degrees centigrade.
- A two-week cooling off period was observed for patients undergoing cosmetic surgery procedures. This was in line with cosmetic surgery guidelines.
- We were provided with a copy of the audit programme for 2017. This was set up under different areas of the service. The programme did not specifically evaluate staffs adherence with some national or professional guidance, for example, with respect to the monitoring of patients temperature during surgery or pain management. However, there was auditing of patient records, WHO safety checks, resuscitation, hand hygiene, and medicines for example.

- We noted several resuscitation trolley audits had been planned, for February 2017, and going forward at set intervals. Equipment management audits were part of the programme, as were surgical specific audits.
- Surgical service audits included WHO checklists, NEWS, and records management. The new theatre manager had conducted monthly audits for NEWS. A random set of 10 records were checked against 13 competencies for NEWS. For November 2016, the compliance was 100% and for December 2016 and January 2017, the scores were compliant for 12 of the 13 checks. The theatre manager said feedback on mistakes was given to staff on a one to one basis.
- A records management audit had been undertaken in June 2016, which included a review of processes in theatre and a number of sets of patient records. The findings were presented, along with any corrective action to be taken, and the responsible person. We noted the next records audit was planned to take place in May and November 2017.

Pain relief

- Prescribed local and analgesic medication was administered for effective pain relief during the procedure.
- Pain relief was prescribed by the anaesthetist or consultant surgeon and was recorded on patient's medication records.
- Staff recorded pain scores to determine the patient's level of pain and if the analgesia given was effective.
- If required, patients were given pain relief medication to take home post procedure. Their expectations of pain and mobility were discussed prior to discharge by nursing staff.
- There was no access to dedicated pain team but the patient's consultant surgeon or anaesthetist, or the RMO could be contacted where there were concerns about pain management.
- Although there was no specific audit to check if staff followed best practice with regard to pain management, a patient who spoke with us during the inspection told us their pain was managed well, and they were routinely asked by staff if they were in any pain.

Nutrition and hydration

- Pre-operative guidance included information about fasting times. We were told individual consultants also had their own instructions regarding fasting, and such information was shared with their patient directly.
- A limited menu, including soft food was available, with items purchased locally for heating. Patient s were not discharged home until they had tolerated fluids and food where relevant.
- There was no input from nutritionists or dietitians at this service, as the type of patient activity did not require such interventions.

Patient outcomes

- The Royal College of Surgeons encourage services that carry out cosmetic surgery to routinely collect and report on Patient Reported Outcome Measures (Q-PROMs) for all patients receiving the following procedures: abdominoplasty, augmentation mammoplasty, blepharoplasty, liposuction, rhinoplasty, and rhytidectomy.
- The service was not collecting data for (Q-PROMS) for relevant cosmetic procedures performed at the location. However, the service had a system in place to collect patient outcome data (subject to patient consent), which was more relevant to the services practices and allowed for a general level of scrutiny.
- The patient outcome data was collected by two separate methods. The first consisted of a Total Quality Management (TQM) questionnaire that was administered to all theatre patients. The TQM consisted of a series of questions which related to reception, catering and overall general experience. These were completed before the patient left the clinic.
- The second method of collecting patient outcomes was through their 30-day follow up questionnaire. This consisted of a structured telephone interview based on five questions, which was conducted by the recovery nurse after a theatre procedure.
- Patients were required to give consent for this follow up, and if consent was refused, the call was not made. The questions were designed to determine whether there had been immediate complications such as infection, use of antibiotics and visits to other doctors including the GP.

- The TQM data and 30 day follow up data was reviewed by senior managers on a fortnightly basis. Any matters of concern were raised with the medical director.
- The service was reliant on patients completing a 30-day patient follow up review to monitor surgery site infection rates and other quality outcomes. Patients, who were willing, consented to be contacted with a view to providing feedback on various aspects of the service they had received.
- The two sets of patient outcome data were reported to the clinics infection control committee (ICC), which met on a quarterly basis. The ICC reviewed the data and in turn reported it to the MAC who also met on a quarterly basis.
- We were provided with the 30-day follow up compliance rates for January to December 2016, which was collected through a quality questionnaire. This captured feedback on pain relief, nutrition and staff competency. The data we reviewed indicated a variation in responses to the nurse follow up call, ranging from the lowest at 40% in June 2016, to the highest (100%) in December 2016.As there was no actual number of respondents stated we were not able to make an informed judgement on the usefulness of the information.
- We reviewed other information, which indicated the number of responses from the 30 day follows up including; problems reported, unhealed wounds, infections reported and post-operative GP visits. Information was collated by consultant, for example, out of 20 patients, there were three problems reported for one consultant, plus two unhealed wounds (10%) and a GP visit. Another consultant had just under 90 patients and of these six (6.6%) had unhealed wounds and four (4.4%) reported problems. The level of detail was not sufficient to identify what the problems were.
- The medical director told us they used the appraisal process to discuss the audit of patient outcomes. The surgeons were required to produce evidence of their own clinical audit, and as such, they were encouraged to obtain in-depth and independent reviews of their own outcomes. Whilst we reviewed one consultant file, which contained some evidence of their patient outcomes, these had not been subject to independent review.
- The service did not accept patients requiring emergency surgical opinion or intervention, and therefore did not collect outcome data for this. They did however collect data for any unplanned or returns to theatre, of which there had not been any in the year up to the time of our inspection.
- In the reporting period (October 2015 to September 2016), there were no readmissions to surgery within 28 days, and no unplanned transfers of inpatients to other hospitals. There had not been any of these outcomes in the period October 2016 to the date of inspection.
- The service had engaged with the Private Healthcare Information Network (PHIN) in accordance with the Private Healthcare Market Investigation Order 2014 regulated by the Competition Markets Authority (CMA).

Competent staff

- Surgeons and anaesthetists working at the location were required to have approved practising privileges. A database was used as a formal system for monitoring and managing the provision of required information. Such information included evidence of the consultants General Medical Council (GMC) membership number, evidence of revalidation, a performance review, and certification of qualifications and experience.
- We were informed by the quality assurance manager the QASMC practising privileges list was normally updated and sent to key staff on a weekly basis every Friday.
- During our checks, we identified one doctor who was listed on the services approved practising privilege list but was suspended by the GMC, and could not practise in the UK. We brought this to the attention of the provider and subsequently received information detailing how this matter had arisen, and the actions taken, which included terminating their practising privileges. It was confirmed the suspension took place in between revalidation and appraisal committee meetings, and at the time the service had not received any notification from the GMC regarding this.
- It was confirmed the doctor had not undertaken any procedures in the period of time since their suspension by the GMC.

Requires improvement

Surgery

- There were formal arrangement for staff to keep up to date with checks on the GMC database. This included staff cover in the absence of the nominated staff member who had direct responsibility.
- Where the consultant did not have a substantive post in an NHS hospital, the medical director took responsibility for checking their competence and other relevant information. We saw a detailed information file related to a consultant who was the main user of the service. This included for example; their professional registration, indemnity insurance, appraisals, surgical activity figures, formal teaching activities, clinical studies, and management meeting reports.
- The service had a number of surgeons who received their appraisal through the registered officer.
- Certain surgeons were accompanied by a practice nurse who assisted with the patient journey, and may also have appropriately qualified nurses who assisted in theatre for example as a scrub nurse, but who did not perform a role as a first assistant.
- Further information was provided to us which related to provider assurance regarding the staff brought in by consultants. We were told there was a comprehensive process in place in order to monitor staff who were brought in by consultants. These persons were required to provide QASMC with the following: curriculum vitae, NMC registration and educational qualifications/ certificates, a copy of the Hepatitis B immunity status, copies of CRB check, copies of references, and a copy of passport as proof of right to work in UK.
- The directors of the companies who employed these persons were required to complete and sign the QASMC 'Pre-Employment Checks for Authorised Practitioners' document in order to confirm the necessary pre-employment actions had been carried out for these persons on their behalf. The QASMC governance and finance manager kept a record of all staff brought in by consultants and checked that all pre-employment checks had been carried out to the standard expected by QASMC.
- We checked the British Association of Aesthetic Plastic Surgeons (BAAPS) register and noted none of the surgeons undertaking plastic surgery at the location were on this register. BAAPS Members are usually on the Specialist Register of Plastic Surgeons maintained by the General Medical Council (GMC). Amongst the aims of BAAPS is to facilitate training in cosmetic surgery through annual meetings. BAAPS registered consultants were required to feed back their patient outcomes as part of their membership to the British Association of Aesthetic Plastic Surgeons.
- It was confirmed by the provider that all surgeons who performed major procedures at QASMC were on the specialist surgical register for cosmetic surgeons. One surgeon was not on the specialist register but had a grandfather clause as a specialist surgeon. This meant there was a provision under an old rule, which continued to apply to some existing surgeons, whilst a new rule applied to subsequent surgeons.
- Two individuals who held practising privileges (authority granted to a physician or dentist by a hospital governing board to provide patient care in the hospital) as aesthetic doctors and did not perform major procedures were also not on the specialist register.
- The training policy included information related to new employee induction, checklists and learning plans. The latter of which were to be completed by departmental managers.
- Agency staff were required to provide evidence of their right to work, references and information about their skills.
- The centre held the appropriate qualifications and certificates for their nursing staff. Nursing staff were required to comply with the Nursing and Midwifery Council (NMC) guidance on revalidation. Support to nursing staff was provided by the theatre manager. Meetings between the manager and staff were arranged to help identify what type of support the staff member required. An annual appraisal system was in place as well as one to one's with their line manager.
- The new theatre manager had introduced an appraisal-tracking sheet which gave details on each staff member and when their appraisals were due. One appraisal had been completed for one theatre nurse; another staff member was in the process of completing their appraisal while the remaining staff were not due for an appraisal until mid-2017.
- The new theatre manager was in the process of implementing supervision processes to support theatre

staff. The theatre manager had introduced NEWS audits and did a daily CD check. For any discrepancies, the manager was able to feed this back to the staff member concerned, offer support, and further training if necessary.

- Outcome data by individual clinician was expected to be provided as part of the appraisal process. We reviewed a consultant personnel file and saw the information therein included this. However, where a consultant only practiced at the location, their outcome data was not subject to external peer review.

Multidisciplinary working

- We were told by the medical director there was no expectation for consultants to hold multidisciplinary meetings (MDT). However, there was collaborative working between the nursing staff, consultants, pharmacy, the RMO, and the medical director.
- There was no formal agreement between the local NHS hospital and independent hospital. The medical director informed us there used to be a service level agreement between the latter, but as they had admitting rights and practising privileges at that location, it was felt to be unnecessary, as they could easily make arrangements to transfer the patients care.
- If a patient became unwell during their stay at QASMC the attending medical staff, including the medical director, the RMO on shift, the surgeon and (where relevant) the anaesthetist were notified and consulted regarding potential transfer of the patient to a secondary centre. This was a rare occurrence and had been documented on three occasions over the previous 10 years. On those occasions the medical director and consultant surgeon were involved in the direct management of the patient and transfer to another centre.

Seven-day services

- Access to diagnostic services was limited to those available on-site. This included ultrasound and respiratory function testing, colposcopy, and urodynamics.
- There were no x-ray facilities or physiotherapy services.
- Blood samples could be sent off to an external provider for relevant testing.
- Consultants with practising privileges were responsible for the treatment and care of the patients having surgery. They arranged their own patient admissions according to patient choice and their own availability. In general, this did not include weekend work.
- Whilst consultants did not remain on-site until the patients were discharged home, an RMO remained on-site until all patients had been discharged.
- All patients who have had elective surgery at QASMC were supplied with detailed post-operative instructions for their post-operative follow-up care which included full contact details of the surgeon and anaesthetist, and contact details for the relevant clinic, if this is different to QASMC. The patients were also given contact details for QASMC. Through contact with QASMC, the patient may call the QASMC medical director who would take appropriate action. However, it is the primary responsibility of the patient's surgeon and their team to respond to the patient's request for help after hours and weekends.

Access to information

- Staff had access to guidance, policies and procedures, as well as expertise from colleagues and line managers.
- There was access to patient records and system for retrieval where patients were returning for follow up or additional procedures.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- The service had a formal consent policy, which was expected to be adhered to. This set out the premise that the clinician was primarily responsible for the care of the patient, and was required to assess and document the adults' capacity to consent to any proposed medical treatment.
- The medical director told us the majority of patients who used the service were not mentally impaired, and consultants elected their own patients on the balance of suitability.
- There was an expectation within the consent process that patients be offered a chaperone or be invited to have a relative or friend present with them during any

examination or procedure. In addition a chaperone was to be made on a routine basis where there was thought to be a clinical requirement, such as when attending the gynaecology clinic.

- We discussed deprivation of liberty safeguards (DoLS), Mental Capacity Act (MCA) and consent with all members of staff except consultants. They all had an understanding and knew where to escalate concerns.
- We discussed with theatre staff DoLS, Mental Capacity Act, and consent and staff had a good understanding of each topic. They knew where to escalate concerns and who to see for advice. MCA was now incorporated as part of safeguarding training.
- There were arrangements between the patient and consultant for a two week cooling off period prior to making decisions to consent for cosmetic surgery.

Are surgery services caring?

Good

We rated caring as good.

Compassionate care

- We observed staff interactions with two patients in the operating theatre. On meeting, each member of staff introduced themselves, made appropriate small talk, putting the patients at ease. This included an explanation of what was happening at each stage. The staff ensured both patients were comfortable and warm, and patient dignity was maintained at all times.
- One patient told us they had received "excellent service from the staff including the consultant." They told us they had received information throughout their treatment.
- In the reporting period (October 2015 to September 2016), as a non NHS service, the provider was not required to collect data for the friends and family test. They did however use a patient satisfaction survey, known as Total Quality Management (TQM). We reviewed the TQM for the period January 2016 to December 2016.
- The information provided to us for 'theatre on the day' responses suggested participation was variable, with no respondents in March 2016, and five months where less than 50% of patients responded, (April, May, June, August and November). The highest response rate achieved was just below 90% in February 2016. However, the information did not specify how many patients responded and therefore we could not make an informed view of this.
- Figures provided to us indicated overall satisfaction achieved almost 100% between January and November 2016. There was no score rating for March, as no patient responded to the survey. We noted December's rating of satisfaction dipped to less than 80%.
- If any scores were particularly low or the data presented was unsatisfactory, then corrective and preventative actions (CAPAs) were agreed by the governance committee members and decisions were disseminated to the relevant individuals. Minutes of medical advisory meetings seen confirmed this.
- Annual satisfaction rating for outpatient on the day scored just under 80%. It was not possible to identify from the information provided if the respondents included all patients attending the department, or if there were separate surveys for other registered services provided at the location.

Understanding and involvement of patients and those close to them

- We saw staff explaining the treatment plan to patients, not using medical jargon and giving the patient every opportunity to pose questions. Staff introduced themselves by name and made the patient feel at ease throughout their treatment of care.
- One patient told us they had received details and knew who to contact if they had a concern. They were happy with the information they had received about their treatment and felt they had been involved at every stage.
- Patients were given advisory information prior to admission with regard to stopping smoking, use of their routine medicines, fasting and postoperative guidance about not drinking alcohol and driving. Patients were also provided with information from their consultant dependant on the treatment they were having.

- Information on the costs for treatment was explained by the admitting consultant. Reception staff were able to provide some information about service related costs, such those in the outpatients.

Emotional support

- Staff were observed to provide an appropriate level of support, including reassurance to the patient at each stage of their pathway.
- Counselling services were not provided within the service. The medical director informed us consultants would be responsible for referring patients to such services externally where required. This included patients who were having gender re-assignment surgery. In this case, we were told by the medical director, the patient may have several counselling sessions over a significant period of time.

Are surgery services responsive?

Good

We rated responsive as good.

Service planning and delivery to meet the needs of local people

- Patients could self-refer; go through their GP or via an approved insurance provider. All surgical procedures were elective in nature, pre-planned and arranged between the third party consultants in accordance with their practising privileges.
- No NHS work was provided at the location, and clinical commissioning groups were not involved in planning or agreeing services.

Access and flow

- The pathway for patients coming in and through the surgical service was efficient and met their needs.
- Surgical admissions were elective and planned in advance with the choice and agreement of the patient and their admitting consultant.
- Patients were booked for treatment via contact between the consultant surgeon's office and the centre. A booking form was completed and submitted to the location. The medical director informed us some consultants would contact the anaesthetist directly to ensure a suitable pre-operative review. In addition, the RMO would assess patients on their arrival.
- The admission processes excluded patients who had an anaesthetic risk higher than two, although the service did accept some patients with comorbidities, such as diabetes. Ophthalmic patients having a procedure under local anaesthesia may have other accepted co-morbidities, which were deemed suitable to attend as day patients.
- In the event the patient needed to return to theatre, this would be organised directly by the consultant and the theatre staff.
- In the reporting period (October 2015 to September 2016), the provider had no cancelled procedures for a non-clinical reason.
- Discharge arrangements were made directly between the patient and the admitting consultant as part of the pre-planning arrangements.
- Discharge summaries were completed and provided by the admitting consultant.
- Nursing staff provided general advice and guidance to the patient prior to their discharge.
- The event of a patient becoming unwell following their discharge, the admitting consultant took responsibility for arranging their hospitalisation and subsequent review and treatment.

Meeting people's individual needs

- The service did not make provision to meet the full needs of the local and wider population demographics. Patients with learning disabilities or cognitive impairment were not accepted at the location.
- Theatre staff told us they would not have patients with particular needs such as those related to dementia. They informed us if a translator was needed the consultant would bring their own or a relative along with them. This is contrary to best practice, which is that authorised interpreters should be used in order to avoid miss-understanding and inaccurate communication.
- Patients using the surgical services, consultation/OPD had access to refreshments.

- Chaperones were available to those who wished to exercise their choice to be accompanied during a consultation or treatment. We saw signs indicating this throughout the centre.

Learning from complaints and concerns

- Patients and relatives who express the wish to complain were given a 'Complaints Procedure' leaflet that explained the QASMC complaints process and the person responsible for overseeing all complaints (the General Manager). Patients or relatives could make a complaint in person, by letter, e-mail or telephone. They could also complain informally at the point of service or, if they preferred, formally using the process described in the Complaints Procedure leaflet.
- All verbal complaints were expected to be dealt with promptly wherever possible, at the point of service, by the person providing the service, ensuring that a comprehensive written record of the complaint was made by the person receiving the complaint.
- If it was not possible to resolve the complaint on the spot or if the complainant did not accept the response, all serious complaints were referred to the general manager or in their absence the medical director.
- We were informed there was a complaints register, which we were able to review. We noted a date was recorded when the initial complaint had been received, the type of complaint, the clinician and the details of the matter. Stage one included an acknowledgment, with a first response at 14 days. If the complainant was not happy, it then went to stage two, with a further acknowledgement with two days and a reply within 28 days.
- In the reporting period (October 2015 to September 2016), the provider received two complaints, with a further one before the end of 2016. There had been one complaint up to the time of our inspection in 2017.
- We asked to see an example of the response to complainants and were able to review one. We were told by the general manager there was no formal letter written, unless the initial concern came by letter. The complaints had been received by email and therefore the response was made by this system.
- Staff we spoke with knew who to escalate patient concerns to if they felt they could not resolve the situation. Theatre nurses said they would speak to the theatre manager if a patient was unhappy.
- We did not see any information and hear anything which provided evidence of learning from complaints, although we were told complaints were discussed in governance meetings.

Are surgery services well-led?

Requires improvement

We rated well-led as requires improvement.

Vision and strategy for this this core service

- The service was in the process of developing its business strategy, a copy of the draft version of which was shared with us. The content was sufficiently detailed to identify the opportunities for development and focus of services going forward, which was on quality and accessibility.
- The focus of the service was concerned with growing the surgical area, with a view to developing the hospital aspect; separate to other activity within the location. The medical director informed us staff were made aware of the service aims and team meetings, as well as 'week ahead' meetings provided an opportunity for information sharing and discussion.
- We reviewed minutes of the 'week ahead' minutes recorded between the periods 9 June 2016 to 16 February 2017. These had standing agenda items, action points, and discussions related to subjects such as activity, quality assurance, training, and pharmacy.

Governance, risk management and quality measurement

- The governance arrangements were not sufficiently robust for managing risks, such as incident and standards related to cleanliness. There needed to be more scrutiny when overseeing the processes in place to manage such risks. For example, not all incidents had a risk score applied, to determine the level of severity, and we did not see mitigating actions for all risks that were listed.

Requires improvement

Surgery

- The Board of Directors were responsible for making adequate provision, and for reviewing the effectiveness of the internal control systems. They oversaw the proper conduct and management of all activities undertaken at the location. The Board were charged with ensuring proper compliance and control measures were functioning effectively.
- The medical director was a member of the Medical Advisory Committee (MAC) and reported to the board. They had responsibility for ensuring clinical governance systems were established, and that these ensured patient safety and quality development. Further, they were responsible for ensuring the appropriate level of risk management was conducted prior to all activities.
- The general manager provided support to staff and other managers to enable them to carry out their duties, as well as providing advice and guidance on health and safety, and the monitoring and assessment of risks.
- The business manager explained to us how there were a series of key performance indicators (KPI), and risk registers, which fed into the governance arrangements. The purpose of this was to ensure the surgical KPIs were working. The governance arrangement was described as "complex", as it needed to be independent. Therefore, an independent chair oversaw this, and the medical director could be outvoted on decisions.
- Internal quarterly KPIs related to; clinical reporting, health and safety, quality assurance, patient satisfaction, committee/management meetings, annual appraisals and revalidations. Monthly KPIs for example included audits, CAPA management, policy/SOP management, deviation management, staff training and support.
- We were provided with information which indicated KPIs related to policy management, including their development and revision, equipment asset tracking and device alerts and management.
- The lead for quality had an audit schedule and they reported directly into governance. Information communicated included the corrective and preventative actions taken by staff.
- A governance committee meeting was held monthly and attendees had a responsibility to review and report on quality matters rated red. They were not required to find a solution but to seek assurance of measures to improve quality outcomes.
- We reviewed minutes of the December meeting, which indicated attendees included an independent chair, the medical director, business manager, governance and finance manager and a note taker. We noted key performance indicators and incidents had been discussed.
- The service identified in November 2016 two red KPI, one of which related to an equipment audit, asset tracking ownership and device alert management. We noted in the subsequent Governance Committee meeting of December 2016 actions taken to address the matters. We were provided with an equipment audit for 2017, which provided details of all equipment held at the centre along with when the next servicing was due.
- The business manager prepared an annual board report, and we were told this was submitted to NHS England. We asked for a copy of the report and saw in the version provided the information contained therein related to consultant revalidation and appraisals. It was confirmed by the provider this report to NHS England was solely concerned with a list of doctors with practising privileges for whom QASMC was the designated body.
- The MAC oversaw all medical services, reviewed medical events, medical practice, medical practitioners, and the safety of patients and staff, via itself or one of its sub-committees. The MAC reported to the Board via the medical director, who was a board member.
- We were told the Medical Advisory Committee (MAC) met quarterly, and would consider clinical practices, as well as any clinical incidents. Such incidents were collated as part of the health and safety performance monitoring. We were not sufficiently assured that the committee was provided with all relevant information in which to make informed judgements. For example, with regard to post-operative outcomes, detailed audits, and clinical policies. Therefore we could not be certain risks were being fully assessed and considered or that quality of practice would be changed.

- The MAC was described as being the main oversight committee for clinical services. A sub-committee had recently been set up, as the time taken to review re-validation matters was taking up too much time in the main MAC.
- MAC minutes were reviewed by us and we saw evidence of clinical incident and near-miss reviews having taken place. We noted the committees, which reported into the MAC, which included the Infection Prevention and Control Committee, Medics Meeting, Resuscitation Committee, and Research Governance Committee (related to the trials branch of the service).
- The service had a risk management strategy, which set out its aims to ensure risks were effectively controlled: It aimed to do this 'through a robust governance structure, sound processes and systems of working, and an open & fair blame culture that was focused on quality of service, patient and staff safety'.
- The corporate governance risk register (related to banking and business) and directorate risk registers, (sitting with the hospital manager), were reviewed in the Governance Committee meetings.
- There was no separate risk register for the consultation/ OPD area.
- We were told that risk assessments completed by staff in their areas fed into the risk register. The directorate risk register was shown to us. We noted this was limited on information, with only six risks, three of which were ranked as red, (a score of 10 or more). None of the risks related to recruitment and retention. The medical director and other staff had described this as a top risk. Further, we noted there was a limitation to information in the register, in particular as to how risks were mitigated.
- Risk assessments were completed within the theatre department and once approved went on to the risk register. We reviewed this and noted the top risks were staffing levels; risk of patient slips trips and falls due to leaks and latex allergies.
- Including the medical director there were 43 consultants with approved practising privileges. Of these, 11 were consultant anaesthetists and 15 consultant surgeons, as well as 16 medical consultants covering a range of specialties. One consultant had their registration validated in the reporting period (October 2015 to September 2016).
- The service reported in their pre-inspection information that 100% of theatre nurses and operating department practitioners (ODPs) had up to date professional registration in the reporting period October 2015 to September 2016.

Leadership / culture of service related to this core service

- There had been recent changes to the senior management team, with individuals appointed to relatively new positions. This included the hospital manager and quality assurance manager. As a result, the leadership and direction of the service was in the early stages of development. There was positive recognition of the direction of travel and how the team were going to enhance the quality of its services through its vision and strategy. There was still work to be done to ensure all information was collected and analysed, and made available for scrutiny by the MAC.
- The theatre manager was experienced and capable, and had the respect of their staff. They were in the process of developing expected processes and policies expected by NICE.
- The theatre staff reported to us being much happier with their change of department lead, they felt their working environment had changed for the better. Further, they told us they could talk to the hospital director and the general manager, and they were listened to.
- Theatre staff reported to us feeling supported by the department lead and would get help if there was any safeguarding or DoLS matter.
- Other staff who spoke with us reported liking working at the service, stating it was a good environment and relationships with colleagues was good. Areas for improvement related to communication, with the need to include staff in discussions about the plans for the future.

Requires improvement

Surgery

- Sickness rates for theatre nurses were 0% throughout the reporting period (October 2015 to September 2016), except in February 2016, when the rate was higher than the average of other independent acute hospitals we hold this type of data for.
- Sickness rates for theatre ODPs and health care assistants were 0% or lower than the average of other independent acute hospitals, we hold this type of data for in the same reporting period.
- Information provided to us in advance of the inspection indicated there were no vacancies for theatre ODPs and health care assistants as at 1 October 2016.
- The services pre inspection information indicated the rate of theatre nurse turnover was higher than the average of other independent acute hospitals we hold this type of data for, in the reporting period October 2015 to September 2016.
- The rate of theatre ODP and health care assistant turnover was higher than the average of other independent acute hospitals we hold this type of data for in the same reporting period.

Public and staff engagement

- The medical director informed us there had been an opportunity for members of the public to attend an information session related to a percutaneous laser disc procedure. Twenty people were said to have attended this session led by a neurosurgeon. It was hoped this procedure might be delivered in the future.
- There had not been any staff survey as such, and engagement with staff happened as a natural part of the general manager role. The general manager advised us he went to each area daily and spoke with staff. In addition, the staff appraisal was used to enquire about individual's job satisfaction. One to one meetings were held with staff according to their needs.

Innovation, improvement, and sustainability

- We were told about plans to increase transgender surgery. The vast majority of patient's required three or four procedures, and it was recognised patients preferred to have this done by the same provider.
- The executive team were aware their website did not reflect the full scope of services offered, and some of the services had changed location. A marketing executive was employed in September 2016, and they had been involved in the rewriting and relaunching of the website, which was anticipated to occur within the next few weeks of our inspection.

Outstanding practice and areas for improvement

Areas for improvement

Action the provider SHOULD take to improve

- Review the contents of the difficult airway box and ensure regular checks are undertaken on this equipment.
- The clinic should include the monitoring of compliance with the NICE guidelines CG65 Hypothermia, Prevention, and Management.
- Include the cleaning of wall mounted storage boxes and the drawers of the Gratnell trolleys in the theatre cleaning schedules.
- Make reference to female genital mutilation (FGM) in the revised safeguarding policy for children and adults.
- Review the risk register so that the content provides a more detailed oversight of risks and the mitigations for each of these, including any which may relate to outpatient areas.
- Review staff turnover rates in theatre with a view to identifying and contributory factors and addressing these.
- Ensure changes in policy, detailed audit results and the associated action plans are communicated to the MAC and other relevant governance groups.