152 Harley Street

Quality Report

152 Harley Street
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Date of inspection visit: 8 & 9 March 2017
Date of publication: 11/09/2017

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

Mental Health Act responsibilities and Mental Capacity Act and Deprivation of Liberty Safeguards

We include our assessment of the provider's compliance with the Mental Capacity Act and, where relevant, Mental Health Act in our overall inspection of the service.

We do not give a rating for Mental Capacity Act or Mental Health Act, however we do use our findings to determine the overall rating for the service.

Further information about findings in relation to the Mental Capacity Act and Mental Health Act can be found later in this report.

Summary of findings

Letter from the Chief Inspector of Hospitals

152 Harley Street is operated by 152 Harley Street Limited. Facilities included three operating theatres, a laser treatment room, a two-bed level two care recovery area, and X-ray, outpatient and diagnostic facilities. There are no inpatient beds.

The hospital provides surgical, outpatient and some diagnostic services for private patients. We inspected surgery, incorporating children and young persons, outpatients and diagnostic services.

We inspected this service using our comprehensive inspection methodology on 8 and 9 March 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.

Services we do not rate

We regulate cosmetic surgery services but we do not currently have a legal duty to rate them. We highlight good practice and issues that service providers need to improve and take regulatory action as necessary.

We found the following areas where the hospital performed well:

- There were systems in place to report and investigate safety incidents and learn from them.
- A regular paediatric agency nurse was used when children's procedures took place.
- Services were planned to meet the needs and choices of patients, and the arrangements for treatment were prompt.
- Complaints were appropriately acknowledged, investigated and responded to in a timely way.

However, we found the following areas where the service provider needs to improve:

- The new policy and protocols for nurses working in a dual role should be monitored effectiveness and updated for new operations.
- Continue to monitor and seek to improve the transportation outside of the hospital of contaminated surgical instruments by staff.
- Continue to update the risk register with the dates risks are identified, their management and date resolved.
- Consider introducing regular infection, prevention and control (IPC) hand hygiene audits.
- Review and resolve the trip hazard identified in the fourth floor operating theatre.
- Monitor and review fire/ emergency evacuation procedures, especially those for less mobile patients.
- Complete a Disclosure and Barring Service (DBS) check for all staff prior to them commencing employment.
- Clear guidance should be given to reception staff about those patients fasted before a surgical procedure and who should therefore not be offered any food or drinks.
- Consider whether formal recovery training is required to fulfil the full range of nursing duties undertaken by the nursing team.
- Update safeguarding policies to reflect triggers relating to slavery, female genital mutilation (FGM), forced marriage and PREVENT.
- Arrange for staff who had not done so, to complete the Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS) training package.
- Introduce methods to effectively measure patient reported outcomes.
- Make copies of the hospital's complaints leaflet readily available to patients.

Summary of findings

Professor Edward Baker
Chief Inspector of Hospitals

Summary of findings

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Summary of this inspection

Background to 152 Harley Street

152 Harley Street is operated by 152 Harley Street Limited. The hospital opened in 2010 and it is a private hospital within the area of central London known as the 'Harley Street enclave', which has a large number of independent hospitals and clinics within it. The hospital provided services to local and international clients.

The registered manager at the time of our inspection had been in post since June 2016.

The hospital occupies the third and fourth floor of its building and is accessed is by means of a lift or stairs.

The hospital provided day care and outpatient services; to both children of any age (excluding neonates) and adult patients. The range of services offered included dermatology, cosmetic, plastic and reconstructive surgery. Oral & maxillofacial surgery and complex dental reconstruction was also undertaken.

Our inspection team

The team inspecting the service was led by a CQC lead inspector supported by a CQC inspector and a CQC specialist advisor with expertise in surgical theatres.

The inspection team was overseen by Nick Mulholland, Head of Inspection: Hospitals (London South).

Why we carried out this inspection

There were no special reviews or investigations of the hospital ongoing by the Care Quality Commission (CQC) at any time during the 12 months before this inspection. The hospital was previously inspected by the CQC in February 2014. When the report was published in March 2014 we had concluded the location had met all the standards inspected. On this occasion we inspected the hospital on the 8 and 9 March 2017, as part of our independent hospital programme.

How we carried out this inspection

During the inspection, we visited the theatres, the recovery area, outpatient, diagnostics and reception areas. We spoke with ten staff including; registered nurses, health care assistants, reception staff, medical staff, operating department practitioners, and senior managers. We spoke with two patients and one relative. We also received four CQC 'tell us about your care' comment cards, which patients had completed prior to our inspection. During our inspection, we reviewed nine sets of patient records.

Information about 152 Harley Street

The hospital is registered to provide the regulated activities:

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

The registered manager has been registered with the commission since June 2016, and also acted as the accountable officer for controlled drugs.

The hospital employed a registered manager, four nurses and four administrative reception staff. The hospital used regular bank and specialist agency staff.

Summary of this inspection

152 Harley Street is a facility providing the following services:

- Five Consulting Rooms with a reception area.
- Three Operating Theatres.
- One laser treatment room and micrographic surgery base.
- A recovery area in which patients can rest and be closely observed in privacy and comfort following a surgical procedure.
- A dedicated cone-beam computed tomography (CBCT) room.

The imaging services are provided in the dedicated CBCT imaging room on the fourth floor. It provides dental/oral x ray and low radiation cone beam scanning of head and neck. This service was overseen by a consultant radiologist from an NHS hospital and is also subject to inspection by a Radiation Protection Advisor.

The hospital is for use by consultants who have been granted practice privileges by the Medical Advisory Committee (MAC) to consult and, if necessary, treat patients.

Activity:

- In the reporting period October 2015 to September 2016 there were 1,206 day case episodes of care recorded at the hospital; of which 52 were patients aged three to 17 years. All patients were independently funded.
- There were 7,282 outpatient total attendances in the reporting period; of which 1,065 were patients aged three to 17 years. All patients were independently funded.
- The hospital had a total of 89 doctors and dentists undertaking procedures under practising privileges (PP), of which 21 held PP for cosmetic surgery and all were on the GMC specialist register.

Track record on safety

During the reporting year October 2015 to September 2016 the hospital reported no never events, Meticillin-resistant Staphylococcus Aureus (MRSA), Meticillin-sensitive Staphylococcus Aureus (MSSA), Escherichia coli (E-coli) or Clostridium difficile (C.diff) hospital acquired infections.

During the same time period, the hospital recorded four clinical incidents of which three resulted in no harm and one in low harm. No incidents of a more serious nature were recorded.

Services accredited by a national body:

- Diagnostic imaging/radiology
- Laser surgery

Services provided at the hospital under service level agreement or contract:

- Clinical and or non-clinical waste removal
- Instrument sterilisation
- Building Maintenance
- Laser protection service
- Fire safety
- Laundry
- Maintenance of medical equipment
- Pathology and histology
- Pharmacy
- I.T services

Summary of this inspection

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?

- We found there were systems to report and investigate safety incidents and learn from these.
- There were sufficient numbers of staff to meet patient's needs. We found the nursing team skill mix had recently changed to include more theatre experienced nursing staff.
- A regular paediatric agency nurse was used when children's procedures took place.
- Risks were understood and a risk register was in place which listed a range of risk including environmental and clinical risks.

However;

- We observed a surgical procedure during which the scrub nurse was required to act in a dual role and assist the surgeon. If not properly trained for the dual role and the procedure not risk assessed, as in this case, the nurse would be working outside of their professional competence.
- Contaminated surgical instruments were transported by trolley to another site for sterilisation by nursing staff, which could expose the staff and public to potential harm. Following our inspection we have been provided with a revised policy and procedure (Policy for the Transportation of contaminated Medical Devices). The new procedure secured the contaminated instruments in a sealed box prior to transportation off site for collection.
- The fire safety evacuation measures required clarification for immobile patients.
- The safeguarding policies had not been updated to reflect triggers relating to slavery, female genital mutilation (FGM), forced marriage and PREVENT.
- Disclosure and Barring Service (DBS) check results were not always seen prior to employment of staff.

Are services effective?

- Care was planned and delivered in accordance with current guidelines, best practice and legislation by suitably skilled and competent staff.
- There was a programme of regular audit which was used to assess the effectiveness of service and to maintain care standards.
- Patients pain management needs were addressed by staff.

Summary of this inspection

- Patients were provided with good information which allowed them to make informed decisions about surgery.

However;

- We found some staff lacked training on the Mental Capacity Act and Dementia.
- Reception staff were not always fully aware which patients were nil by mouth prior to their surgery.

Are services caring?

- Staff at this hospital treated patients with care and compassion and provided patient-focused care which met individual needs.
- Patients gave positive feedback and said staff provided personalised care with kindness and efficiency.

Are services responsive?

- The services were consultant led, and patients' needs were assessed by consultants with practising privileges at the hospital.
- Not all outpatient contacts took place on site, which meant pre-assessments and patient information was provided by each lead consultant prior to booking their surgery on site.
- Services were planned to meet the needs and choices of patients, and the arrangements for treatment were prompt.
- Complaints were appropriately acknowledged, investigated and responded to in a timely way.

However;

- The provider did not display information about its complaints process at the hospital site.

Are services well-led?

- The service had a well-established medical leadership team with a new registered manager who had been in post over the last nine months.
- Working relationships with staff were good and staff understood their contribution to the overall values and purpose of the service.
- There was good leadership at the hospital and evidence of an excellent working relationship between the directors and consultants with practicing privileges, the registered manager, and the other staff.

Summary of this inspection

- Staff understood what was expected of them and had a strong ethos of assuring the delivery of services met the requirements of their patients.
- Patents and staff were encouraged to feedback on the quality of services.
- The governance arrangements provided assurance of systematic monitoring of the quality of service.

However;

- The hospital had a risk register, but it did not contain relevant dates, such as when the risk was identified and when any remedial action was taken.

Surgery

Safe	
Effective	
Caring	
Responsive	
Well-led	

Are surgery services safe?

Incidents

- The hospital had not reported any never events between August 2015 and September 2016. Never events are serious incidents that are entirely preventable as guidance, or safety recommendations providing strong systemic protective barriers, are available at a national level, and should have been implemented by all healthcare providers.
- The staff we spoke with were fully aware how to report incidents. Incidents were logged as clinical or non-clinical and recorded on a spreadsheet. The hospital recorded four clinical incidents during the reporting period, one of which occurred in surgery and one in outpatients/diagnostic services. The remaining two occurred in other non-regulated areas. Each incident had been investigated by the manager or other authorised member of staff. All clinical incidents were discussed at the monthly medical advisory committee and we found the outcomes logged on the spreadsheet and in the incident file.
- The outpatient/diagnostic incident involved a low radiation cone beam CT scan, which had to be repeated due to the initial scan being slightly inaccurate. The patient was not over-radiated as per the Ionising Radiation (Medical Exposure) Regulations (IRMER) guidelines, and the incident was discussed and agreed with the external radiation protection advisor.
- From November 2014, registered persons were required to comply with the duty of candour, Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The duty of candour is a regulatory duty, that relates to openness and transparency, and requires providers of health and social care services to notify patients (or other relevant persons) of certain 'notifiable safety incidents' and provide reasonable support to that person. This means providers must be open and honest with service users and other 'relevant persons' (people acting lawfully on behalf of service users) when things go wrong with care and treatment,giving them reasonable support, truthful information and a written apology. The staff we spoke with had an awareness of 'duty of candour', although they were unable to provide an example of when they had to implement it. Written details were displayed on the staff notice board.

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

- The hospital, unlike NHS trusts, is not required to use the national safety thermometer to monitor areas such as venous thromboembolism (VTE).We explored whether this should be part of the regular monitoring in use and found for most of the surgical procedures undertaken this was not appropriate. However, NICE recommends all healthcare professionals follow the quality standard in the clinical guideline CG92. The provider told us they did not generally conduct VTE assessments as patients did not require general anaesthetic. Patients subject to sedation would be pre-assessed by the anaesthetist.
- A quality monitoring schedule was in place and all adverse events were taken to the Medical Advisory Committee. The hospital used a range of external specialists to support them for example, on radiology safety, wound care management and pharmacy advice.

Cleanliness, infection control and hygiene

- The hospital had an Infection Prevention and Control (IPC) policy based on the Health and Social Care Act 2008:code of practice on the prevention and control of infections and related guidance, and staff we spoke with were aware of infection control procedures.

Surgery

- The registered manager was the interim IPC lead and had undertaken additional IPC training from an external provider.
- The provider recorded nine surgical site infections during the reporting period. All were swabbed and recorded during post-surgery outpatient appointments. Six were patients treated at the hospital and the remaining three were for patients attending for wound dressing having had their surgery elsewhere. The patients who had their surgery at the hospital had undergone minor procedures such as scar revision and cyst drainage. Patients generally left the hospital shortly after their minor procedures were completed and were given instruction regarding any wound/dressing care they may be required to do prior to any follow-up appointment. The hospital kept a log of all possible wound infections and swabs had been taken to ensure appropriate treatment regimes. The results were sent directly to the consulting surgeon who had performed the operation to implement any treatment plan required.
- There were no incidents of MRSA or MSSA in period of October 2015 and September 2016. During the same reporting period there were no cases of C.diff or E.coli infections.
- Patients scheduled for a surgical procedure underwent a pre-operative assessment, which could include screening for MRSA and MSSA. Patients who were at a higher risk of MRSA such as those scheduled for implant surgery, those returning from or residing overseas, those who had recently been in hospital or unwell were screened.
- All areas of the hospital were visibly clean and well maintained. The theatre was cleaned by the nurse after each procedure, and the area was cleaned by a cleaner responsible for the rest of the hospital once a day. We saw evidence which showed the theatres were deep cleaned every six months under contract.
- A contract was in place for the cleaning and sterilisation of the surgical equipment. We found the contaminated surgical equipment was not transported appropriately. Staff were required to transport contaminated surgical equipment on a trolley to another hospital site nearby for collection, This posed a risk to staff and the public. The risk had not been fully risk assessed. It was documented on the risk register as a manual handling risk for staff. We found the method of transportation could expose staff and the public to potential harm from contaminated surgical equipment.
- Since our inspection a new policy and procedure has been implemented and a copy sent to us. This indicated that the contaminated instruments were secured in a sealed box prior to transportation off site for collection. We are assured the new procedures mitigate risks to staff and public.
- Personal protective equipment (PPE) was available to all staff, in line with Health and Safety Executive (2013) Personal protective equipment (PPE): A brief guide. Staff were observed to be bare below elbow, which encourages proper handwashing before and after each patient contact. We observed this happened in practice. An infection control audit carried out in January 2017 by external IPC advisors reported an 81% compliance rate. As a result extra signs were displayed in relevant areas showing correct hand hygiene techniques and the IPC link nurse gave extra instruction to staff. However, we noted the hospital did not undertake regular hand hygiene audits.
- There were notices in all areas highlighting the correct method for hand washing. Hand gel was available in all of the treatment rooms. The examination tables were provided with disposable paper covers.
- Waste was managed by staff in accordance with Department of Health (2013) HTM 07-01: Safe management of healthcare waste.
- Staff disposed of sharps, such as 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.

Environment and equipment

- The environments in which patients received their consultations, treatment and minor surgical procedures were well maintained and mostly arranged to ensure their safety. There were two minor operating theatres, separate consulting rooms, a treatment room and a designated sedation theatre with two recovery bays adjacent to the theatre. We observed the sedation theatre during surgery and found whist the patient was attached to the monitoring equipment this caused a potential trip hazard for staff.

Surgery

- Resuscitation equipment was accessible in each theatre. The resuscitation trolley in each theatre was checked and the grab emergency bag containing emergency drugs and equipment was opened weekly to check for expiry dates. There was a separate paediatric resuscitation grab bag. Our checks confirmed this.
- An automatic external defibrillator (AED) was kept within the theatre on both floors and checked daily.
- Staff told us they had sufficient equipment for their roles and supplies were ordered in a timely manner to ensure continuous availability. The manager had responded to a request from theatre staff to provide additional boxes for the safe storage of equipment.
- Theatre equipment was well maintained and regularly serviced in accordance with a service level agreement from an external company.
- Both the third and fourth floor had a nurse call system for patients to summon assistance in an emergency situation.
- The patient waiting area was well set out and could be observed from the reception desk. Due to restricted space both children and adults shared the waiting area. At the time of inspection the hospital tried to provide young patients with a separate area to wait when possible.
- Age appropriate children's toys were available and we found a cleaning schedule in place.
- The dedicated cone-beam computed tomography (CBCT) room was properly secured against casual entry and there was signage outside to indicate a procedure was taking place. We noted the CBCT machine was regularly maintained. We also saw evidence of regular testing and recording of its use compliant with the Ionising Radiation (medical exposure) regulations 2000 as amended, (IR(ME)R).
- The hospital had a carbon dioxide (CO2) laser which was used for various treatments. There was a sign warning against entry and the laser room door could be locked from inside. Blackout blinds were fitted on the windows and other reflection hazards were minimised. We saw evidence of regular testing and servicing of the equipment and the availability of safety eyewear.

Medicines

- All medicine storage units were visibly clean and lockable to prevent unauthorised access.
- The controlled drugs (CD) were in a locked cabinet within the locked medicines cupboard. The key was kept separately in a secure safe to which only the authorise staff knew the code. Daily checks were in place for the quantities of CDs' kept on site.
- No CD's were dispensed to patient's to take away; any such drugs required were prescribed on a private CD prescription.
- The CD policy set out the procedure for disposal of CD's which involved destruction of the drugs in the presence of the pharmacist and registered manager.
- Fridge temperatures were checked daily and recorded. Staff were able to tell us how they would respond if they found the temperatures out of permitted range.

Records

- We looked at nine sets of patient notes relating to patients treated at 152 Harley Street. All records were scanned onto the computer system and the paper records shredded on a daily basis. The records were legible, signed and dated, and had been completed to a good standard.
- Patient medical history was received at the hospital from the consultant and included with the patient's record generated by the hospital on the day of treatment. This included consent and a further medical history completed by the patient. Medical records generated at the hospital were retained although consultants were able to take copies for their own files.
- We noted patients having intravenous sedation had a pre-operative check which included recording of allergies, completed and signed consent form. A perioperative care plan was in place for each patient and operation notes.
- The records included the procedure carried out and details of any implants used.
- We found an implant register was in place which listed all dental and cosmetic implants used in surgery.

Safeguarding

- There had not been any safeguarding matters reported to the commission during the year up to our inspection visit.
- The registered manager and the front of house manager were the safeguarding leads for the hospital and were both trained at level 3. All other reception and nursing staff were trained to level 2. Staff we spoke with were aware of safeguarding and what to do it they identified a concern.

Surgery

- The consultants who carried out procedures on young patients were trained to children and young people safeguarding level 3.
- The hospital had a safeguarding policy titled 'safeguarding adults'. Staff we spoke with were aware of its contents and how to report a concern. We also saw a children and young person safeguarding policy titled 'safeguarding children' and again staff we spoke with were aware of its contents. The leads had additional information on sources of support and advice outside of the hospital they could contact.
- The adult safeguarding policy had recently been updated and included a definition of adult abuse; however, the children's safeguarding policy was in the process of being updated. Following our inspection we have seen an updated draft policy.
- The hospital staff had all completed adult and children and young person safeguarding training a few weeks before our inspection. However, the active policies at the time of inspection had not been updated to reflect triggers relating to slavery, female genital mutilation (FGM) and forced marriage. In addition the policies did not include the PREVENT strategy; a cross government policy requiring healthcare organisations to work with partner organisations to contribute to the prevention of terrorism by safeguarding and protecting vulnerable individuals who may be at a greater risk of radicalisation and by making safety a shared endeavour.
- We reviewed staff records and found one member of staff recently recruited did not have a Disclosure and Barring Service (DBS) check prior to employment. This meant not all safety checks had been completed before the member of staff had started in post. Immediate action to rectify the error was taken by the manager. The nurse in question had previously been employed at an NHS hospital and so had a DBS check completed there

Mandatory training

- A mandatory training schedule was followed, and we found the manager monitored staff completion and training requirements. Subjects expected to be completed included for example; first aid, infection control and manual handling.
- All staff were certified in basic life support (BLS adults and paediatrics). During our inspection we saw a staff training schedule and evidence in staff personal records confirming training undertaken.
- All nine members of staff had completed safeguarding, information governance, basic life support and paediatric basic life support. Seven members of staff had completed IPC training, six members of staff had completed fire safety training, four had completed equality and diversity training and three had completed moving and handling training. Three members of staff had completed Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS) training and none of the staff had completed the dementia awareness training. We saw evidence training had been arranged for the staff who had not completed the above training and scheduled to be completed by the end of March 2017.

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

- We saw evidence within the patient notes reviewed of risk assessments relevant to the patient's needs having been carried out.
- Theatre staff used a surgical checklist based on the World Health Organisation (WHO) guidance. We followed a patient through their procedure and saw the WHO checklist completed. The WHO five steps to safer surgery 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. However, neither its use nor its format is mandatory for independent hospitals and WHO encourage modifications to suit local situations.
- Surgical procedures carried out on-site were performed under local anaesthetic or conscious intravenous sedation. The anaesthetist was required to remain with the patient until the patient was awake and orientated after each procedure where conscious sedation was used. The surgeon also remained on-site. Conscious sedation is defined as 'a technique in which the use of a drug or drugs produces a state of depression of the central nervous system enabling treatment to be carried out, but during which verbal contact with the patient is maintained throughout the period of sedation. The drugs and techniques used should carry a margin of safety wide enough to render loss of consciousness unlikely'.
- The hospital did not provide high dependency, intensive or overnight care. In an emergency situation the

standard 999 system was used to transfer the patient to an NHS hospital. If the patient had not recovered sufficiently to return home safely the patient would be transferred under a service level agreement to a larger local independent hospital. In the year leading up to our inspection there had been no such transfers.

- The hospital did not have a policy in place setting out patient admissions or exclusions criteria. We were given a statement by the provider which stated;

"There is no policy in place for admissions, patient selection or exclusions. The clinic does not 'admit' patients as we are an outpatient day case facility however there is an agreed set of patient exclusions for sedation procedures as listed below:

Patient Exclusions for sedation procedures:

1. Patients with an ASA score of above 2.

2. Patients taking lithium.

3. Patients with a cardiac condition (this would be taken care of under the ASA scoring exclusions).

4. Type 1 diabetic patients.

5. No children to undergo sedation".

- Patients' clinical observations were recorded and monitored in line with the National Institute for Clinical Excellence (NICE) guidance (CG50) 'Acutely Ill-Patients in Hospital.' We saw patient's post-operative observations were recorded as a recovery record within their notes.
- There was a service level agreement (SLA) with a nearby larger private hospital to admit patients who had deteriorated to the point of requiring more intense medical input.
- Patients were provided with contact numbers for the consultant and other staff should they have post-operative concerns. Discharge advice sheets informed patients "in the event of an emergency outside office hours a recorded message will tell you how to contact your consultant." Specific discharge advice following intravenous sedation was provided to ensure patients had clear instructions and were escorted home. Patients were requested to sign the document to acknowledge receipt.
- Staff were aware of the two week cooling off period for patients who were to have surgery which is generally recognised within the cosmetic industry as good practise. A consultant told us the cooling off period before surgery was normal practice at the hospital. The latest guidance from the GMC which was published in June 2016 states; 'The amount of time patients need for reflection and the amount and type of information they will need depend on several factors. These include the invasiveness, complexity, permanence and risks of the intervention, how many intervention options the patient is considering and how much information they have already considered about a proposed intervention.'

Nursing and surgical staffing

- The theatre staffing levels were in line with those recommended by the Academy of Medical Royal Colleges' 'safe sedation practice for healthcare procedures October 2013'.
- The hospital had recently changed its nursing team's skill mix. The newly employed nurses were required to have recent surgical theatre experience. We reviewed two recruitment files and found this to be the case. The hospital used one regular bank recovery nurse and a regular specialist paediatric agency nurse.
- The small surgical list allowed procedures to be scheduled to suit patient's needs and staff availability. We noted, for example, paediatric procedures were scheduled to ensure a paediatric nurse was present. We reviewed three paediatric records and the paediatric nurse was present during each procedure.
- Radiography staffing consisted on one staff member who had undertaken a postgraduate course in radiology. She had been trained to operate the CT cone machine and as a laser theatre assistant.
- The cone CT scanning machine is used to take images of the head and neck areas. The provider used an agency member of staff to cover periods of leave; however, patients were usually scheduled when the regular staff member was on duty.
- There were SLA agreements for the provision of a radiation protection advisor and laser protection advisor services.
- The one staff member acted as the radiation supervisor and their role was clearly stated in the radiation policy and signed by the staff member. The same member of staff was the laser protection supervisor (LPS).
- During our inspection we observed a surgical procedure which required the scrub nurse to assist the surgeon. The procedure witnessed took over an hour to complete

and was not considered minor due to its complexity. This put the scrub nurse into a dual role situation; required to work both as a scrub nurse and a surgical first assistant.

- In 2011, the Royal College of Surgeons of England called for greater clarity in relation to the wide range of titles used by practitioners assisting in surgery. The Perioperative Care Collaborative (PCC) released a position statement in November 2012, which defined the role of the surgical first assistant (SFA) as "the role undertaken by a registered practitioner who provides continuous competent and dedicated assistance under the direct supervision of the operating surgeon throughout the procedure, whilst not performing any form of surgical intervention. This distinguishes the role from that of the scrub practitioner who may provide assistance on an 'as required' and risk-assessed basis particularly during minor procedures, such as carpel tunnel release, within the context of and without compromise to the scrub role". The statement continued, "In the event that an employer considers that a dual role is required, then this decision should be endorsed by a policy that fully supports this practice and should also be based on a risk assessment of each situation in order to ensure patient safety".
- We discussed what we had witnessed with the surgeon and registered manager. The hospital did not have a policy in place to support the theatre nurses in undertaking a dual role. At the time of our inspection the nurses did not have specialist training to undertake the role and their competencies had not been assessed. The immediate reaction of the senior management team was to cancel surgical procedures scheduled for the following day whilst they took advice on how they should structure their surgical list and allow the nursing staff to work appropriately within remit. Within a few days the scrub nurse had been additionally trained and certified, surgical procedures had been risk assessed and included in the newly written 'Policy for the Management of Risk in a Surgical Setting'. As a result we were assured the hospital had taken active steps to maintain patient safety.

Emergency awareness and training

- Fire risk assessments were carried out on an annual basis by a fire officer. Fire alarms were subject to testing on a weekly basis. There were fire extinguishers at the hospital and these were labelled with an annual service tag.
- Fire safety awareness and fire warden training was part of the mandatory training for staff. We spoke with staff who told us they had received recent fire training and had taken part in a fire evacuation drill during the week of our inspection. Staff told us they were not confident in the use of the fire evacuation chair due to safety issues related to the narrow and steep fire escape. The theatre staff told us they would keep any sedated patients in theatre behind the closed fire doors until help arrived in line with advice from the fire officer. Following a fire safety review this has been adopted and incorporated in to the hospital's policy. The manager was aware of the concerns related to the use of the fire chair and had looked into an alternative.
- There was a backup generator which would operate for a period of two hours to provide continuity of electrical supply to the theatres in the event of a loss of 'mains' power.

Are surgery services effective?

Evidence-based care and treatment

- Nurses and surgeons generally delivered care in line with the relevant National Institute for Health and Care Excellence (NICE) and Royal College guidelines, such as the Royal College of Anaesthetists and the Academy of Medical Royal Colleges. The hospital protocols were based on national guidance used to deliver care to patients receiving cosmetic procedures.
- Hospital policies were developed against those used in the NHS and NICE and GMC guidelines.

Pain relief

- Prescribed local and conscious sedation medication was administered for effective pain relief during the procedure. If required, patients were given a private prescription for pain relief medication to take home post procedure. At the stage of pre-operative assessment and at discharge patient's expectations of pain and mobility were discussed and recorded.

Surgery

Nutrition and hydration

- The hospital provided water, tea and coffee to all patients and could provide soup for surgical patients as required.
- Some procedures undertaken at the hospital did require fasting prior to admission. The pre-operative assessment checklist includes a nil by mouth review with the patient. The fasting requirements were not excessive and followed fasting guidelines.
- We found the reception staff were not always aware which patients were fasting and could inadvertently offer the patient a drink whilst in the waiting area. Staff suggested this information could be added to the booking schedule for each patient and the manager agreed this would be processed straight away to avoid future occurrence.

Patient outcomes

- The hospital had completed 1,206 surgical procedures during 2015 to 2016 prior to our inspection. Information provided showed there were no returns to theatre and no re-admissions during that time.
- Fifty-two of these procedures were performed on children and young people under local anaesthetic. No conscious sedation procedures were provided to children on site.
- Prior to our inspection the hospital had not cancelled any appointments over the last year. The registered manager informed us they have never cancelled any appointments, although they are aware the consultant and their own teams could cancel and rearrange their own appointments, which was not in the control of the hospital booking team.
- There was a hospital program of audits undertaken, which included audits of infection control measures, medicine management and radiology quality assurance. Such audits were conducted to gather information to improve patient care and safety.
- The hospital at the time of our inspection had not 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).
- The Royal College of Surgeons has requested providers of cosmetic surgery to submit Q- Patient Reported Outcome Measures (Q-PROMs) for cosmetic surgery procedures such as liposuction, rhinoplasty and breast augmentation. PROMs are distinct from more general measures of satisfaction and experience, being procedure-specific, validated, and constructed to reduce bias effects. The data gathered from the use of PROMs can be used in a variety of ways to empower patients, inform decision making and, where relevant, support quality improvement. At the time of our inspection the hospital did not collect and submit Q-PROMS data; although they had plans to introduce Q-PROMS questionnaires during 2017.
- This meant the hospital had little information with which to measure patient outcomes in order to demonstrate quality of care.

Competent staff

- Staff we spoke with reported they received annual appraisals and opportunities for professional development.
- The nursing team were expected to rotate through theatre working as a scrub nurse and recovery nurse. All nurses felt confident in their roles; although it was noted none of the nurses had formal additional recovery training, with the exception of the bank recovery nurse.
- Practising privileges is a term used when doctors have been granted the right to practise in an independent hospital. Under the hospital's practicing privileges agreement each surgeon was required to attend their patient in person. We noted the policy regarding practicing privileges was last reviewed in 2013. At the time of our inspection the hospital had authorised practicing privileges for 89 doctors and dentists.
- Consultants with practising privileges were required to keep their skills and practices updated as part of their contract. They were also required to remain on the specialist register of either the General Medical Council (GMC) or the General Dental Council (GDC) as appropriate.
- We examined a random selection of ten practising privileges folders and saw they contained the required documents such as DBS checks, indemnity insurance, CV's and appraisals.
- We saw evidence of yearly appraisals for most staff and a plan was in place to ensure outstanding appraisals were completed.
- The hospital manager ensured professional registration, fitness to practice, and validation of qualification checks were undertaken for all staff. Medical staff holding practising privileges had all undertaken revalidation. This was confirmed in the ten records we examined.

- Staff told us there was an on the job induction programme in place. The manager had been responsive to staff gaps in competency and had arranged for new staff to receive specific wound management training from an external wound care specialist. Certificates confirming this training were seen in staff files.

Multidisciplinary working

- All of the staff we spoke with told us communication was good at the hospital, being such a small team meant they were able to have their say, get feedback and report any problems immediately.
- Regular monthly team meetings were held, which supplemented the general day to day staff contact. The meetings were used to provide more formal feedback on previously raised issues, and to give an open forum to raise new matters.
- The staff told us there had been a recent improvement as they could now view minutes of meetings, including the medical advisory committee minutes, on the computer records shared folder files and this helped to ensure staff were aware of current issues and actions taken.

Seven-day services

- The hospital did not provide a seven day service.
- If patients had any concerns they were able to contact the hospital, the surgeon or the anaesthetist post-operatively by means of telephone numbers supplied as part of their discharge information.

Access to information

- Previous medical notes were transported to the site by the consultant at the time of the booked appointment and later scanned into hospital records.
- The hospital stored patient information on a secure digital patient database. There were no paper files held on site, all records are stored electronically. Paper records were scanned and shredded daily.
- Authorised staff had access to the electronic and paper patient records and all staff had access to hospital policies, audits and the complaints folder.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Hospital appointments for surgical procedures were made following an outpatient consultation, some of which take place at other venues outside 152 Harley Street. Patients are provided with information by their consultant and are then booked into 152 Harley Street for their theatre appointment. Staff told us they have never encountered a walk in patient booked for a surgical procedure.
- Staff had a general awareness of the Mental Capacity Act 2005, but felt they would not be leading this process. Staff stated the consultant would lead the process. The consultants we spoke with understood their responsibilities under the Act.
- We found some staff lacked training on the Mental Capacity Act and Dementia. The manager told us three of the nine staff had recently completed the e-Learning module which all staff are required to complete.
- The hospital only accepted children and young people as patients if accompanied by a parent or guardian with legal authority to give consent. The consent policy makes it clear to staff that not all parents have 'parental responsibility. There is a separate paediatric consent form used for patients under the age of 18 years. Verbal consent was checked at all stages. One of the paediatric consultants explained the process to us and that the child was able to withdraw their consent at any time.

Are surgery services caring?

Compassionate care

- Patients we spoke with described their care as "excellent." We observed interactions between staff and a patient prior to, during and following a surgical procedure. Staff were very caring and kind in their administrations and demonstrated a calmness and compassion. Any discussions were open and informative, with checks on understanding and agreement. We did not witness any staff interaction with patients less than 18 years of age.
- The hospital gave patients a satisfaction survey to complete after each consultation. Although the response rate was low, all responders viewed their care by the consultant and nurse as "excellent" (84%) or "good" (16%). The provider had recently improved the questionnaire to increase its response rate.

Understanding and involvement of patients and those close to them

- The hospital had improved its website and created a new YouTube channel with in-house patient experience videos; all of which provided patients with information about the treatment pathways provided.

Surgery

- Patients we spoke with told us they had researched the service and consultant through its web site. One patient told us the YouTube videos had provided helpful information.
- Staff gave patients clear instructions about managing their surgical wounds and any follow up appointments required.
- Patients were offered the opportunity to have a friend or relative present during consultations and examinations. The hospital had a chaperone policy and patients their availability was brought to patient's attention prior to consultation.

Emotional support

- We were told consultants provided psychological assessment for cosmetic surgery outside of 152 Harley Street.
- A new scar clinic established in 2016 has a psychologist as part of the expert multidisciplinary team.

Are surgery services responsive?

Service planning and delivery to meet the needs of local people

- The hospital provided consultant led dermatology, plastic surgery, oral and maxillofacial surgery and complex dental reconstruction.
- Prospective clients made contact via the web site or by telephone and staff responded to enquiries on a daily basis. Patients were put in touch with the relevant consultant's personal assistant who gathered information and organised an assessment appointment. Some appointments were carried out on site, although some may have taken place at other venues.
- As the hospital provided private elective surgery, admissions were planned in advance at times to suit the patients. None of the procedures carried out at the hospital involved an overnight stay, although transfer arrangements were in place should the patient unexpectedly require it.

Access and flow

- Patients we spoke with told us they had not experienced any delays in obtaining an outpatient appointment.
- Staff confirmed no unplanned surgery took place.
- Patients for surgery arrived at the hospital close to the time of surgery and a pre-operative assessment took place with the surgeon and anaesthetist. A pre-operative checklist was completed and consent obtained.
- Procedures on children and young people were planned and scheduled so as to be able to provide appropriate the correct staffing levels and to keep waiting times to a minimum.
- There were 7,282 outpatient appointments in the 12 months prior to our inspection. A total of 1,206 procedures were performed under local anaesthetic or conscious sedation during the same period.
- No appointments were cancelled directly by the hospital, although the consultant and their team could cancel and rearrange with the patients independently.
- Patients were discharged home with post-op care instructions, and pre-booked appointments for follow-up care either at the hospital or at a location arranged by the surgeon.
- As part of the aftercare service offered we saw evidence that a hospital nurse made a follow up telephone call to patients within 24 hours of a surgical procedure.

Meeting people's individual needs

- Each patient was provided with a patient guide booklet, which set out information about the services provided at the hospital.
- Information on a range of patient pathways had been made accessible on the providers YouTube channel including frequently asked questions about the sedation service.
- The patient's discharge plan included advice specific to the procedure undertaken as well as information relating to any pain relief or wound care advice.
- The hospital had links with various embassies if interpreting services were required, although we were told most patients who had difficulty understanding English attended with someone able to interpret. The hospital did not provide a translation service.
- We saw patient information was given following a procedure such as wound care advice and after care following intravenous sedation.
- The hospital had a lift which enabled access to the services, which were based across both the third and fourth floor of the building.

Surgery

Learning from complaints and concerns

- In the year prior to our inspection the hospital had logged three complaints which were investigated, resolved and lessons learnt shared. For example, one patient complained on attending for a wound care dressing the appropriate dressing was not available. Staff were now checking on the schedule of appointments and contacted the consultant to clarify the type of dressing required if the initial treatment had not taken place at the hospital.
- Hospital staff were aware of the complaints policy, however the complaints policy was not well publicised at the hospital site. Since our inspection the hospital has introduced a leaflet advising clients how they can complain about the service and what would happen when they did.

Are surgery services well-led?

Leadership / culture of service related to this core service

- The medical director and the hospital manager were both visible and easily accessible according to the staff we spoke with. Staff reported they felt supported and their views respected.
- We observed a team attitude amongst the staff members. Staff were seen to be able to approach senior medical staff during and as part of their day to day work.

Vision and strategy for this core service

- The hospital manager provided us with a copy of the hospital's vision and strategy which in summary was "to put the safety and well-being of the patient first at all times and to work collaboratively with consultants and specialists to achieve the best possible treatment outcomes for our patients with a modern, holistic and synergistic approach. The continuing strategy was "to work with and strengthen our relationships with local and international referrers and the medical community, continuing to attract only the highest calibre of surgeons and specialists to the business."
- Staff were aware of the hospital's mission statement and values and had been part of the recent developments such as the web site update and updating patient information.

Governance, risk management and quality measurement

- We saw evidence from the Medical Advisory Committee (MAC) meeting minutes of consistent monitoring of provided services by reviewing audit results. There was also discussion and agreement around ways to improve the service offered. The MAC meetings took place quarterly. It was usual practice for the MAC to advise the registered manager on matters relating to the granting of practising privileges, clinical standards, new and emerging professional guidance, the introduction of new treatments and capital investments.
- The hospital had just introduced a clinical governance committee into its structure in January 2017. The clinical governance committee was chaired by an external clinical advisor and aimed to meet quarterly to focus on clinical matters such as infection control and medicine management.
- The hospital did have a formal risk register which was reviewed by the management team. A risk register is a management tool that enables an organisation to understand its comprehensive risk profile. We reviewed the risk register with the manager and found it did not include dates when risks were identified and managed. Since our inspection we have received a revised risk register which included dates the risk was identified and date any action taken.
- We found the hospital had used the risk register to support service improvements such as updating equipment.
- We saw the laser equipment and safety audit, the laser Local Rules and the contract with a local NHS hospital to provide Laser Protection Advisor (LPA) services.
- Audits were discussed at the Medical Advisory Committee and actions following audits taken swiftly; for example reducing the antibiotic stock kept on site.

Public and staff engagement

- The hospital engaged with the public through its website and YouTube channel where consultants can be seen answering frequent questions and taking patients through key procedures.
- Patients were able to email any questions or give email feedback. New patients were able to request an appointment via email.

Surgery

Innovation, improvement and sustainability

- During 2016 152 Harley Street introduced new procedures such as breast augmentation under local anaesthetic and sedation, facelift under local anaesthetic and sedation. They also reported growth in areas such as specialist dermatology and laser treatments.
- The hospital introduced the London scar clinic where patient care was delivered by a multidisciplinary team of expert scar specialists.

Outstanding practice and areas for improvement

Areas for improvement

Action the provider SHOULD take to improve

- The new policy and protocols for nurses working in a dual role should be monitored effectiveness and updated for new operations.
- Continue to monitor and seek to improve the transportation outside of the hospital of contaminated surgical instruments by staff.
- Continue to update the risk register with the dates risks are identified, their management and date resolved.
- Consider introducing regular infection, prevention and control (IPC) hand hygiene audits.
- Review and resolve the trip hazard identified in the fourth floor operating theatre.
- Monitor and review fire/ emergency evacuation procedures, especially those for less mobile patients.
- Complete a Disclosure and Barring Service (DBS) check for all staff prior to them commencing employment.
- Clear guidance should be given to reception staff about those patients fasted before a surgical procedure and who should therefore not be offered any food or drinks.
- Consider whether formal recovery training is required to fulfil the full range of nursing duties undertaken by the nursing team.
- Update safeguarding policies to reflect triggers relating to slavery, female genital mutilation (FGM), forced marriage and PREVENT.
- Arrange for staff who had not done so, to complete the Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS) training package.
- Introduce methods to effectively measure patient reported outcomes.
- Make copies of the hospital's complaints leaflet readily available to patients.