The Andrology Company Limited

The Andrology Company

Inspection report

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

Ratings

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

Summary of findings

Overall summary

We rated it as good because:

- The service had enough staff to care for patients and keep them safe. Staff had training in key skills, understood how to protect patients from abuse, and managed safety well. The service controlled infection risk well.
- Staff assessed risks to patients, acted on them and kept good care records. The service managed safety incidents well and learned lessons from them.
- Staff provided good care and treatment, gave patients enough to eat and drink, and gave them pain relief when they needed it.
- Staff worked well together for the benefit of patients, advised them on how to lead healthier lives and supported them to make decisions about their care.
- Patient feedback was positive and showed that staff treated patients with kindness, respected their privacy and dignity, provided emotional support to patients, and helped them understand their condition(s).
- The service planned care to meet the needs of local people, took account of patients' individual needs, and made it easy for people to give feedback. People could access the service when they needed it and did not have to wait too long for treatment.
- Leaders ran services well using reliable information systems and supported staff to develop their skills. Staff understood the service's vision and values, and how to apply them in their work.
- The service had an open culture where patients and staff could raise concerns without fear. Staff felt respected, supported and valued.
- Leaders identified and escalated relevant risks and issues and identified actions to reduce their impact.

However:

- Leaders had implemented governance structures and processes which were in their infancy and more time was needed to embed them.

Victoria Vallance

Director of Secondary and Specialist Healthcare

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Surgery	Good 	Surgery was the main activity at this service. See the overall summary for details.

Summary of findings

Contents

Summary of this inspection

Background to The Andrology Company

The Andrology Company is operated by The Andrology Company Ltd. The service opened in September 2021. It is a private clinic in London. The clinic offers services on self-referral or referral from other healthcare professionals.

The clinic has a registered manager in post. A registered manager is a person who has registered with the CQC to manage the service. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

The main service provided is surgery. The service offers andrology and urology services and day case operations. The clinic has an operating theatre, a recovery area and a clinic room. The clinic provides specialist services in men's sexual health, urogenital health, fertility and well-being. The clinic offers circumcisions for medical reasons only and provides Low Extracorporeal Shockwave Therapy (LEWST) for the treatment of erectile dysfunction and Peyronie's Disease.

Between July 2021 and June 2022, the breakdown of clinic activity was:

- initial appointments – 1433
- non-surgical treatment appointments – 1839
- surgeries – 277
- follow up appointments – 917

Track record on safety since registration in September 2021:

- No never events
- One clinical incident
- No serious injuries
- No incidences of clinic acquired Meticillin-resistant Staphylococcus aureus (MRSA),
- No incidences of clinic acquired Meticillin-sensitive staphylococcus aureus (MSSA),
- No incidences of clinic acquired Clostridium difficile (c. diff)
- No incidences of clinic acquired E-Coli.
- Four complaints.

This is the first inspection of the service since registration in 2021. Our inspection team was led by a CQC lead inspector, specialist advisor and an assistant inspector.

How we carried out this inspection

We reviewed documents that related to the running of the service including policies and standard operating procedures, meeting minutes, staff training records, eight patient records, results of surveys, audits and patient feedback.

We interviewed 12 staff members including the management team, clinical staff and administrative staff.

We carried out a short-announced inspection on 13 July 2022. Although it was not possible to speak with patients due to subject sensitivity, we were able to review patient feedback.

Summary of this inspection

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

Areas for improvement

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

- The service should ensure that the records audit includes completion of NEWS.
- The service should ensure that the revised Venous thromboembolism (VTE) risk assessment tool is completed in patients' records.
- The service should continue to work on obtaining the necessary service level agreements with the nearby NHS hospital to transfer a deteriorating patient without delay.
- The service should ensure they continue to embed and strengthen their governance structures and processes.

Our findings

Overview of ratings

Our ratings for this location are:

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

Good

Surgery

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

Are Surgery safe?

Good

We rated it as good.

Mandatory training

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

Staff received and kept up to date with their mandatory training. The mandatory training was comprehensive and met the needs of patients and staff. The training was delivered via an e-learning platform by an external provider and some modules were face to face such as safeguarding and resuscitation. As of July 2022, the mandatory training compliance for all permanent staff was 100%. Managers monitored mandatory training and alerted staff when they needed to update their training.

Although the agency providing bank and agency staff checked mandatory training completion and audited this, the service sought reassurance by obtaining reports which had details of completed mandatory training. We reviewed the mandatory training records for the regular bank Operating Department Practitioner (ODP) and recovery nurse and found that it was up to date.

Safeguarding

Staff understood how to protect patients from abuse. Staff had training on how to recognise and report abuse and they knew how to apply it.

Staff received training specific for their role on how to recognise and report abuse. Mandatory training included safeguarding training and all staff were 100% compliant for safeguarding adults (level one and two) and children (level one and two). The scrub nurse, registered manager and practice nurse were booked onto the safeguarding adult's level three training in August and September 2022 and we saw evidence of this.

The service had a safeguarding policy and process which staff were aware of and knew how to access. However, we found the policy did not mention children. We raised this with the registered manager who told us the policy was available, but the service had chosen not to integrate it into the main policy. After the inspection, we saw evidence of this as the service provided a copy of the safeguarding policy for children.

The service told us that the individual they had hoped would be the safeguarding lead representative was unable to do so. However, the registered manager told us they would be taking on the lead role and had booked the safeguarding adult's level four training for November 2022.

Staff knew how to make a safeguarding referral and who to inform if they had concerns. Staff were able to provide an example of a safeguarding concern which was referred appropriately to the local authority and logged on the incident reporting system.

Cleanliness, infection control and hygiene

Staff used equipment and control measures to protect patients, themselves and others from infection. They kept equipment and the premises visibly clean.

Clinic areas were clean and had suitable furnishings which were clean and well-maintained. The service had an external contractor who completed weekly deep cleans for the theatre. Staff cleaned equipment after patient contact and labelled equipment to show when it was last cleaned.

Staff followed infection control principles including the use of personal protective equipment (PPE). The service had a Covid-19 protocol which included information on social distancing, hand hygiene, temperature, PPE, testing for both patients and staff and vaccination status for staff. Patients were asked to complete a Covid-19 risk assessment questionnaire on arrival to the site. Where patients were not fully vaccinated, they were required to take a lateral flow test 24 hours prior to their visit.

We reviewed the Infection Prevention and Control (IPC) environment audit for June 2022 which reviewed the overview of the environment, consultation/therapy, clinical rooms/ treatment, sluice/dirty utility, toilets, cleaner's room, kitchen areas and a comments section. Results showed a few actions steps which we were told had been addressed. On the inspection, we found the environment visibly clean.

There were safe arrangements for the handling, storage and disposal of clinical waste, including sharps bins in accordance with HTM 07/01 The Safe Management of Healthcare Waste 2013. We observed correctly assembled and labelled sharps bins and they were not overfilled. The service outsourced an external provider to decontaminate surgical instruments.

Recent patient survey results showed that 90.3% rated the clinic's cleanliness as excellent whilst 9.7% rated it as satisfactory.

Environment and equipment

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

The service had a service level agreement (SLA) with the provider next door for renting the clinic space. The clinic had a reception area which was bright and airy with ample seating and a television. The service had a hot drinks machine and fridge. There were two toilets of which one was a disabled toilet, one clinic room and one theatre with a recovery area.

Although the service had suitable facilities to meet the needs of patients' families, staff told us that more space was needed and had fed this back to management who were exploring options.

Good

Surgery

The service had enough suitable equipment to help them to safely care for patients. The service kept an equipment register which included equipment descriptions, model, manufacturer and serial number, warranty, portable appliance testing (PAT) completed and date service was due. All equipment listed had been tested. Equipment with services due in July 2022 had been actioned and those for August had been booked.

Staff carried out daily safety checks of specialist equipment when the clinic was open. We checked various items of equipment such as the automated external defibrillator (AED) and found they had been safety tested and were all within service date. We saw evidence that equipment was routinely, and regularly serviced and calibrated.

There was safe provision of emergency equipment with accessible resuscitation trolleys and equipment used for the management of unanticipated difficult airways. The resuscitation trolley containing the emergency medication and equipment was kept in the recovery area. There was a trolley checklist which contained the list of medication present in the crash trolley and this checklist was completed ahead of surgery which we saw evidence of. We found the trolley was tamper proof.

Staff told us that the resuscitation trolley was checked on surgery days and we saw evidence of this. Staff informed us that the emergency equipment was always kept in the same place, so they knew where to locate it. There was piped oxygen and suction equipment and call bells to be used in the event of an emergency.

Fire extinguishers were stored securely and in date throughout the clinic.

The service completed *Control of Substances Hazardous to Health* (COSHH) risk assessments which we reviewed and found them to be comprehensive. The document included information on substance, use, potential hazard, person(s) likely to be affected, risk level, storage, control measures in place, actions required and date of next review. We saw evidence that COSHH items were locked away.

Assessing and responding to patient risk

Staff completed and updated risk assessments for each patient and removed or minimised risks.

Staff completed risk assessments for each patient on arrival, using a recognised tool, and reviewed this regularly, including after any incident. Pre-operative assessments were sent to patients online, reviewed in clinic by the surgeon and discussed with patient. Any risk factors were raised with anaesthetists.

Staff used a nationally recognised tool to identify deteriorating patients. Staff told us that the patients using the service were classed using the American Society of Anaesthesiologists (ASA) guidelines as ASA1 (a normal healthy patient) or ASA2 (a patient with mild systemic disease).

Staff knew about and dealt with any specific risk issues. All staff had completed NEWS2 sepsis training and we saw evidence of this. The service displayed a sepsis poster in the recovery area. Although we saw reference to *Venous thromboembolism* (VTE) assessments on prescription charts, we did not see the assessment tool in the patient notes. We raised this with the registered manager who told us that they would address this. After the inspection, we saw evidence that the service had amended the VTE Risk Assessment Tool and made changes to the SOP to reflect this. Staff were informed of the change via email and the change was added as an agenda item for the next Clinical Operations Meeting (COM) and Medical Advisory Committee (MAC) meetings.

The scrub nurse completed the World Health Organisation (WHO) checklist and the registered manager would check that all the 5 steps of Safer Surgery were completed. The service completed quarterly WHO checklist audits and results were

discussed at the MAC meetings. We reviewed the audit results for quarter one (April and June 2022) which showed 70% compliance for completing the team debrief, 100% compliance for sign in, 96% compliance for time out, 98% compliance for sign out and 85% compliance for completion of dates and all times. Actions taken to improve compliance rates included discussion with the team with regards to areas of improvement. We asked the registered manager if audits were done prior to April 2022 and we were told that the service started clinical activity in November 2021 and completed CQC readiness audits between January and March 2022. Hence, the service started clinical audits from April 2022 onwards.

The service had surgical planning meetings to discuss upcoming surgery with relevant clinical staff and management in attendance. This weekly meeting was scheduled to discuss upcoming surgery for the next two weeks to ensure all the necessary arrangements were made ahead of time. We reviewed the last three minutes for June and July 2022 and found there was consistency in the format and structure of the meetings. Staff told us that on surgery days, they had team huddles to discuss key communications and the surgery list for the day. Staff told us that there had been no instances of bottlenecks in the service.

We saw evidence to show that National Safety Standards for Invasive Procedures (NatSSIPs) was embedded in the service. NatSSIPs provided a framework for the production of Local Safety Standards for Invasive Procedures (LocSSIPs).

SBAR (situation, background, assessment and recommendation) tool is a technique used to facilitate prompt and appropriate communication during handover from theatre to recovery. The service used the SBAR tool routinely for all patients as the main part of the handover from the theatre team.

The resuscitation policy stated that all clinically trained staff should have Intermediate Life Support (ILS) training. However, none of the substantive staff had completed ILS training at the time of the inspection. Staff told us that the regular bank Operating Department Practitioner (ODP) and regular bank recovery nurse had completed ILS training. We raised this with the registered manager who told us that as part of mandatory training, all clinical staff had completed Basic Life Support (BLS) and Resuscitation Adults (level one to three) which the external training company classed as ILS.

However, after the inspection, we saw evidence to confirm that the Resuscitation Council accredited ILS training had been booked for both the registered manager and scrub nurse on 4 August and 21 September 2022 respectively. The practice nurse was on the waiting list for this training. The registered manager told us they would also arrange an in-situ scenario training on site with the team.

The service had standard operating procedures (SOP) in place to deal with any emergencies during surgery such as catastrophic blood loss, hyperthermia and anaphylaxis. Although the service to date had not had an unplanned admissions or transfers, we saw evidence that the service had SOPs on how to deal with unplanned admissions and post-operative complications and on how to support patients out of hours should they have any concerns or medical emergencies. The service's discharge criteria was based on NEWS scores and staff told us that if a patient couldn't be discharged for example, due to post-operative nausea and vomiting and pain, the patient would be accompanied to the nearest NHS hospital.

However, the service did not have an agreement to use in-patient facilities at a local private hospital. The management team told us that the process to set up a service level agreement was in process but the two individuals with whom the registered manager liaised with, had left and this meant the process had to be restarted again. We saw evidence that the service had oversight of this risk as it was discussed at the last MAC meeting in June 2022 and the registered manager was in the process of adding it to the risk register.

Good

Surgery

The management team told us that should any complications arise, the anaesthetist's remaining surgery list would be cancelled, and they would accompany the patient to the nearest NHS hospital after calling 999. Clinical staff would manage on site until the ambulance arrived using resuscitation medicines and equipment. If needed, the service would arrange a private ambulance as mentioned in the SOP. However, staff told us that this situation had not occurred to date.

Staffing

The service had enough staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed and adjusted staffing levels and skill mix, and gave bank, agency and locum staff a full induction.

The service had enough nursing and support staff to keep patients safe. The service had surgical planning meetings which reviewed booked surgeries in advance so that management could make the necessary staffing arrangements.

The service had two company directors, one clinical director, one office manager, one business manager, scrub nurse, practice nurse, receptionist and two patient coordinators. The service used a regular bank anaesthetist and recovery nurse on surgery days. The service had a service level agreement with a sexual therapist and a psychosexual counsellor.

Management told us that the service used regular bank staff to fill other shifts as needed. The registered manager told us the service had plans to recruit a substantive Operating Department Practitioner (ODP) with recovery experience.

The service had four medical consultants working under practising privileges of which one of the consultants, had a service level agreement to be the medical director.

The registered manager told us that the overall use of bank and agency in the last 12 months was 46% (this included the regular bank ODP and recovery nurse). The staff sickness rate for the last 12 months was 1%.

Managers made sure all bank and agency staff had a full induction and understood the service.

Records

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

The service used an online secure electronic system for patient records and some paper-based notes which were handwritten. These included the recovery anaesthetic charts, WHO checklist, implant record, discharge letter and drug stickers. Staff told us that paper-based notes were scanned onto the electronic system and then shredded.

Patient notes were comprehensive, and all staff could access them easily. We reviewed eight patient records and found all had been completed. In all the records reviewed, the following had been completed: patients' observations, consent forms, nutritional status, WHO checklist, recovery charts, diagnosis and management plan documented, allergies and all notes were signed and dated.

The service completed quarterly patient medical records audits and results showed 100% compliance with completion of patient information and seven out of the eight records included allergy status. All criteria for clinical entries was 100% completed and seven out of eight records recorded consent. As an action point to address this, the relevant staff members received reminders around consent to prevent reoccurrence. Although the service's discharge criteria included National Early Warning Score (NEWS) scores, the audit did not include NEWS as a criteria in the records audit.

Good

Surgery

Medicines

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

The service had a service level agreement with an external pharmacy for the supply of pharmaceutical products and clinical pharmacy services. The pharmacy completed quarterly medicines management audits and provided recommendations for improving regulatory compliance and medicines management. Staff told us they could obtain advice from the external pharmacy during the opening hours of the pharmacy. Results were discussed in the clinical operations meetings and managers meetings.

We reviewed the quarter two audit results which showed the following areas of improvement needed: there was no biohazard spill kit, information was not correctly recorded for all entries in controlled drug (CD) register (albeit there were no stock issues), witness signatures missing for some entries, site had not applied for Environment Agency Waste Exemption (T28) and room temperature for the medication room was not recorded. We asked the registered manager about this and they explained how the service had addressed these action points. We saw evidence of the biohazard spill kit and the room thermometer in the medication room. The registered manager told us they had completed competency training with all staff (including regular bank) on completing CD entries. The service had ordered another CD register and was in the process of applying for the T28.

During the inspection, we found all drug cupboards and the drug fridge were locked. We saw evidence that the medicines fridge was checked daily and staff told us this was logged in a book and on the electronic system. We also saw evidence that room temperatures were recorded. We found that the CD register had been completed appropriately.

Staff followed systems and processes to prescribe and administer medicines safely. Staff stored and managed all medicines and prescribing documents safely. Medication and CD keys were kept with the anaesthetic ODP/nurse for surgical days. Otherwise, CD and medication keys were kept locked in a small combination key secure in a cupboard.

Staff completed monthly checks on expiry dates and assessed stock levels every two to three weeks. We checked a sample of medicines and found them to be in date. Staff told us that previously on surgery days there were delays due to not having certain medicines stock. The service addressed this by introducing a surgery checklist and medicines inventory and there had been no further delays.

The service had a service level agreement with an external company for the supply of medical gases which included an annual service. Oxygen cylinders were securely stored which was compliant with Health Technical Memorandum 02-01. The oxygen cylinder attached securely to the resuscitation trolley was in date and at full capacity.

Staff completed medicines records accurately and kept them up to date. As part of our review of patient records, we reviewed eight prescriptions and found they were fully completed.

We reviewed the pharmacy audit for dispensed medicines between April and June 2022. Results showed that 87.5% of patient information was copied on prescriptions. The service briefed the relevant staff to remind them of the requirements to improve compliance. Prescriber information including prescription requirements and medicines information was completed 100%.

Staff learned from safety alerts and incidents to improve practice as the service had a system in place to respond to Medicines and Healthcare products Regulatory Agency (MHRA) and the Central Alert System (CAS) alerts. The service did not report any medicines related incidents since registration.

Good

Surgery

The service only kept Controlled Drugs on a Named Patient basis and the service showed us evidence of their recent home office application. The registered manager was the accountable officer.

The service carried out most procedures under a general anaesthetic apart from circumcisions where local anaesthetics were used.

Although the service had arrangements to prescribe and obtain to take away (TTA) medications for patients, the registered manager informed us that the service with immediate effect had decided to revert back to previous practice whereby the patient was given a prescription to take away and have dispensed at a pharmacy as this was logistically easier to manage.

Incidents

The service managed patient safety incidents well. Managers investigated incidents and shared lessons learned with the whole team. When things went wrong, staff apologised and gave patients honest information and suitable support.

Staff knew what incidents to report and how to report them. Managers investigated incidents thoroughly and involved patients in these investigations.

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

From September 2021 to July 2022, the service reported one serious incident. We saw evidence of the incident report which included lessons learnt, how the learning was shared and details of how duty of candour was applied. Staff told us they received feedback from investigation of incidents in team debriefs.

Are Surgery effective?

Good

We rated it as good.

Evidence-based care and treatment

The service provided care and treatment based on national guidance and evidence-based practice and staff could easily access policies on shared drives.

Staff followed up-to-date policies to plan and deliver high quality care according to best practice and national guidance. Policies and standard operating procedures (SOPs) were available on shared drives for staff (including regular bank staff) to easily access as well as paper copies in the office.

We reviewed the service's policies and found they were dated, had version control and detailed**.** Policies referenced national guidelines from organisations such as the National Institute for Health and Care Excellence (NICE) and Royal Colleges.

Although the local anaesthetic toxicity guidelines stated that the airways equipment was in an airways trolley, we found it was stored in the resuscitation trolley. We raised this with the registered manager who told us they would address this. After the inspection, we saw evidence that the service had clearly labelled the resuscitation trolley to make it clear to staff where to find the airways equipment and amended the SOP.

Clinical guidelines were written by the clinical director in conjunction with the medical director. Consultants we spoke with told us they would be asked for their feedback. Staff told us they would be informed of new policies and SOPs either face to face, via emails and reminders at staff meetings. Staff told us they would need to sign on the electronic system to show they had read the policy or SOP.

The service's website provided evidence-based information regarding the diagnosis and treatment options for their main services.

Nutrition and hydration

Staff gave patients enough food and drink to meet their needs and improve their health. The service planned for patients' religious, cultural and other needs.

The service provided day case procedures which meant there was limited need for a formal catering provision or nutrition monitoring. Patients waiting to have surgery were not left nil-by-mouth for long periods. The preassessment questionnaire included a question on special dietary needs.

Staff told us that patients were sent a survey via email one week before their procedure to submit their food choices which was followed up by phone call after. Staff told us that patients had asked for hot food post operatively and the service had put provisions in place to allow this.

The reception area had water available and the service had a tearoom to offer hot and cold drinks to patients.

Pain relief

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

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

Although staff told us pain assessments were carried out, it wasn't clear where this was documented. We raised this with the registered manager who told us that the service used the National Early Warning Score (NEWS2) taken from the Royal College of Physicians (RCP) website. Although it appeared that pain wasn't being scored periodically as this feature was removed when NEWS2 replaced NEWS1, the service assessed pain and recorded this on the recovery chart. We spoke with the recovery nurse who explained where pain assessments were recorded and talked us through the various tools used including non-verbal tools.

Patient outcomes

Although there was no benchmark nationally for this speciality, the service used key performance indicators and audits to improve their performance.

Managers used information from the audits to improve care and treatment. The management team told us that as the service started clinical activity in November 2021, the service initially focussed on Care Quality Commission (CQC) readiness audits.

Good

Surgery

In December 2021, the service completed audits which matched with the five key lines of enquiry (KLOE) for the (CQC). For each KLOE, the service produced action plans which included areas to improve and told us they were working through these. We reviewed the actions plans and found they included descriptions for each task, who the task was assigned to, due date and priority.

The service had recently started using the Association for Perioperative Practice (AfPP) audit tool. We reviewed the audit results for July 2022 which achieved six reds, four ambers and 175 greens. The registered manager told us the service was in the process of addressing the areas of improvement.

Clinical leads told us that clinical audit activity started from April 2022. The service monitored knife to skin time as a key performance indicator (KPI). Between April and June 2022, there were a total of 60 procedures of which 98% were completed within the scheduled time.

The management team told us it was difficult to obtain outcome data for this speciality as there was no benchmark for this nationally. However, in order to capture some patient outcome data, the service was looking to implement an automatic three-month review with patients to see how they were and check if they needed to seek any medical attention post procedure.

Competent staff

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

Staff were experienced, qualified and had the right skills and knowledge to meet the needs of patients. The office manager was responsible for recruitment, screening, onboarding, checking right to work, legal documents including Disclosure and Barring Service (DBS). The agency used by the service provided reports for agency staff members which included information on their mandatory training and DBS checks.

Managers gave all new staff a full induction tailored before they started work. Staff (substantive and regular bank/agency) received a handbook of competencies that staff needed to demonstrate before being signed off. We saw evidence of clinical competencies such as medical gases training, controlled drug competencies and medical devices.

Managers supported staff to develop through yearly, constructive appraisals of their work. Staff told us that they had regular one to ones. As of July 2022, the service reported an appraisal rate of 62.5% with two planned appraisals and four were overdue. We asked the registered manager about this who told us that the overdue appraisals were for the managers and these had been scheduled. The appraisal template included completion rates for mandatory training, objectives and linked in with the provider's values.

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

Multidisciplinary working

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

Staff held regular and effective multidisciplinary meetings to discuss patients and improve their care. Consultants told us they had informal meetings with their peers to discuss surgery lists and difficult cases.

Good

Surgery

The service's patient criteria policy stated that it was the responsibility of the treating medical practitioner to assess the patient in terms of suitability for treatment during the pre-treatment consultation. This included consultation with the patient's General Practitioner (GP) regarding surgery.

Although staff could not share information with the GP without the patient's consent, consultants advised patients to do so and documented this within the patient's records. Consultants gave us an example where they explained to a patient the urgency to notify their GP as the patient had to be referred for external tests. The prompt action of the consultant lead to the early diagnosis of a tumour.

Seven-day services

Key services were available five days a week to support timely patient care.

The service was open Monday to Friday from 09.00 to 18.00 and day case procedures were scheduled on Tuesdays and Thursdays. However, where needed, the service was flexible to external circumstances such as transport strikes, where procedures were moved to another day.

The clinic provided patients with a 24-hour number in the event of any queries which was manned using an on-call rota.

Health promotion

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

Staff assessed each patient's health during pre-assessment and provided support for any individual needs to live a healthier lifestyle.

Consultants told us they provided advice on aspects of lifestyle during consultations and this included diet, exercise, alcohol, reduce stress, smoking and sleep. Patients were signposted to NHS websites for more information.

The sexual therapist and psychosexual counsellor provided health promotion during consultations. This included lifestyle advice for example: weight loss, stop smoking, reduce alcohol consumption, reduce stress and anxiety.

Post-operative letters included information on diet and exercise after the given procedures. The service had also created A-Z patient guides on their website for the core services provided which included information about the effects of a healthy lifestyle on the patient's presenting issues.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

Staff supported patients to make informed decisions about their care and treatment. They followed national guidance to gain patients' consent.

Staff understood how and when to assess whether a patient had the capacity to make decisions about their care. Clinical staff received and kept up to date with training in the Mental Capacity Act and Deprivation of Liberty Safeguards and Consent.

The consultant ensured effective consent had been obtained from the patient for the procedure and the consent form had been signed by both the consultant and the patient. The patient was provided with a copy of the consent form. Consent would be obtained again on the day of surgery and patients would have a cooling period of at least two weeks in between.

Good

Surgery

Staff clearly recorded consent in the patients' records. In the eight records that we reviewed, we saw evidence of documented consent and cooling off period.

Are Surgery caring?

Good

We rated it as good.

Compassionate care

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

Staff told us they took time to interact with patients in a respectful and considerate way. Due to the subject sensitivity, we were unable to observe care and gain patient consent to speak with them. However, we were able to review patient feedback.

Staff told us they requested patient feedback prior to discharge. Results were collated into a spreadsheet and discussed at staff meetings. Previously patients had complained about the waiting times for consultation appointments which the service addressed by extending appointment times where necessary and reminding consultants about time keeping.

The recent patient survey results from April 2022 showed that 93.5% rated the service as excellent and 6.5% rated the service as satisfactory. When asked about the caring concern of clinical staff, 93.5% of patients rated the service as excellent and 6.5% rated it as satisfactory. Results showed that 90.3 % of patients felt that staff preserved their privacy and dignity during appointments whilst 9.7% rated it as satisfactory.

The following was representative of the feedback received: "Best choice I have ever made was to walk through the doors", "I found the whole process straight forward with a very short waiting time, wonderful staff, excellent facilities", "I felt really well looked after and cared for" and "Everyone one is so nice and professional."

As of July 2022, the service had 141 reviews via a verified online platform (Doctify). From a maximum rating of five, the service was rated 4.91 for overall experience, 4.72 for wait time, 4.95 for friendliness and 4.91 for cleanliness. The following was representative of patients' comments: "Very friendly staff and professional", "Great experience for a difficult problem", "Best decision I have made in a long time", "Words cannot describe how grateful I am for the services of the Clinic," and "The experience is quite daunting but I was put at ease, treated with respect and kept informed throughout the process."

Emotional support

Staff provided emotional support to patients to minimise their distress.

Staff supported patients and signposted them to appropriate external charities for support. The registered manager gave us an example of how the service engaged with an upset patient and how the service agreed to have a consultation at no charge with the patient to discuss their options.

Good

Surgery

Staff understood the emotional and social impact that a person's care, treatment or condition had on their wellbeing and on those close to them. The service referred patients to the sexual therapist & psychosexual counsellor for emotional support where required at no additional cost to the patient. Patients would have a one-hour video call with the therapist who produced a report for the consultant. Discussion would include lifestyle advice and the options available for the patient.

Clinicians understood the emotional impact of some of the conditions that patients had. However, clinicians prioritised the patient's wellbeing and would not perform surgery without counsellor involvement if they were concerned around expectations and for conditions such as penile dysmorphia.

Staff told us the service made reasonable adjustments to meet the needs of patients from all cultures or those who may be living with a disability. Staff received and kept up to date with training in person centred care and privacy and dignity as part of their mandatory training.

Understanding and involvement of patients and those close to them

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

Staff made sure patients understood their care and treatment. Staff supported patients to make informed decisions about their care.

The service carried out day cases with no overnight stay. This meant there were no issues around limited visiting hours. The service advised patients to ensure they had a chaperone to collect them at the time of discharge as part of the criteria for discharge. However, on the odd occasions where patients did not make such arrangements, the service requested signed disclaimers from patients to reflect this.

Patients could give feedback on the service and their treatment and staff supported them to do this. Staff told us that most surgical feedback was positive.

Are Surgery responsive?

Good

We rated it as good.

Service delivery to meet the needs of local people

The service planned and provided care in a way that met the needs of local people and the communities served.

The Andrology Company was a private clinic and did not have any concerns around missed appointments. Managers planned services so they met the needs of the local population. Facilities and premises were appropriate for the services being delivered.

The clinic provided care to patients from the local area as well as further afield. The clinic was based in an area where there was good public transportation links, making it accessible to patients from a wide geographical area.

Good

Surgery

The service had a standard operating procedure (SOP) for the patient eligibility which established if it was safe for the patient to proceed with the surgery. Staff told us that the pre-operative assessment linked in with the patient criteria. We reviewed the SOP for criteria and preparation of the patient for elective day surgery and found it was comprehensive and included pre-screening and patient information.

Patients were offered choices of appointment times and with patient consent, information was shared appropriately with the general practitioner (GP) where necessary.

The service had systems to help care for patients in need of additional support or specialist intervention. Consultants gave us examples of how they had referred patients to cardiology specialists ahead of any procedures.

Meeting people's individual needs

The service was inclusive and took account of patients' individual needs and preferences. Staff made reasonable adjustments to help patients access services.

Staff received and kept up to date with training in dementia awareness and communication as part of their mandatory training.

Managers made sure staff and patients could get help from interpreters or signers when needed. Although the service allowed patients to bring an interpreter with them, if staff were not confident in the interpretation, treatment would be declined. Where possible, the service used an impartial interpreter.

Patients were given a choice of food and drink to meet their cultural and religious preferences. Patients were offered varied options such as vegan, vegetarian, halal, hot meals and salads.

The service had a telemedicine platform (video and telephone consultations). The service completed 365 video consultations between July 2021 and June 2022.

Patients could give feedback on the service and their treatment and staff supported them to do this (refer to Compassionate Care subheading).

The service had a disabled toilet and staff told us they had ramps to ensure the service was wheelchair accessible. Patients were provided with the 24-hour telephone number on discharge should they have any queries.

Staff gave us examples where the service offered reasonable adjustments to help patients access services. For example, the service had explored hiring a hoist for the day to help a patient with paralysis of the lower body and legs to access the service.

Access and flow

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

The clinic provided a private service on request of the patient. Patients accessed the service by self-referral or on referral from another clinician. The pre-consultation patient coordination team would call the patient, answer queries, provide information about diagnosis and treatment options and complete the consultation booking.

Good

Surgery

The clinic had short waiting times: one week for a consultation appointment and one to three weeks for surgery. Surgery days were on Tuesday and Thursday whilst the remaining weekdays were for consultations. Patients were either sent to a contracted external provider nearby for blood work ahead of surgery or they could make arrangements via their General Practitioner (GP) if easier. After the consultation, patients received a report via email which the consultant advised to share with the GP.

Patients who proceeded to have surgical treatments would undergo an in depth

pre-operative assessment. At various stages of the patient care pathway, the service had eligibility criteria for patients accessing the service. Staff provided examples of several occasions where consultants had identified undetected comorbidities at the pre-operative assessment stage.

In the last 12 months, the clinic had six cancellations due to reasons such as referrals to specialists (such as pain management team, cardiologists, endocrinologists) or patients required antibiotic treatment beforehand.

Post-operative letters included information on medication, how patients may feel after the operation, aftercare and recovering at home, lifestyle advice, when to contact the General Practitioner (GP) or hospital, details of follow up consultation and frequently asked questions for the procedure.

The service had a structured post-surgical follow up process which included the following stages (either in person or telehealth appointments): surgeon follow up on day one, surgeon follow up at seven to ten days, nurse follow up at six to eight weeks, and patient coordinator or surgeon follow up at three months.

As of July 2022, the service's activity was 10 to 20 surgical consultations a week (then some other consultations) and 20 to 30 surgeries per month. For breakdown of clinic activity, refer to background information at the start of the report.

Learning from complaints and concerns

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

Staff understood the policy on complaints and knew how to handle them. Managers investigated complaints and identified themes.

We reviewed the complaints policy which stated acknowledgements were sent within three working days and a full response within 20 working days. Where investigations took longer, the service would write to the patient to explain the delay. Where patients were not happy with the response, the policy included details on how to refer to the Independent Sector Complaints Adjudication Service (ICAS). The policy also signposted patients to share their experience with the Care Quality Commission (CQC) and made the CQC's remit clear in that they did not investigate individual complaints.

Staff knew how to acknowledge complaints and patients received feedback from managers after the investigation into their complaint. Managers shared feedback from complaints with staff and learning was used to improve the service. From September 2021 to July 2022, the service received four complaints of which none were upheld.

Staff could give examples of how they used patient feedback to improve daily practice. For example, in December 2021, the service had a complaint following the decision not to operate due to high body mass index (BMI) which was a risk. The

service explained to the patient that the procedure needed to be completed in another hospital where the equipment was more suitable. As a result of this complaint, the service amended their pre-operative assessment form and standard operating procedure to make it more robust. The service sent out the pre-operative questionnaire to patients earlier with early input from the anaesthetist. The updated processes were shared with staff and discussed at staff meetings.

Are Surgery well-led?

Good

We rated it as good.

Leadership

Leaders had the skills and abilities to run the service. They were visible and approachable in the service for patients and staff.

The management team included two company directors (of which one was the nominated individual), one clinical director (also the registered manager), practice manager, office manager and medical director.

We spoke with both permanent and non-permanent staff who described the management team as approachable and visible. Staff told us the clinical director was easily accessible.

Vision and Strategy

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

The service's vision was to be the one stop shop for all men's andrological healthcare needs. Staff told us it was about putting patients first and leading the way for men's health as a healthcare provider.

Staff told us that as part of their induction, they had received a leaflet on the services' vision and strategy.

The clinical director told us that the business plan focussed on increasing surgical capacity and theatre utilisation.

Culture

Staff felt respected, supported and valued. The service had an open culture where patients and staff could raise concerns without fear.

Staff we spoke with told us they felt supported by the management team and colleagues. Staff described the environment as friendly with an open culture. Staff told us they felt listened to if they raised concerns.

Staff told us they enjoyed working at the service as there was good teamwork and communication within the team. Staff told us they were able and encouraged to share ideas and that their input was valued.

Governance

Although leaders had implemented governance structures and processes which were in their infancy, more time was needed to embed them. Staff had regular opportunities to meet, discuss and learn from the performance of the service.

Governance meetings consisted of the Medical Advisory Committee (MAC) meetings, the manager's meetings and the Clinical Operations Meetings (COM).

The MAC attendees included the clinical director (who was also the registered manager), medical director (Chair), company directors, and operating and anaesthetic consultants. We reviewed the quarterly MAC meetings between January and June 2022 and found there was consistency in the format and structure of the meetings. Discussions included complaints, practising privileges, policy updates, list scheduling, patient pathway, new protocols that need to be developed and theatre turnover times.

The service had an established process for assessing and granting practising privileges for clinicians. We reviewed the agreement for practising privileges which detailed the appropriate checks carried out such as regulatory requirements, professional requirements, responsibilities, legal requirements and indemnity insurance. Practising privileges applications were reviewed at the MAC meetings, or in a meeting between the Medical Director, Clinical Director and Company Director if the practising privileges needed to be implemented prior to the next MAC meeting. A lapse, or expiration of any compliance documentation was highlighted by the IT software to both the consultant and the management team one month prior to the expiry date.

The service had fortnightly managers meeting to address key organisational issues and developments, such as: complaints, new services, issues, processes and protocols, staffing and costing. Attendees included clinical director (registered manager), office manager, company director(s) of which one is the nominated individual, and practice manager. We reviewed a sample of minutes for each month of April, May and June 2022 and found the minutes included a list of attendees, apologies, actions and dates and time of next meeting.

The COM meeting was chaired by the clinical director and had a multidisciplinary cohort of attendees, including management, clinical staff, reception staff and patient co-ordinators. These meetings were scheduled every two weeks. We reviewed the last four COM minutes between May and July 2022 and found there was consistency in the format and structure of the meetings. The meeting discussed relevant agenda topics for safe and efficient clinical operations and the minutes included a list of attendees, apologies, actions and dates and time of next meeting.

Management of risk, issues and performance

Leaders and teams used systems to manage performance effectively. They identified and escalated relevant risks and issues and identified actions to reduce their impact. They had plans to cope with unexpected events.

The service had an Emergency and Business Contingency Plan which we reviewed and found to be comprehensive. For example, the plan covered the protocol for emergencies such as power cuts and major incidents.

The service had 13 service level agreements (SLA) with various external contractors for cleaning, equipment such as the air conditioning, medicines and computer software. Management staff told us that SLAs were reviewed on an annual basis and renewed if appropriate to do so.

The service had a risk register which was reviewed every four months and when a risk presents itself. We reviewed the risk register which included information such as description, category, impact of risk, risk response, owner, review dates, risk score, controls outstanding and controls implemented. Although the service had put in mitigation steps to reduce the risks documented, we found that information for controls implemented had been documented in the wrong column and made the registered manager of this.

However, the risk regarding the lack of SLA with a nearby hospital to manage deteriorating patients was not listed. We raised this with the registered manager who told us they were in the process of adding this as this had been discussed at recent MAC meeting in June 2022. After the inspection, the service provided evidence of the updated risk register which showed all the points raised had been addressed.

Staff told us the service completed weekly fire testing and carried out mock fire drills. Transport monitors and emergency packs were available for use.

Information Management

Staff could find the data they needed, in easily accessible formats, to understand performance and improvements. The information systems were integrated and secure.

Staff had access to all the information they needed through their laptops. Staff were aware of how to use and store confidential information. Staff completed training on information governance as part of their mandatory training.

The service outsourced an external company for support with Information Technology (IT). Staff we spoke with told us they did not have any issues with IT equipment or software.

The premises had an emergency backup generator and the external company who owned the building completed the testing for the generator and informed the service accordingly as part of their service level agreement.

Engagement

Leaders and staff actively engaged with patients and staff.

We spoke with substantive staff and bank staff who told us they received service updates in person, in weekly meetings and emails. Staff told us they had regular one to ones with their managers.

The staff survey used a scoring from one (strongly disagree) to five (strongly agree). The last survey was done in May 2022 and had 13 responses. Recent survey results showed that 38.5% of staff strongly agreed that they worked well as a team, 30.8% scored four and 30.8% scored in the middle. When asked how connected staff felt to co-workers, 23.1% scored five, 46.2% scored four, 15.4% scored in the middle and 15.4% scored two. When asked if management valued staff feedback, 30.8% scored five and four respectively, 15.4% scored two and 23% scored one. When asked if happy at work, 30.8% scored five and four respectively, 23.1% scored in the middle and 15.4% scored two.

Although the management team were working on an action plan for the survey results, they had started to address some of the points made. For example, survey results showed that staff wanted more development opportunities. As a result, two of the nurses will each be attending a conference, one for Infection Prevention Control (October 2022) and one to the Association for Perioperative Practice (AfPP) Annual conference (Sep 2022). Managers told us that the service was planning to repeat the survey in six months to ascertain if improvements had been made.

The service requested patients to complete feedback questionnaires at the time of discharge and reviewed the results to identify themes and areas of improvement (refer to Compassionate Care subheading).

Staff told us they would like more space in the clinic. Staff we spoke with told us they had fed this back to managers who were currently addressing this. We raised this with the management team who told us they had recently acquired additional building space and were carrying out renovation works at present.

Good

Surgery

Learning, continuous improvement and innovation

Staff were committed to continually learning and improving services. Leaders encouraged innovation and participation in research.

The service offered specialist treatments in men's healthcare. Since 2014, the provider had expanded internationally in four countries with the aim to become market leaders in each country.

The provider was a member of International Andrology (IA), an international collaborative network of the leading practitioners of Andrology. The provider was a member of the British Association of Urological Surgeons which is open to medical practitioner(s) in urological practice interested in promoting the objects of the organisation.

Management staff told us that the consultants were experienced Urologist-Andrologist surgeons who had been involved in the development, co-development or improvement of many of the modern surgical techniques currently standardised throughout the world. For example, the clinic had been involved in new technology to detect erectile potency.

Consultants attended conferences internationally where they presented on their relevant speciality, published literature and even contributed to the development of national guidelines for urology. Consultants used this platform as an opportunity to network. For example, one of the consultant's had reached out to the psychosexual counsellor as part of networking for the British Society of Sexual Medicines.

Staff told us that senior management encouraged them to give ideas to make changes.