Harley Health Village

Quality Report

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

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

Harley Health Village is operated by Linia Ltd. The hospital spread over the lower ground and ground floor of this multi-storey building has four recovery/overnight beds. Facilities include two operating theatres, consulting rooms, outpatient rooms and a reception area. There is in addition a training/meeting room on the second floor.

The hospital provides cosmetic surgery for adult private patients. We inspected cosmetic surgery services.

We inspected this service using our comprehensive inspection methodology, and carried out the inspection on 17 January 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 service but we do not currently have a legal duty to rate them when they are provided as a single specialty service. We highlight good practice and issues that service providers need to improve, and take regulatory action as necessary.

Our key findings were as follows:

- There were systems to keep people safe and to learn from adverse events or incidents.
- The environment was visibly clean and well maintained, and there were measures to prevent and control the spread of infection.
- There were sufficient numbers of suitably qualified, skilled and experienced staff to meet patients' needs, and staff had access to training and development, which ensured they were competent to do their jobs.
- There were arrangements to ensure patients had access to suitable refreshments, including drinks.
- Treatment and care was delivered in line with national guidance and the outcomes for patients were good.
- Patient consent for treatment and care met legal requirements and national guidance.
- Patients could access care in a timely way, and had choices regarding their treatment day.
- Staff ensured patients privacy and the dignity of patients was upheld.
- The leadership team were visible and appropriate governance arrangements meant the service continually reviewed the quality of services provided.

However, we also found the following issue that the service provider needs to improve:

- We observed a member of the theatre staff undertake a procedure without wearing the required protective goggles. This was contrary to the hospital's infection, prevention and control policy and national guidance.

Following this inspection, we told the provider that it should make improvements, even though a regulation had not been breached. Details are at the end of the report.

Professor Edward Baker
Chief Inspector of Hospitals

Summary of findings

Contents

Harley health Village

Services we looked at
Surgery

Summary of this inspection

Background to Harley Health Village

Harley Health Village is operated by Linia Ltd. The hospital opened in July 2015. It is a private hospital in Harley Street, London and primarily serves the communities of central London. It also accepts patient referrals from outside this area.

The hospital has had a registered manager in post since 1 July 2015.

Our inspection team

The team that inspected the service comprised a CQC lead inspector,another CQC inspector, and a specialist advisor with expertise in surgical theatres. The inspection team was overseen by Nick Mulholland, Head of Hospital Inspection (London South).

Why we carried out this inspection

There were no special reviews or investigations of the hospital ongoing by the CQC at any time during the 12 months before this inspection. This was the hospital's first inspection since registration with CQC. It was inspected as part of our independent hospital programme.

How we carried out this inspection

During the inspection, we visited the reception area, the operating theatres, consulting rooms, recovery rooms and other related areas. We spoke with nine staff including; registered nurses, health care assistants, reception staff, medical staff, operating department practitioners, and senior managers. We spoke with two patients. We also received eight CQC 'tell us about your care' comment cards, which patients had completed prior to our inspection. As part of our inspection, we reviewed 13 sets of patient records.

Information about Harley Health Village

The hospital is registered to provide the following regulated activities:

- Surgical procedures (6 July 2015)
- Treatment of disease, disorder or injury (6 July 2015).

Activity (October 2015 to September 2016)

- In the reporting period October 2015 to September 2016 there were 1,016 inpatient and day case episodes of care recorded at the hospital, all of which were privately funded.
- 11% of patients stayed overnight at the hospital during the same reporting period.
- There were 430 outpatient total attendances in the reporting period; all privately funded.

Summary of this inspection

- 52 medical practitioners including surgeons and anaesthetists worked at the hospital under practising privileges. A small number of regular resident medical officers (RMO) worked overnight when required. The hospital staff consisted of three registered nurses, four ODP and Health care assistants and seven other staff including administrative and receptionists. The hospital used regular bank staff as required. The accountable officer for controlled drugs (CDs) was the medical director.

Track record on safety

- No never events
- Seven reported clinical incidents which caused no harm but were outside of regulated activity.
- No serious injuries
- No incidences of hospital acquired meticillin-resistant Staphylococcus Aureus (MRSA),
- No incidences of hospital acquired meticillin-sensitive Staphylococcus Aureus (MSSA)
- No incidences of hospital acquired Clostridium Difficile (C.diff)
- No incidences of hospital acquired Escherichia coli (E.coli)
- Four complaints

Services accredited by a national body:

- None

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

• Air and water sampling

• Anaesthesia machine servicing

• Clinical waste

• Emergency ITU

• Fire alarms

• Health and safety

• Human Resources and employment

• Infection control

• Medical equipment maintenance

• Medical gases

• Occupational health

• Pathology

• Patient beds maintenance

• Southern eastern air

• Sterilisation surgical instruments

• Theatre air ventilation

• Theatre isolated power supply (IPS)

. Theatre uninterruptable power supply (UPS) maintenance

• Theatre operating table maintenance

• Washroom maintenance

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 saw evidence of good incident reporting and follow up investigations from which changes were implemented and learning was disseminated.
- The hospital environment was visibly clean and equipment was well maintained.
- Controlled drugs and other medications were safely stored and managed.
- The hospital had a good mandatory training programme which was properly managed.
- There was a robust procedure for granting practising privileges.

However,

- We witnessed a nurse perform a procedure in the theatre without wearing suitable personal protection equipment.

Are services effective?

- Care was planned and delivered in accordance with current guidance, best practice and legislation by suitably skilled and competent staff.
- There was a programme of audit, which was used to assess the effectiveness of services and to maintain standards.
- The hospital had policies and procedures in place to ensure staff were competent in their roles.
- Mental capacity act and deprivation of liberty safeguards was part of the mandatory training programme and staff we spoke with understood their responsibilities.

Are services caring?

- We observed consultants and other staff treat patients in a caring manner.
- Patients we spoke with told us their care was good.
- The completed CQC feedback comment cards and comments shown to us by the hospital praised the staff and the care received.

Are services responsive?

- Services were planned to meet the needs and choices of patients, and the arrangements for treatment were prompt.
- There were arrangements to ensure the individual needs of patients were fully considered, assessed and met.

Summary of this inspection

- Complaints were appropriately acknowledged, investigated and responded to in a timely way. Learning from complaints was fed back to staff.

Are services well-led?

- The hospital had a well-established senior management team, who had a good working relationship with their staff.
- Staff understood what the values and purpose of the service were, and what was expected of them. They were committed to meet the requirements of their patients.
- Patients and staff were encouraged to feedback on the quality of services.
- The governance arrangements provided assurance of systematic monitoring of the quality of services.
- The hospital managed risk comprehensively by means of a risk register and daily health and safety checks.

Surgery

Safe	
Effective	
Caring	
Responsive	
Well-led	

Are surgery services safe?

Incidents

- The hospital reported there were no never events for the period October 2015 to 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 hospital had not reported any surgical site infections (SSI) in the reporting period up to our inspection. An SSI is a type of healthcare associated infection in which a wound infection occurs after an invasive (surgical) procedure.
- The hospital reported a small number of clinical incidents in the year to September 2016 but none occurred during surgery or other registered activities. We saw evidence of those incidents reported having been investigated, and any required changes to practice were made. We saw evidence of incidents being discussed and actioned at the quarterly Clinical Governance Committee and Medical Advisory Committee (MAC) meetings.
- Although no surgical incidents had been reported prior to our inspection there was an unplanned patient transfer on the day of our inspection. A patient had a rare reaction called a laryngospasm (the vocal cords suddenly seize or close up, blocking air flow to the lungs). The patient was transferred to the NHS hospital accompanied by the anaesthetist. The patient had been pre-assessed as low risk and made a complete recovery. The surgeon explained the delay to waiting patients. Our specialist advisor spoke with the theatre manager about the incident, and concluded the event had been handled efficiently with the safety of the patient at the forefront. We have since seen the report of the incident.
- The hospital had an in date comprehensive policy relating to recognising and reporting of incidents. This was available in paper and electronic form. The policy set out the way incidents were to be reported and who would investigate further. The document encouraged staff to be vigilant and to report incidents, and stressed being open with clients referencing the duty of candour regulation. The policy referenced the National Patient Safety Agency, the Health and Safety Executive, Department of Health publications and NHS England amongst others. The staff we spoke with were aware of the contents of the policy and how to report incidents.
- 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 a good understanding of 'duty of candour'.
- The hospital reported 100% screening rates for venous-thromboembolism (VTE) and no incidents of hospital acquired VTE or Pulmonary Embolism (PE) for the reporting period October 2015 to September 2016. We saw evidence of VTE assessments recorded in each of the patient records we viewed.

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

- The hospital was not required to use the NHS Safety Thermometer, which is an improvement tool to measure patient "harms" and harm-free care as it was a private

healthcare provider. The hospital did however measure rates of thrombosis, infections and pain. These were all recorded in the patient's notes and discussed at various meetings.
- The Clinical Governance Committee and Medical Advisory Committee (MAC) met quarterly and reviewed aspects of provided care effecting patient safety including staffing levels, incidents, complaints and risks.

Cleanliness, infection control and hygiene

- The business manager was the infection prevention and control (IPC) lead, assisted by the registered manager and the theatre manager.
- The theatres were visibly clean with surfaces in good condition and easily cleanable. Theatre staff cleaned the theatres between patients and at the start and end of each working day. The hospital housekeeping staff performed a general clean each night. The theatres had a half yearly deep clean.
- We observed all staff use the readily available hand gel each time they entered or left the theatre.
- We saw hand hygiene audits which showed 100% compliance by staff, which was in line with our observations. The hospital performed internal hand hygiene audits every three months.
- The IPC lead told us they had practical staff training days for IPC matters and appraisals and support for extra staff training as required. We saw evidence to support this during our inspection.
- There were suitably displayed posters for staff regarding 'sharps' disposal and what to do if a 'sharps' injury occurs. Sharps are items such as disposable bladed instruments or hypodermic syringe needles which could cause an injury and/or an infection if not disposed of safely.
- We saw 'five moments of hand hygiene' posters displayed at washing locations to remind staff of when and why they should clean their hands. Posters were also displayed reminding staff of the correct way to clinically wash their hands.
- We witnessed good surgical scrub technique by the surgeon and other theatre staff. Staff were seen to 'double glove' when required and all surgical gowns were disposable.
- The hospital's IPC in pre-operative environment policy provided good information regarding latex allergy and stated staff must ask about and document any patient latex sensitivity. Non-latex gloves were available for staff use.
- The IPC policies were comprehensive and referenced national guidance.
- We observed good checking and recording of instruments, swabs and other items used during the surgical procedure. This was done for every operation to prevent items being left behind and decrease the risk of post-surgical infection. This was in line with guidance from; the Association for Perioperative Practice (AfPP), the National Institute for Health and Care Excellence (NICE) and was included in the 'sign out' section of the World Health Organisation WHO surgical safety checklist.
- All instruments used for anaesthesia were single use and disposable. The decontamination of reusable medical devices was undertaken in line with national guidance, via an external provider under a service level agreement. Surgical instrument sets were stored in a designated area, and were noted to have appropriate labelling and dates of the last decontamination. The used equipment was boxed up each night, collected at 8am and returned the following day.
- The hospital had sufficient stock of reusable instruments to allow for the one day turnaround.
- The designated scrub nurse prepared surgical instruments as part of the setting up process. We saw this was undertaken in a clean area, using safe practices.
- We observed the irrigation of a patient's nose at the end of an operation but noted the scrub practitioner was not wearing safety goggles, which was contrary to the hospital's IPC policy which states, "Eye protection and masks are used to protect health care workers from splashes of body fluid and should be worn for any activity where there is a risk of body fluid splashing into the face." The theatre manager was made aware of this matter and we were told they would remind staff about the use of personal protection equipment (PPE).
- During the reporting year October 2015 to September 2016 there were no incidences of meticillin-resistant Staphylococcus Aureus (MRSA), meticillin-sensitive Staphylococcus Aureus (MSSA), Escherichia coli (E-coli) or Clostridium difficile (C.diff) hospital acquired infections.

Surgery

Environment and equipment

- The patient shower facilities appeared clean and tidy and we saw evidence they were cleaned five times a day.
- We saw the staff changing rooms were well organised and appeared clean with a good supply of theatre wear (scrubs).
- Post-surgery the patient recovered in the theatre before transfer to a bedded recovery area. This was well equipped with oxygen, suction equipment, skin temperature probe and a forced air blanket warmer. There was also an emergency bell and a patient call bell to summon a nurse. A television was provided for patient use if desired. In the second recovery area we saw a marble fireplace, which was unusual in a clinical area but we noted it appeared very clean.
- We checked the resuscitation (resus) trolleys. All the items were in date and we saw evidence of daily checks and regular routine maintenance. We saw Resuscitation Council (UK) guidelines displayed to help staff during an emergency situation.
- We saw the fire extinguishers had been checked and noted in the training record staff had recently undergone fire response training.
- There were no piped medical gases in the establishment. The bottled medical gases were securely stored and in date.
- We saw the theatre equipment was checked annually with the exception of the anaesthetic machine and the target controlled infusion (TCI) pump, which had half yearly checks.
- We noted the compression leggings (these are used to prevent blood clots developing in the leg) were single patient use and that arm supports were also available.
- We saw that all theatre stock was kept behind closed glass doors. Anti-microbial glass had been installed within the theatre areas.
- During the surgical procedure we observed the patient warmer was used in line with NICE guidelines CG65.
- The hospital had a policy and system for the recording of surgical implants used for procedures. The stickers provided with the prosthesis were affixed in the prosthesis book and the patient's name, hospital number, date, and the names of the surgeon and anaesthetist were recorded alongside. Another set of stickers were affixed in the patient's notes beside where the surgeon wrote the notes of the operation. We saw patient notes with this completed as per the policy.
- A daily health and safety check of the building was carried out.
- The beds in the recovery areas were visibly clean and safety tested.
- All of the supplies in these areas were safely stored and within date.
- It was noted all of the electrical equipment had been safety tested.
- We saw the sharps containers were correctly labelled, closed and not too full.

Medicines

- We found medication was kept secure in lockable cabinets, which were locked. We saw an internal medicines management audit which looked at accountability, security and staff training around medicines. The audit showed 100% compliance.
- Medicines and controlled drug (CDs) were provided when required by a local pharmacy.
- The CD cabinet in the theatre was locked but we saw other non-controlled drugs were also kept within the cabinet. This was contrary to the advice of the Department of health - Safer Management of Controlled drugs – A guide to good practice in secondary care (England) which states in section 4.5.4: "The cupboard should be dedicated to the storage of CDs. No other medicines or items should normally be stored in the CD cupboard. Occasionally, in response to local circumstances health care organisations may decide to allow other drugs that are not CDs to be stored in the CD cupboard. Trusts should carry out a risk assessment and have clear guidelines and SOPs in place to cover this".
- Subsequent to our inspection we were provided with a copy of an internal memo reminding staff of the requirement that only controlled drugs were to be kept in the CD cupboard.
- We observed the anaesthetic drugs used in the theatre environment were appropriately labelled as per the Royal College of Anaesthetists (RCoA) guidelines.
- The CD record book was checked. We noted stocks were checked morning and afternoon by two members of staff who then signed the record book.
- We checked the drug fridge temperatures and found all were within specified range and the recording of the temperature was properly completed. Staff we spoke with were aware of the action to take if the temperatures went out of range.

- The equipment and emergency drugs stored in the resuscitation trollies was checked and found to be complete and in date.

Records

- The surgeons and nurses had printed name stamps with their General Medical Council (GMC) or Nursing and Midwifery Council (NMC) numbers, which aided the readability of the patient records and other documents.
- We examined 13 sets of patient notes which were consistently well completed. They included consultation dates, consent, pre-operative assessments, MRSA screening and VTE assessments, National Early Warning Scores (NEWS) and pain scores. The notes also included details of any prosthesis used and the patient's discharge plan.
- The patient notes were kept securely. We noted all of the interaction with the patient, including pre-operative consultations and post-operative follow up was within the single set of notes.
- The hospital performed an audit of patient records twice a year. The result of the last audit available at the time of our inspection showed 99% compliance. Out of the 20 sets of notes audited a surgeon had not countersigned the patient's signature at the consent stage and in another blue ink had been used for a couple of lines of writing when the policy stated black ink. We did not see any similar errors on the random notes we checked.

Safeguarding

- The hospital had a comprehensive safeguarding vulnerable adult's policy with clear guidance for the procedures staff were to follow if they suspected a safeguarding issue.
- The CQC registered manager for the hospital was the safeguarding lead and had been trained to level 3. Staff we spoke with knew who the safeguarding lead was.
- Although the safeguarding policy had some children and young people content, the hospital made it clear to patients no children were permitted, and patients should make suitable arrangements for childcare before attending for treatment.
- All staff were trained at a safeguarding level 2 as part of their mandatory training with a three yearly revalidation.
- There had been no safeguarding alerts raised by any staff member between October 2015 and the date of our inspection.

Mandatory training

- All staff received mandatory training. Mandatory training, depending on the requirement of the topic, was completed either yearly or three yearly. Staff completed annual training in basic life support, fire safety, infection prevention and control and information governance. Safeguarding, equality and diversity training and Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS) training was carried out every three years. Manual handling was updated every two years. At the time of our inspection all staff had completed their mandatory training package.
- Staff training was mainly carried out on site, although staff could request specialised external training. This was decided on a case by case basis by the management team. Staff who attended such training were expected to pass on their knowledge to other staff members and place any training manuals into the hospital library.
- Mandatory training for the registered medical officers (RMO) was monitored through the MAC. All were inducted by the registered manager.

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

- The hospital had a Patient Admission Policy, which set out a list of criteria for patients requesting surgery. The American Society of Anaesthesiologists (ASA) classification system was used to assess a patients' fitness for surgery. The patients should be fit and healthy and classified as ASA1 (a normal healthy patient) or controlled ASA2 (a patient with mild systemic disease). Patients were also required to have a body mass index (BMI) of less than 35.
- Patients were monitored by the nursing staff for a number of clinical and physiological markers during and following surgery by means of the National Early Warning Score (NEWS) system to detect patients who may be at risk of deterioration. By allocating scores according to observations such as blood pressure, pulse rate and temperature the NEWS system assisted staff in recognising unwell or deteriorating patients. There were different protocols to guide staff where a concern was triggered. The NEWS chart was part of the surgical pathway section of each patient's notes.
- The patients' notes we reviewed contained a surgical five-point safety checklist based on World Health Organisation (WHO) guidance. The WHO checklist was

launched in June 2009 and recommended by the National Patient Safety Agency (NPSA) for use in all NHS hospitals in England and Wales in 2010. The original three steps of sign in, time out and sign out have been enhanced by the addition of two further steps; an initial briefing and a final debriefing. 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.

- During the operation we observed the WHO checklist in use and witnessed the 'time out' stage, which was managed by the theatre health care assistant (HCA).
- The hospital's internal WHO checklist audit reported 100% compliance, which was evidenced by our observations and the patient records.
- We noted the theatre manager had designed a bespoke operation register in place of a standard pre-printed version. It allowed additional information required by the hospital to be entered.
- The hospital had a service level agreement in place for the transfer of a deteriorating patient to a local NHS hospital. This had not been used for at least the year preceding our inspection.
- All surgeons were required under Practising Privileges, to provide 24 hour cover for the patients they had operated upon. At discharge the hospital ensured the patients had been provided with a full post-operative care pack, including the phone numbers for emergency cover. The surgeons were expected to remain within 30 minutes travel time of the hospital whilst the patient was an inpatient. Anaesthetists were required to remain with the patient until sufficiently recovered for transfer to the recovery area and to remain contactable until the patient is discharged.
- Pre-operation photographs were taken (with patient consent) after skin marking for the surgical records.
- Upon discharge surgical patients were given the surgeons contact number for them to use if required. (responding to patient risk)

Nursing and support staffing

- The hospital employed three registered nurses, one operating department practitioner (ODP) and two healthcare assistants (HCA). At the time of our inspection some of the nursing and support staff were regular bank staff. To supplement permanent teams and help with peaks and troughs they had a team of 'bank staff' who provided cover for planned and unplanned shortfalls in staffing, covering vacancies and staff absences as well as bringing specific required skills for short periods of time. No agency staff were used.
- The hospital used guidance from the Association for Perioperative Practice (AfPP) and the Royal College of Nursing (RCN) to ensure they had the correct number of trained staff available for the patient schedule for each day. The hospital was also able to schedule surgical procedures around staffing levels as well as client need.
- The hospital used bespoke staff competency matrices to ensure the skill mix of staff and competences were maintained.

Medical staffing

- The hospital did not provide a seven day service, although on a low number of occasions (a maximum of ten per month) inpatients stayed overnight as part of their recovery plan. On those occasions the services of a bank resident medical officer (RMO) and recovery nurse were employed.
- At the time of our inspection 52 doctors and other medical professionals had been granted practising privileges at the hospital, of which 33 were cosmetic surgeons. Practising privileges is a term used when medical practitioners have been granted the right to practise in an independent hospital.
- As part of practising privileges each consultant was required to provide 24 hour consultant led care, visit each inpatient under their care at least once a day or more frequently if requested by the RMO or lead nurse, and be able to attend the hospital within 30 minutes.

Emergency awareness and training

- Fire response training was included in the mandatory training matrix and staff had received refresher training shortly before our inspection.
- The fire/emergency action plan was displayed around the hospital and detailed the required staff response to such an event. It included actions to be taken to protect patients undergoing operations at the time of the fire/ emergency.
- The hospital had emergency lighting installed which also had a battery back-up and sufficient numbers of fire extinguishers. The theatre an isolated power supply (IPS) and an uninterruptable power supply (UPS) back-up in case of mains electricity failure.

- Fire and emergency readiness formed part of the health and safety (H&S) report prepared for the hospital by an external H&S consultant.

Are surgery services effective?

Evidence-based care and treatment

- We reviewed the hospital's policies and procedures which were up to date and within their review dates. They referenced relevant national guidance. This included National Institute for Health and Care Excellence (NICE), Nursing and Midwifery Council, the Association for Perioperative Practice (AfPP), and Department of Health guidance. Staff could access policies and procedures on the provider's intranet and were able to demonstrate this for us.
- Patient records we reviewed showed evidence of pre-operative checks, clinical observations carried out during and after the procedures and discharge arrangements in line with national guidance such as NICE CG50, and accepted best practice.
- Staff we spoke with were aware and had an understanding of the various hospital policies and procedures. The procedures we observed conformed to those policies, with the one exception already mentioned of the failure to wear PPE.
- The hospital had a comprehensive audit programme to be completed on a rolling basis, with audits for WHO checklists, patient records and pain management completed every six months. The IPC audit was completed yearly by an external company and internally by the hospital; although the audit periods overlapped meaning an IPC audit was completed every six months. The internal hand hygiene audit was completed quarterly.

Pain relief

- Pain following surgery was discussed as part of the pre-operative consultation.
- Pain levels as reported by patients were monitored as part of the NEWS observations and recorded in the patient's notes as part of the surgical pathway.
- The hospital managed patient's pain during and after surgery. Pain relieving medication for after the patient had left the hospital was provided as part of their discharge pack. In addition patients were able to contact the hospital or the surgeon to discuss pain related issues via the provided contact numbers.

Nutrition and hydration

- Pre-operative patients were advised on fasting times prior to attending the hospital for surgery in line with the Royal College of Anaesthetists (RCA) guidance and the hospital's own policy.
- The information booklet states patients with diabetes should be placed first or second on the theatre list so as to keep fasting times to a minimum.
- Post-operative sickness was recorded in the patient's notes as part of the NEWS and recovery sections of the 'surgical pathway' documentation.

Patient outcomes

- Effectiveness of patient outcomes was measured via patient feedback, engagement with consultants and was supported by listening and reacting to the views of staff. During our inspection we spoke with staff and saw evidence which supported this.
- All patients are given a hospital patient questionnaire after their treatment and the registered manager told us the feedback was consistently over 90%. The hospital posed questions regarding the patient's experience and the care they received throughout their journey. The evidence from our own 'tell us about your care' cards would support this. Patient satisfaction feedback was audited quarterly and the results displayed in the hospital's reception.
- The Private Healthcare Information Network (PHIN) is the independent, government-mandated source of information about private healthcare, working to empower patients to make better-informed choices of care provider. PHIN is a not-for-profit organisation that exists to make more robust information about private healthcare available than ever before, and to improve data quality and transparency.
- The hospital has been providing information to PHIN since January 2017. We saw on the hospital's booking form a PHIN procedure code was required from the surgeon. At the time of publication of this report there was no publically searchable information about the hospital available on the PHIN database.
- 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 and breast augmentation (Body-Q). 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. The hospital had recently started submitting Q-PROMS data, however, they were not yet able to benchmark against national averages.

Competent staff

- The hospital was a General Medical Council (GMC) designated body for revalidation. A representative from the GMC visited annually, checked the practising privileges (PP), and produced a report on anything which should be improved.
- The Medical Advisory Committee (MAC) granted and reviewed practising privileges. The MAC met quarterly and discussed practising privileges as required. We observed checklists and documents provided to surgeons who had applied for PP which set out their roles, responsibility and accountability while working at the clinic. We observed completed copies of the documents and a checklist in the surgeons file.
- The hospital's GMC Responsible Officer carried out quarterly checks on the PP file. Each doctor had an appraisal, certificate of revalidation, proof of indemnity insurance, hepatitis B status and a Disclosure and Barring Service (DBS) certificate on their PP file. The medical practitioners with PP provided the hospital with proof of competence, for example relevant continuing professional development undertaken.
- The hospital reported 33 medical practitioners held PP for cosmetic surgery, of which 26 were on the GMC speciality register. During our inspection we checked nine PP files and all the relevant documentation was present. All showed the practitioner was on the GMC speciality register for cosmetic surgery.
- Staff employed by the hospital had employment checks, including but not limited to, DBS and relevant professional registration. We noted all staff had appraisals within the last year and their training was up to date.
- The hospital ensured its staff and those with PP were competent to carry out their roles by applying a robust PP process, annual appraisals and maintaining levels of training. (Nursing staff appraisals and so on.)
- Shortly before our inspection visit all healthcare staff, including the bank recovery staff, had recovery training led by an anaesthetist with PP at the hospital.

Multidisciplinary working

- We observed good interaction between hospital staff, especially within the theatre areas.
- Services were planned so patients were discharged at an appropriate time. Surgical procedures were performed so patients had sufficient time to recover before being discharged home later the same day. Some procedures required an overnight stay, which was pre-arranged with the patient.
- There were scheduled monthly team meetings attended by all staff where possible. Subjects discussed included overall hospital performance, staff engagement, audits, values and culture and complaints.

Access to information

- Original paper patient records were kept on site for six to eight months before being sent to an external secure storage facility for nine years.
- A scanned electronic version of the patient's notes was available to authorised staff by logging on to the hospital's IT system. The software was encrypted and password protected to meet patient data protection guidelines.
- Staff could access local policies and procedures electronically through the provider's intranet.
- Hospital staff were updated on hospital policy and relevant changes in procedures via the various team meetings and notice boards.
- Patients were provided with the details of the implant which had been used during surgery and the information provided with the implant.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- The General Medical Council (GMC) offers the following guidance to doctors undertaking cosmetic procedures, "You must give the patient the time and information they need to reach a voluntary and informed decision about whether to go ahead with an intervention. 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. You must tell the patient they can change their mind at any point".

Surgery

- The hospital's consent policy stated there must be at least a two week cooling off period before surgery. We examined 13 sets of patient notes and found at that to be the case in each.
- The operating surgeon explained the risks of surgery and ensured the patients understood the expected outcomes of surgery before going ahead with the procedure. We observed a detailed discussion between a patient and the operating surgeon during our inspection. Outcomes and risks were explained to patients before they agreed to go ahead with surgery and signed the consent form. Consent was additionally confirmed on the day of the surgery.
- Patients were consented in a private room and two consent forms were used, one for the hospital and a cosmetic surgery consent form.
- One patient we spoke with during our inspection was able to explain the procedure to us herself after the consultation.
- Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS) training was part of the hospital's mandatory training. Staff we spoke with told us they expected the surgeons to address MCA during consultations but they would refer to the registered manager if they had any concerns.
- The hospital had a policy relating to patients requiring psychological counselling. In the normal course of business a patient would meet with the patient co-ordinator, the surgeon and the hospital nurse. The policy states if at any time there were concerns regarding the attitude or psychological health of the patient they were to be actively encouraged to speak to their GP about the proposed treatment. In such a situation treatment would not be offered until information was received from the patient's GP. This policy was in line with the recommendations in the Royal College of Surgeons' Professional Standards for Cosmetic Surgery 2016.

Are surgery services caring?

Compassionate care

- Consultations were held in private rooms and we observed staff knock and receive permission to enter before doing so.
- We saw five patient feedback forms which related specifically to Consultants. All stated the patients were either mainly or completely satisfied.
- We observed staff interacting with patients in a respectful and considerate manner. Staff were polite and courteous in all their dealings with patients.
- As part of our inspection process we provided the hospital with CQC feedback cards, collection boxes and posters informing staff, patients and other visitors at the hospital an inspection was taking place and asking for confidential feedback. We received eight completed cards, which all praised the nursing staff and the cleanliness of the environment. Patients told us "staff were very caring", "I was listened to", and "my experience with the clinic was wonderful".
- The hospital also showed us a number of positive care comments received via their internet presence.
- Chaperones were available for patients during consultations or treatments.

Understanding and involvement of patients and those close to them

- We observed a patient/surgeon consultation for a rhinoplasty procedure. The staff nurse was also present throughout. The surgeon explained everything thoroughly and clearly, taking time to make sure the patient understood. The patient was encouraged to write in the notes in their own words what they expected from the operation. Medication, pain relief and post-operative procedures were all explained and an appointment made at a clinic local to the patient which the surgeon would attend. The patient also received this information in written form.
- The patient told us they had chosen this clinic as it was the only one where they had met and spoken with the actual surgeon. The patient had also telephoned many times and all their questions had been answered to their satisfaction.
- The hospital's website provided details of payment options including credit financed schemes.

Emotional support

- During our inspection we observed a patient in theatre ask the staff to pray with them before the surgery took place. All of the staff agreed to support the patient in this manner.
- Patients could talk with any of the hospital staff or the surgeon during their stay at the hospital if they had any concerns.

- Patients were able to speak with the surgeon again if they were unsure about their procedure or had questions after a consultation.

Are surgery services responsive?

Service planning and delivery to meet the needs of local people

- The clinic only provided private care, which meant the services provided were elective. Hospital admissions were arranged in advance between the patient, the consultant and the hospital for a convenient time and date. As a consequence in the year preceding our inspection no operations were cancelled.

Access and flow

- The hospital treated patients aged over 18 years old. Providing patients met the admission criteria, treatments were available to those aged 75 and over.
- The hospital was open Monday to Friday and some Saturdays from 7am for surgical and outpatient treatments.
- The surgical lists were prepared in advance taking the individual patients pre-operation notes and other factors such as dietary requirements into account.
- The hospital's surgical pathway, part of the patient's medical record, contained a discharge checklist to ensure patients were sufficiently recovered and with pain within acceptable limits for the patient.
- Discharges were managed with the patients' input. Discharge letters giving details of the procedure and take home medication were given to patients and with their consent could be sent to the patient's GP.

Meeting people's individual needs

- Services were planned to take into account the requirements of different people to enable them to access care and treatment. The hospital's admission criteria required patients to be aged over 18 years and generally fit and healthy.
- The hospital was able to provide translation services for patients who had difficulty with understanding English. The service was via telephone with conferencing capability and would involve a three way conversation between the patient and the surgeon in the consulting room and the translator at the external service provider.
- The hospital provided patients with a comprehensive patient information booklet in which were details of what and when patients should eat and drink and the arrangements for food and drink after surgery.
- After surgery patients were freely supplied with water and hot drinks of their choice and once recovered enough to eat were brought the food they had chosen before the operation.
- We were told large print versions of hospital documentation could be provided for patients upon request.
- A patient information booklet was provided to all patients prior to their treatment date which contained information about the patient's journey from consultation to discharge.

Learning from complaints and concerns

- The hospital had policies and processes to ensure the appropriate investigation, monitoring and evaluation of complaints.
- We saw information in a file in the patient recovery rooms and the reception providing details of how to make a complaint. Staff we spoke with had a good understanding of the complaints procedure. We saw the complaints procedure described in the patient information booklet provided to each patient.
- The hospital received four complaints in the reporting period October 2015 to September 2016, which was lower than the rate of other independent acute hospitals we hold this type of data for. The complaints were investigated in line with the hospitals policy. Actions taken as a result of the investigations included implementing a new call bell system, conducting further staff training around interacting with patients and the importance of maintaining prompt contact.
- In addition no complaints about this service were made to the CQC, or referred to the Parliamentary and Health Ombudsman or the Independent Healthcare Sector Complaints Adjudication Service (ISCAS). The complaints received while responded to as per the policy were not serious.
- Patients would be directed to ISCAS within six months of their original complaint if they were dissatisfied with the outcome of the internal hospital complaints process. The clinic had not been required to use this route within the last year.

Surgery

Are surgery services well-led?

Leadership / culture of service related to this core service

- There was effective and responsive leadership at the executive level, and staff we spoke with commented favorably on the hospital manager and other senior staff.
- Staff we spoke with told us the senior management team were visible and approachable.
- The Clinical Governance and Medical Advisory Committees were led by experienced medical practitioners with years of experience of working both in the NHS and the independent health sector. In addition the theatre manager had over 20 years' experience working with cosmetic surgery patients.

Vision and strategy for this hospital

- The hospital provided this statement when asked about their vision and strategy "Our vision is to deliver high quality care to patients in a safe, comfortable and welcoming environment. We want to expand this location to achieve optimal capacity and set very high standards which can be emulated. We want to develop this location with financial stability and long lasting sustainable service which enhances our brand in the areas."
- Staff we spoke with were able to talk to us about the vision and strategy for the hospital and what was expected of them by its implementation.

Governance, risk management and quality measurement

- We looked at the hospital policies folder. The policies were found to be well written and in depth. Where relevant they referenced national guidance and best practice. The policies were readily available to all staff via the hospital's IT system.
- The hospital was a member of the Association of Independent Healthcare Organisations (AIHO). This is a trade organisation which aims to protect and promote the interests of the independent healthcare sector by providing a voice for the sector to stakeholders, media and government. We saw a number of AIHO documents, including their publication on duty of candour (regulation 20 Health and Social Care Act 2008). Our inspectors thought this demonstrated a willingness to be part of a wider provider community and keep up with current issues in the sector.
- At this hospital the clinical governance committee and the MAC held joint quarterly meetings as they shared many members.
- The role of the MAC was to be the formal organisational structure that ensured clinical services, procedures or interventions were provided by competent medical practitioners. MAC meetings were held every quarter and were attended by the registered manager who chaired the committee and the medical director, as well as a number of consultants with practising privileges and the theatre manager. Both the MAC chair and other members presented reports to the committees, and in addition matters affecting the hospital medically and its reputation were discussed. Applications for practising privileges were also discussed and approved at those meetings.
- Quarterly MAC and clinical governance meetings minutes reviewed by us contained standard agenda items, such as; hospital activity, finances, patient satisfaction, corporate policies, incidents and complaints, and updates to the risk register. The report was considered and any issues arising followed up, actioned and addressed.
- Identifying risk is important as risks have wide implications within the healthcare sector. The identification of risk, and use of a risk register, enables senior management of the organisation to prioritise individual risks and to structure efforts and resources into reducing risk and thereby improve quality and standards of care. Sources to identify risk include incident reporting, serious incidents, patient feedback, observation and complaints.
- We were provided with a copy of the hospital's risk register. This was divided into five sections identified as the five key areas inspected by the CQC: safe, effective, caring, responsive and well led. There was also a folder containing risk assessments of other common risks prepared by an external assessor. In addition there was a maintenance folder in which was recorded any risk incidents and repairs. The reception team completed a daily health and safety check list. All staff, including the cleaning staff, were aware of the need to report any potential risks.

Surgery

Public and staff engagement

- Patients were given and asked to complete a patient questionnaire comprising of a number of questions with tick box answers. The questionnaire had eight sections and asked about the patient experience from first arrival to discharge. The completed forms were audited and the results displayed in the reception area. They were also used to inform management decisions around possible improvements to the provided service.
- The hospital engaged with potential clients by telephone, visits to the hospital and via their website. The website provided details of the services offered and of the surgeons who could perform the treatments. It also showed prices of treatments and details of payment options.
- The hospital had introduced a theme of the month based on patient feedback and displayed around the hospital for staff and patients to view.
- The hospital had monthly business team meetings to discuss the service they provided. Any changes made resulting from those meetings are communicated to staff via formal and informal team meetings.

Innovation, improvement and sustainability

- The hospital had used the feedback in our inspection report of their satellite clinic in Bristol last year to enhance patient safety and care at the Harley street site.

Outstanding practice and areas for improvement

Areas for improvement

Action the provider SHOULD take to improve

- The provider should ensure staff wear appropriate personal protection equipment (PPE) when carrying out procedures requiring such equipment to be used and in line with the hospital's infection, prevention and control operating theatre environment policy.