

# Inspection Report

3 October 2024



## Fitzwilliam Clinic

Type of service: Independent Hospital (IH)  
surgical services (day case only)  
Address: 70-72 Lisburn Road, Belfast, BT9 6AF  
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[www.rqia.org.uk](http://www.rqia.org.uk)

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Assurance, Challenge and Improvement in Health and Social Care

Information on legislation and standards underpinning inspections can be found on our website <https://www.rqia.org.uk/> The Independent Health Care Regulations (Northern Ireland) 2005 and the [Minimum Care Standards for Independent Healthcare](#)

## 1.0 Service information

<b>Organisation/Registered Provider:</b> Fitzwilliam Clinic Belfast Limited	<b>Registered Manager:</b> Ms Rebecca Watson
<b>Responsible Individual:</b> Mr James Small	<b>Date registered:</b> 21 February 2024
<b>Person in charge at the time of inspection:</b> Ms Rebecca Watson	
<b>Categories of care:</b> Acute Hospital (Day Surgery) - AH(DS) Private Doctor - PD	
<b>Brief description of how the service operates:</b> Fitzwilliam Clinic is registered with the Regulation and Quality Improvement Authority (RQIA) as an independent hospital with acute hospitals (day surgery only) AH (DS); and private doctor (PD) categories of care.  Fitzwilliam Clinic provides a range of services and treatments to adults. This includes outpatient clinics on all aspects of cosmetic, plastic and reconstructive surgery and some general surgical procedures. There are no overnight beds provided in this hospital.  Prior to the inspection a minor variation to registration application was submitted to RQIA to the change of purpose of the board room on the first floor to create two separate consultation rooms. Following the inspection the variation to registration application was approved from a care and estates perspective.  During the inspection we were advised that Ms Watson, Registered Manager, was resigning and Ms Denise Shields, a director of Fitzwilliam Clinic, would be acting as registered manager effective from 10 October 2024. We were informed that a new registered manager application would be submitted to RQIA upon the appointment of a new clinic manager in due course.	

## 2.0 Inspection summary

A short notice announced inspection was undertaken to Fitzwilliam Clinic which commenced with an onsite inspection on 3 October 2024 from 10.00 am to 4.00 pm and included a request for the submission of information electronically.

The onsite component of the inspection was completed on 3 October 2024 by two care inspectors. Feedback of the onsite inspection findings was delivered to Ms Watson on the day of the inspection. Feedback also was delivered to Ms Shields via the telephone following the inspection.

The electronic submission of additional documentation in relation to the premises aspect of the inspection was reviewed remotely by an RQIA estates inspector and feedback was provided to Fitzwilliam Clinic following the inspection.

This inspection focused on four main key themes: organisational and clinical governance; staffing arrangements; the management of the patients' care pathway; and estates management.

There was evidence of good practice in relation to organisational and clinical governance; the management of the patients' care pathway; and estates management.

One area for improvement was identified against the regulations in relation to staff training which is discussed further in sections 5.2.1 and 5.2.2 of this report.

No concerns were identified in relation to patient safety and the inspection team noted areas of strength, particularly in relation to the delivery of front line care.

### **3.0 How we inspect**

RQIA is required to inspect registered services in accordance with legislation. To do this, we gather and review the information we hold about the service, examine a variety of relevant records, meet and talk with staff and management and observe practices on the day of the inspection.

Prior to the inspection we reviewed a range of information relevant to the hospital. This included the following records:

- notifiable events since the previous care inspection
- the registration status of the hospital
- written and verbal communication received since the previous care inspection
- documentation in relation to the minor variation to registration application
- the previous care inspection report and quality improvement plan (QIP)

One week prior to the onsite of the inspection the hospital was provided with a list of specific documents requesting items to be reviewed remotely in respect of the maintenance of the premises and grounds. These items were to be sent electronically to our estates inspector on or before 13 October 2024 for review remotely.

The information obtained was then considered before a determination was made on whether the establishment was operating in accordance with the relevant legislation and minimum standards.

The inspection team undertook a tour of the premises and the inspection was facilitated by Ms Watson and Ms Shields.

During the inspection we spoke with; Ms Watson, Ms Shields, a hospital consultant and four nurses.

Examples of good practice are acknowledged and any areas for improvement are discussed with the person in charge and detailed in the QIP.

#### 4.0 What people told us about the service

Posters were issued to Fitzwilliam Clinic by RQIA prior to the inspection inviting patients and staff to complete an electronic questionnaire. No completed staff or patient questionnaires were received prior or following the inspection.

Through discussion with a number of staff who have differing roles and responsibilities it was determined that staffing levels and morale were good with evidence of good multidisciplinary team working and effective communication between staff.

#### 5.0 The inspection

##### 5.1 What has this service done to meet any areas for improvement identified at or since last inspection?

Areas for improvement from the last inspection on 18 October 2023		
Action required to ensure compliance with <a href="#">The Independent Health Care Regulations (Northern Ireland) 2005</a>		Validation of compliance
<b>Area for Improvement 1</b>  <b>Ref:</b> Regulation 15 (1) (b)  <b>Stated:</b> First time	The applicant registered person shall ensure venous thromboembolism (VTE) assessment and management is carried out in line with best practice.	<b>Met</b>
	<b>Action taken as confirmed during the inspection:</b> Following the previous inspection evidence was provided to RQIA to confirm that VTE assessment and management is carried out in line with best practice. This area for improvement has been assessed as met.	

#### 5.2 Inspection findings

##### 5.2.1 Governance and Leadership

#### Organisational Governance

There was a clear organisational structure within the hospital and staff were able to describe their roles and responsibilities.

Fitzwilliam Clinic Belfast Limited includes four directors one of whom is Mr James Small, Responsible Individual of Fitzwilliam Clinic and also the medical director. As previously stated, we were advised that Ms Watson was resigning and Ms Shields, a director of Fitzwilliam Clinic, would be acting as registered manager effective from 10 October 2024.

Various aspects of the organisational systems were discussed with Ms Watson and Ms Shields. We were advised that Board of Directors meetings take place on a regular basis. In addition, quarterly Medical Advisory Committee (MAC) meetings take place and are attended by Mr Small, Ms Watson, Ms Shields, directors of Fitzwilliam Clinic and medical staff.

Minutes of Board of Directors meetings and MAC meetings were retained and available for inspection. The MAC minutes reviewed included information on staffing and staff management, medical staff practising privileges status, professional registration status of all relevant staff, risk management, audits, clinical incidents, complaints and patient experience. It was confirmed that information is disseminated to staff following these meetings. In addition, monthly staff meetings are also held which are attended by nursing staff and administrative staff.

The hospital's risk register, accurately reflected the risks associated with the management of the service.

Audits are completed monthly, quarterly and annually as per the Fitzwilliam Clinic audit schedule. The results are monitored and actions identified for improvement are embedded into practice. The regular audit programme includes; hand hygiene audit, aseptic non touch technique (ANTT) audit, infection and complication audit, safe handling and disposal of sharps audit, tissue samples audit, environmental audit, theatre and treatment room cleaning audit, intravenous cannula audit, clinical incident audit, clinical education and training audit and patient theatre records audit. A VTE risk assessment audit had not been undertaken and it was advised that VTE risk assessments should be audited in the future. A clinical and administration audit report for April 2024 to June 2024 was also available for inspection.

Where the business entity operating a registered establishment is a corporate body or partnership or an individual owner who is not in day to day management of the service, unannounced quality monitoring visits by the registered provider, or person acting on their behalf, must be undertaken and documented every six months; as required by Regulation 26 of The Independent Health Care Regulations (Northern Ireland) 2005. It was established that six monthly unannounced quality monitoring visits are undertaken by Mr Small and the reports are shared with Ms Watson, Ms Shields and presented at the Board of Directors and MAC meetings.

Policies and procedures were available for staff reference. Staff were aware of the policies and procedures in place and how to access them. Advice and guidance was given to ensure that the policies and procedures included the date of implementation along with the date of review. Following the inspection RQIA received confirmation that this issue had been addressed.

Ms Shields described an effective governance structure that provides a process and system of accountability to support the delivery of good quality service and to monitor and maintain high standards of care.

## Clinical governance

A team of consultant surgeons who have specialist qualifications and skills in surgical services work in the hospital. During the inspection it was confirmed that two of the consultants were considered to be wholly private doctors as they are no longer affiliated with the Health and Social Care (HSC) sector in Northern Ireland (NI) and are not on the general practitioners (GP's) performer list in NI.

A review of two of the private doctors' details confirmed there was evidence of the following:

- confirmation of identity
- current General Medical Council (GMC) registration
- professional indemnity insurance
- qualifications in line with service provided
- ongoing annual appraisal by a trained medical appraiser
- each doctor/surgeon has an appointed responsible officer (RO)

Following the inspection, RQIA received confirmation that there were three consultants who are classed as wholly private doctors. We were informed that records, as outlined above, were in place for the third private doctor.

Evidence of ongoing professional development and continued medical education that meets the requirements of the Royal Colleges and the GMC was not available to review in respect of the two private doctors with the exception of fire safety awareness training. Advice and guidance was given to Ms Shields to ensure that all staff working in Fitzwilliam Clinic, both employed or under practising privileges, complete training in keeping with RQIA guidance and their professional regulatory body. This is discussed further in section 5.2.2 of this report.

All medical practitioners working within the establishment must have a designated RO. In accordance with the GMC all doctors must revalidate every five years. It was advised that the revalidation date should be included in the private doctors' files reviewed. The revalidation process requires doctors to collect examples of their work to understand what they are doing well and how they can improve. Experienced senior doctors, called ROs, work with the GMC to make sure doctors are reviewing their work. As part of the revalidation process RO's make a revalidation recommendation to the GMC. Where concerns are raised regarding a doctor's practice, information must be shared with their RO who then has a responsibility to share this information with all relevant stakeholders in all areas of the doctor's work.

The current arrangements supporting medical appraisal and revalidation with a RO for all consultants working in the establishment was discussed. A review of the arrangements supporting medical governance across the hospital evidenced that the hospital maintains established links with the wider HSC Trusts. They have a robust system for exchanging information with other relevant HSC or independent sector organisations when there are concerns or potential concerns regarding an individual clinician's practice. No concerns were noted at this time.

It was confirmed that the MAC meets quarterly and has responsibility for the consultants' surgical performance and surgery specific matters. The individual consultant files are monitored, checking registration with the GMC, professional indemnity and appraisals on an ongoing basis.

It was confirmed that all private doctors are aware of their responsibilities under GMC Good Medical Practice.

### **Practising Privileges**

The only mechanism for a medical practitioner to work in a registered independent hospital is either under a practising privileges agreement or through direct employment by the hospital.

Practising privileges can only be granted or renewed when full and satisfactory information has been sought and retained in respect of each of the records specified in Regulation 19 of The Independent Health Care Regulations (Northern Ireland) 2005, as amended.

A detailed policy and procedural guidance for the granting, review and withdrawal of practicing privileges agreements was in place.

Two practising privileges agreements were reviewed and found to be in accordance with best practice. It was confirmed that practising privileges agreements are reviewed at least every two years.

Discussion with Ms Shields demonstrated the oversight arrangements of the granting of practicing privileges agreements and provided assurance of robust medical governance arrangements within the organisation.

### **Quality assurance**

Arrangements were in place to monitor, audit and review the effectiveness and quality of care and treatment delivered to patients at appropriate intervals.

It was confirmed that Fitzwilliam Clinic have established governance arrangements, as previously discussed at the organisation's Board of Directors and MAC meetings.

There was a programme for internal audit to monitor compliance with policies and processes. If required, an action plan is developed to address any shortfalls identified during the audit process.

A system was also in place to ensure that urgent communications, safety alerts and notices are reviewed and, where appropriate, made available to key staff in a timely manner.

### **Notifiable Events/Incidents**

A policy for the management and reporting of clinical risks, incidents and near misses and a policy for the management of national safety alerts was in place.

It was confirmed that any learning from incidents would be discussed with staff. There was a process in place for analysing incidents and events to detect potential or actual trends or weaknesses in a particular area in order that a prompt and effective response can be considered at the earliest opportunity.

Significant incidents and themes reported are discussed at the organisation's Board of Directors meetings and MAC meetings and disseminated to staff as appropriate.

## Complaints Management

A copy of the complaints procedure was available in the hospital and was found to be, in the main, in line with the relevant legislation and the Department of Health (DoH) guidance on complaints handling.

It was confirmed that a copy of the complaints procedure is made available for patients/and or their representatives on request and staff demonstrated a good awareness of complaints management.

It was confirmed that complaints received will be investigated and responded to appropriately to include details of all communications with complainants; the result of any investigation; the outcome and any action taken. It was demonstrated that information gathered from complaints will be used to improve the quality of services provided.

Overall, the governance structures within the hospital provided the required level of assurance to the Board of Directors, the MAC and senior management.

### 5.2.2 Does the hospital have appropriately qualified and skilled staff in place?

The arrangements for the recruitment and selection of staff were reviewed. A recruitment policy and procedure was in place in keeping with legislation and best practice guidance.

A staff register was available to review and was found to be up to date and contained staff details in keeping with legislation.

It was evidenced that staff were recruited and employed in accordance with relevant employment legislation and best practice guidance. Two staff personnel files were reviewed of newly recruited staff, and evidenced that information required by legislation was obtained and retained in the files. An induction programme was available for newly recruited staff.

A review of duty rotas and discussion with staff evidenced that there were sufficient staff in various roles to fulfil the needs of the hospital and patients.

A review of a sample of records and discussion with staff evidenced that appraisals had been completed on an annual basis.

A review of a selection of training records evidenced that not all staff had completed mandatory training in keeping with the RQIA training guidance. A training matrix was in place to monitor the status of staff training requirements however, the training matrix did not include any of the medical staff who worked in the hospital. It was advised that the training matrix should be further developed to include all of the staff working within the establishment, either employed or under practising privileges, to ensure that they have completed training in keeping with the RQIA training guidance, continuing professional development and in accordance with their role within the hospital. Assurances were given that this issue would be addressed as a matter of urgency. An area for improvement against the regulations has been made in this regard.

Staff told us that there were good working relationships throughout the hospital and we found clear evidence of multidisciplinary working.

A system was in place to review the registration details of all health and social care professionals with their professional bodies. Records were available for review in this regard.

It was determined that appropriate staffing levels were in place to meet the needs of patients.

Addressing the area for improvement will ensure that all staff are suitably trained to carry out their duties.

### **5.2.3 Are there safe practices in place for the surgical service?**

The arrangements in place to support the provision of safe and effective surgical practices were reviewed which confirmed that the hospital was operating under their statement of purpose and categories of care.

A wide range of comprehensive policies and procedures were in place. The scheduling of patients for surgical procedures is co-ordinated by the hospital's booking system with the involvement of senior nursing staff and the consultants. Scheduling takes into account individual patient requirements, staffing levels, the nature of the procedure and any associated risks.

Patients are admitted to a consultation room. The patient has a full consultation with the performing consultant surgeon prior to the day of admission and is sent information about the procedure to be undertaken and any preparation necessary in advance, together with the consent form. The consent process is completed by the consultant carrying out the procedure as part of the admission process.

It was confirmed that three nursing staff and the consultant are present during the procedure, all with identified roles. There is an identified member of nursing staff, with relevant experience, in charge during all procedures. Staff complete a surgical safety checklist based on the World Health Organisation (WHO) guidance and completion of the surgical checklist and compliance is routinely audited through the hospital's auditing process.

Sterile theatre packs are supplied under contract from an accredited central sterile service department (CSSD) based at the Ulster Hospital Dundonald.

A review of the surgical registers maintained for all surgical procedures undertaken in the hospital was found to contain all of the information required by legislation.

It was confirmed that patients are observed during and after the surgical procedure by appropriately trained staff. Patients are discharged in accordance with discharge criteria by the nursing staff. It was confirmed that, if there were any concerns about the patient's condition, the consultant and/or the anaesthetist would be immediately informed for ongoing management. Patients are provided with clear post-operative advice, information on follow up and who to contact in the event of a post treatment emergency.

Patient care pathway records were reviewed and found to provide a framework for the clear record of admission, medical history, infection status, medication, observations on admission, pre-procedure checklist, VTE risk assessments, WHO surgical safety checklist, intra-procedure details, traceability details, post procedure observations and discharge record.

Assurance was sought that an information sharing agreement existed between the hospital and NHS Digital with appropriate control measures in place to manage patient data on the Breast and Cosmetic Implant Registry (BCIR). Theatre staff demonstrated the process in place for recording and reporting this information

An emergency trolley was located in the recovery area and checked daily by staff. A massive blood loss policy and procedure was in place. A massive blood loss tray was available for use which is stipulated in the regional guidance, "Preventing transfusion delays in bleeding and critically anaemic patients". Discussion on emergency transfer arrangements noted that the patient's consultant would arrange the transfer out, liaising with HSC hospital services. A policy was in place to guide staff on the management of medical emergencies to include the on call arrangements for medical staff and the transfer of patients to HSC hospitals.

There were procedures for the collection, labelling, storage, preservation, transport and administration of specimens. Staff clearly described these procedures and the procedure for reporting results to the appropriate clinical staff and GP. It was confirmed there is a contract in place with a pathology laboratory service. The pathology services are subject to internal audit.

It was determined that there are safe practices in place for the surgical service.

#### 5.2.4 Estates

The estates/engineering services review was completed remotely. The hospital management team was provided with a checklist of services/estates maintenance assurance items, which were to be submitted to the RQIA estates inspector for review.

The checklist included building services maintenance certificates, engineering services controls assurance inspection documents, risk assessments and building engineering services Authorising Engineer (AE) validation reports.

All requested engineering services validation/assurance reports and certificates were submitted for estates inspector review, and were found to be compliant with the relevant Health Technical Memoranda (HTM) guidance.

Specialist contractors/competent persons completed the range of building engineering maintenance activities required within the hospital.

The fire risk assessment (FRA) review was completed by a competent fire safety consultant on 27 November 2023, and was evaluated as tolerable fire safety risk.

The Authorising Engineer (AE) audit report for the engineering services was completed on 4 July 2024, the report contained an evaluation of the following engineering services:

- Medical Gas Pipeline System, HTM 02-01 Pt A
- Water Hygiene/Legionella safety, HTM 04-01
- Electrical LV, HTM 06-02
- Specialist ventilation, HTM 03-01

The AE report action plan was reviewed by the AE on 7 October 2024 and all the action plan recommendations were confirmed as implemented.

Assurance documents received confirmed that the passenger lift is maintained and inspected in accordance with the Lifting Operations and Lifting Equipment Regulations (LOLER) requirements.

There were no estates/engineering services issues noted that required action to be taken or an area for improvement to be made.

### 5.2.5 Minor variation to registration application

Prior to the inspection, a minor variation to registration application was submitted to RQIA to the change of purpose of the board room on the first floor of Fitzwilliam Clinic to create two separate consultation rooms. The two new consultation rooms were reviewed during the inspection. The rooms were found to be clean, tidy, uncluttered and finished to a high standard of décor. Some minor issues were identified regarding infection prevention and control which were addressed immediately during the inspection. Following the inspection the variation to registration application was approved from a care and estates perspective.

## 6.0 Quality Improvement Plan/Areas for Improvement

One area for improvement has been identified where action is required to ensure compliance with [The Independent Health Care Regulations \(Northern Ireland\) 2005](#).

	Regulations	Standards
<b>Total number of Areas for Improvement</b>	1	0

The area for improvement and detail of the QIP were discussed with Ms Watson as part of the inspection process. The timescale for completion commences from the date of inspection.

<b>Quality Improvement Plan</b>	
<b>Action required to ensure compliance with <a href="#">The Independent Health Care Regulations (Northern Ireland) 2005</a></b>	
<b>Area for improvement 1</b>  <b>Ref:</b> Regulation 18  <b>Stated:</b> First time  <b>To be completed by:</b> 3 November 2024	<p>The responsible individual shall ensure that all staff working within Fitzwilliam Clinic, either employed or under practising privileges, have completed training in accordance with their role and in keeping with RQIA training guidance and continuing professional development.</p> <p>A record of the training should be maintained.</p> <p>Ref: 5.2.1 and 5.2.2</p>
	<p><b>Response by applicant registered person detailing the actions taken:</b></p> <p>Fitzwilliam Clinic is dedicated to the ongoing development of all staff through training and mentoring. We have included a training matrix for staff who have practising privileges in addition to the training matrix used for staff that are directly employed. The matrix details the courses undertaken and the date that the certificate is due to expire. This is checked</p>

	<p>monthly to ensure that training is up-to-date. The clinic avails of an external training provider to assist with courses held in-house to ensure that training is effective, relevant to the environment and appropriate for our types of patient care. The staff training and development policy has been updated to reflect the addition of training tracking for clinicians who have practising privileges.</p>
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***\*Please ensure this document is completed in full and returned via Web Portal***



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