The Private Clinic Limited - Manchester

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

Overall summary

The Private Clinic - Manchester is operated by The Private Clinic Ltd. The clinic provides cosmetic surgery services for private fee-paying adult patients over the age of 18 years. Patients are admitted for planned day case surgery procedures. The services do not provide overnight accommodation for patients. Facilities include two treatment rooms and two theatres.

The main service provided by the clinic is surgery. We inspected this service using our comprehensive inspection methodology. We carried out the announced part of the inspection on 27 October 2016.

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.

We do not currently have a legal duty to rate cosmetic surgery services or the regulated activities they provide but we highlight good practice and issues that service providers need to improve and take regulatory action as necessary.

We found the following areas of good practice:

- Patient safety was monitored and incidents were investigated to assist learning and improve care. Patients received care in visibly clean and suitably maintained premises and were supported with the right equipment.
- Medicines were stored safely and given to patients in a timely manner. Patient records were completed appropriately. The staffing levels and skills mix was sufficient to meet patients needs and staff assessed and responded to patient risks.
- All staff had completed their mandatory training and annual appraisals. Care and treatment was provided by suitably trained, competent staff that worked well as part of a multidisciplinary team.
- Patients received care and treatment according to national guidelines such as National Institute for

Summary of findings

Health and Clinical Excellence (NICE) and the Royal Colleges. Performance data was submitted to the Private Healthcare Information Network (PHIN) in September 2016.

- We spoke with six patients and they all spoke positively about their care and treatment. Staff treated patients with dignity and respect and patients were kept involved in their care. Patient satisfaction surveys showed patients were positive about the care and treatment they received.
- There was sufficient capacity and daily planning by staff so patients could be admitted and discharged in a timely manner. There was one case of a cancelled procedure for a non-clinical reason in the last 12 months and this patient was treated within 28 days of the cancellation.
- Patient consent was obtained prior to commencing treatment. Complaints about the services were resolved in a timely manner and shared with staff to aid learning.
- The providers purpose statement and objectives had been shared with staff. There was clearly visible leadership within the services. Staff were positive about the culture within the services and the level of support they received. There was routine public and staff engagement.

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

- The services did not participate in national audit programmes as a way to compare and benchmark patient outcomes, such as performance reported outcomes measures (PROMs). The services planned to participate in the national varicose vein procedure PROMS by March 2017.
- Completed World Health Organization (WHO) surgical checklist records were reviewed as part of the routine patient record audits. However, there was no specific audit in place to observe staff practice and adherence to the WHO checklist.

Following this inspection, we told the provider that it should make other improvements, even though a regulation had not been breached, to help the service improve.

Ellen Armistead

Deputy Chief Inspector of Hospitals

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Surgery		The Private Clinic – Manchester carries out cosmetic surgery procedures. We do not currently have a legal duty to rate this service but we highlight good practice and issues that service providers need to improve and take regulatory action as necessary.

Summary of findings

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Services we looked at:
Surgery

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Background to The Private Clinic Limited - Manchester

The Private Clinic - Manchester is operated by The Private Clinic Ltd. The clinic opened in 2009. It is a private healthcare service located in Manchester, Greater Manchester and primarily serves the communities of the Greater Manchester. It also accepts patient referrals from outside this area.

The clinic has had a registered manager in post since October 2016. The registered manager is based at another of the providers locations. The service appointed a clinic manager in February 2016. At the time of the inspection, the clinic manager was in the process of applying to become the registered manager for the clinic.

There were no special reviews or investigations of the service on-going by the CQC at any time during the 12 months before this inspection. The clinic was previously inspected in March 2014. We found that the service was meeting all standards of quality and safety it was inspected against during that inspection.

The clinic is registered to provide the following regulated activities:

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

Our inspection team

The team that inspected the service comprised a CQC lead inspector and two other CQC inspectors. The inspection team was overseen by Ann Ford, Head of Hospital Inspection.

Information about The Private Clinic Limited - Manchester

The Private Clinic - Manchester provides cosmetic surgery services for private fee-paying adult patients over the age of 18 years. Patients are admitted for planned day case surgery procedures.

Seven surgeons worked at the hospital under practising privileges. The clinic employed two registered nurses, a patient coordinator and two receptionists. Facilities include two treatment rooms and two theatres.

The main service provided by the clinic is surgery. The surgical procedures offered at the clinic are liposuction, varicose vein removal and hair transplants.

In the reporting period July 2015 and June 2016 there were 124 day case episodes of care recorded at the clinic; all of these were privately funded. The service does not provide overnight accommodation for patients.

The service offers cosmetic procedures such as dermal fillers and laser hair removal and laser skin rejuvenation treatments. We did not inspect these services.

The service also offers patients a range of cosmetic surgery treatments, such as breast augmentation, facelifts and ear pinning. The initial consultations and post-operative follow up appointments take place at the clinic. These surgical procedures are carried out at an external hospital by consultants working under practicing privileges at the clinic.

There is a service level agreement in place where the external hospital provides the theatre facilities, equipment and theatre staff when carrying out these procedures. There were 36 cosmetic surgery procedures carried out at the external hospital between October 2015 and September 2016.

During the inspection, we visited the treatment rooms and the theatre areas. We spoke with nine staff including; a registered nurse, the senior receptionist, a consultant, the operating department practitioner, the registered

Summary of this inspection

manager, the clinic manager, the head of regional operations and the clinical governance lead. We spoke with six patients. During our inspection, we reviewed five sets of patient records.

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 do not currently have a legal duty to rate cosmetic surgery services.

We found the following areas of good practice:

- Patient safety was monitored and staff reported incidents using a paper based incident reporting system. Learning from incidents was shared with staff.
- There were no serious patient safety incidents reported between July 2015 and June 2016. There were 12 clinical incidents reported during this period and these resulted in low or no patient harm.
- Patients received care in visibly clean and appropriately maintained premises. Suitable equipment was available to support patients.
- Medicines were stored safely and given to patients in a timely manner. Patient records were completed appropriately.
- There were no cases of Methicillin-resistant Staphylococcus aureus (MRSA) bacteraemia, Methicillin-sensitive Staphylococcus aureus (MSSA) bacteraemia, Clostridium difficile (C. diff) or Escherichia coli (E. coli) at the clinic between July 2015 and June 2016.
- All staff had completed their mandatory training. The staffing levels and skill mix was sufficient to meet patients needs. Staff understood how to identify and report safeguarding concerns.
- Staff had access to a contingency policy that listed key risks that could affect the provision of services. Instructions for staff to follow in the event of a fire or medical emergency were in place.

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

- Completed World Health Organization (WHO) surgical checklist records were reviewed as part of the routine patient record audits. However, there was no specific audit in place to observe staff practice and adherence to the WHO checklist.

Are services effective?

We do not currently have a legal duty to rate cosmetic surgery services.

We found the following areas of good practice:

Summary of this inspection

- Patients received care according to national guidelines such as National Institute for Health and Clinical Excellence (NICE), Royal Colleges guidelines.
- The services submitted performance data to the Private Healthcare Information Network (PHIN) in September 2016 in accordance with legal requirements regulated by the Competition Markets Authority (CMA).
- Patient outcomes and performance data was collated and this was used to review individual consultant performance. Records showed most patients experienced positive outcomes following their procedure.
- Patients were prescribed pain relief medication and their pain symptoms were managed effectively.
- There were no reported cases of unplanned patient readmissions within 28 days of discharge between July 2015 and June 2016.
- Care and treatment was provided by suitably trained, competent staff that worked well as part of a multidisciplinary team. All staff had completed their appraisals. There were no consultants with any outstanding queries relating to their practising privileges.
- Staff sought consent from patients prior to delivering care and treatment and understood what actions to take if a patient lacked the capacity to make their own decisions.

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

- The services did not participate in national audit programmes as a way to compare and benchmark patient outcomes, such as performance reported outcomes measures (PROMs).

Are services caring?

We do not currently have a legal duty to rate cosmetic surgery services.

We found the following areas of good practice:

- We spoke with six patients. They all spoke positively about the care and treatment they received. They told us they were treated with dignity and compassion and their privacy was respected.
- Feedback from monthly patient satisfaction surveys between June 2016 and October 2016 also showed that patients were positive about the care and treatment they had received.
- Patients were kept fully involved in their care and the staff supported them with their emotional and spiritual needs.

Summary of this inspection

- The patient coordinator acted as the main contact and supported patients throughout the treatment process.
- During consultations patients were offered a chaperone (such as the patient coordinator) or were invited to have a friend or relative present.

Are services responsive?

We do not currently have a legal duty to rate cosmetic surgery services.

We found the following areas of good practice:

- Services were planned and delivered to meet the needs of patients. There was daily planning by staff so patients could be admitted and discharged in a timely manner.
- The initial patient consultations allowed staff to plan the care and treatment in advance so patients did not experience delays in their treatment.
- The pre-operative assessment process identified patients with dementia, learning difficulties or other medical conditions and this allowed the staff to determine if they were suitable for surgery at the clinic.
- The services reported one case where a procedure was cancelled for a non-clinical reason in the last 12 months. This patient was offered an alternative date within 28 days of the cancellation.
- Patients were offered follow up appointments to ensure they received the right level of care before and after surgery. Where a patient did not attend their planned appointment, staff contacted them to arrange an alternative date.
- Complaints about the services were resolved in a timely manner and information about complaints was shared with staff to aid learning.

Are services well-led?

We do not currently have a legal duty to rate cosmetic surgery services.

We found the following areas of good practice:

- The provider's vision and values had been cascaded across the surgical services and staff had a clear understanding of what these involved.
- There was a clear governance structure in place with committees such as medicines management, clinical outcome and patient safety and infection prevention and control feeding into the providers quality and governance committee and medical advisory committee (MAC).

Summary of this inspection

- Key risks to the services were recorded and managed through the use of a risk register. Audit findings and quality and performance was routinely monitored in order to improve the services.
- There was effective teamwork and clearly visible leadership within the services. Staff were positive about the culture within services and the level of support they received from the management team. There was routine public and staff engagement.
- The appointment of the clinic manager in February 2016 and the appointment of two permanently employed clinic nurses had led to an improved work culture and a reduction in staff turnover and agency staff usage.
- The current registered manager was based at a neighbouring clinic. The clinic manager was in the process of applying to become the registered manager for the services.

Surgery

Safe	
Effective	
Caring	
Responsive	
Well-led	

Are surgery services safe?

Incidents

- There were no 'never events' reported in relation to the surgical services at the clinic between July 2015 and June 2016. Never Events are serious incidents that are wholly preventable as guidance or safety recommendations that provide strong systemic protective barriers are available at a national level and should have been implemented by all healthcare providers.
- There were no serious patient safety incidents reported in relation to surgery between July 2015 and June 2016. There were 12 clinical incidents reported during this period; five were rated as 'no harm' and seven were 'low harm' incidents. There were also five non-clinical incidents reported during this period.
- We saw evidence to show these incidents were investigated and remedial actions were implemented to improve patient care. For example, an incident was reported in May 2016 where skin discolouration was observed on a patient during a post-operative follow up clinic.
- The incident report showed a root cause analysis was carried out. Remedial actions included improved communication between staff and to review and identify alternative wound dressings used following the procedure.
- Staff were aware of the process for reporting any identified risks to patients, staff and visitors. All incidents, accidents and near misses were logged using paper-based incident reporting forms.
- Incidents were reviewed and investigated by staff with the appropriate level of seniority, such as the clinic manager or a consultant.
- Staff told us they received verbal feedback about incidents reported and that this was used to improve practice and the service to patients. Incidents and complaints were discussed during monthly clinic meetings so shared learning could take place.
- Staff across all disciplines were aware of their responsibilities regarding duty of candour legislation. 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.
- The clinic reported there had been no patient deaths relating to surgery between July 2015 and June 2016. There was a process in place to allow all patient deaths to be reviewed and investigated through the corporate provider's medical advisory committee (MAC).

Clinical Quality Dashboard or equivalent

- The clinic did not have a clinical quality dashboard in place to monitor patient safety. All patient safety incidents were reported using a paper-based form and logged on a spreadsheet to look for improvements to the service.
- The clinic manager was responsible for analysing the data for trends and to look for improvements to the service.
- There were no serious patient safety incidents (such as falls or pressure ulcers) reported in relation to surgery between July 2015 and June 2016.
- The clinic reported that it had carried out venous thromboembolism (VTE) risk assessments for 100% of its patients between July 2015 and June 2016. We saw evidence of this in the patient records we looked at.
- There had been no cases of healthcare-acquired VTE or pulmonary embolism (PE) reported by the hospital during this period.

Surgery

Cleanliness, infection control and hygiene

- There were no cases of Methicillin-resistant Staphylococcus aureus (MRSA) bacteraemia, Methicillin-sensitive Staphylococcus aureus (MSSA) bacteraemia, Clostridium difficile (C.diff) or Escherichia coli (E. coli) reported by the clinic between July 2015 and June 2016.
- There were no surgical site infections reported between July 2015 and June 2016.
- The clinic rooms and theatre areas were visibly clean and tidy. Staff were aware of current infection prevention and control guidelines. Cleaning schedules and daily checklists were in place, and there were clearly defined roles and responsibilities for cleaning the environment and cleaning and decontaminating equipment.
- There were arrangements in place for the handling, storage and disposal of clinical waste, including sharps. There were enough hand wash sinks and hand gels. We observed staff following hand hygiene and 'bare below the elbow' guidance.
- Staff were observed wearing personal protective equipment, such as gloves and aprons, while delivering care. Gowning procedures were adhered to in the theatres.
- There were arrangements in place with an external contractor who carried risk assessments and water testing every two years to minimise the risk of Legionella.
- Patients underwent MRSA screening prior to undergoing surgical procedures at the clinic. The infection control policy stated that patients with a suspected or confirmed contagious condition would not be treated at the clinic.
- There was a monthly hand hygiene audit in place to monitor staff compliance with hand washing guidelines. Audit results from April 2016 and September 2016 showed high levels of compliance by staff (94% to 100%). Where hand hygiene issues were identified this was discussed with individual staff members to improve compliance.
- Infection control audits were carried out every three months to check compliance against national infection prevention and control guidelines and to monitor the cleanliness of the general environment and equipment. Audit results showed the clinic achieved 100% compliance in April 2016 and 98% compliance in August 2016.

Environment and equipment

- The treatment rooms and theatres were well maintained and free from clutter. All the equipment we saw was visibly clean and well maintained.
- Reusable surgical instruments were sterilised in an accredited sterilisation unit by an external contractor. Single use sterile instruments were stored appropriately and kept within their expiry dates.
- Staff told us that all items of equipment were readily available and any faulty equipment was repaired or replaced in a timely manner.
- There was a planned maintenance schedule in place that listed when equipment was due for servicing. Equipment servicing was managed by the clinic manager who arranged for equipment to be serviced by external contractors. We looked at a selection of service records for equipment such as vaser liposuction equipment, varicose vein equipment and these were within their service dates.
- There was a system in place to ensure safety alerts relating to patient safety, medicines and medical devices were cascaded to staff and responded to in a timely manner.
- Emergency resuscitation equipment was available across all areas and checked on a daily basis by staff.

Medicines

- We found that medicines were ordered, stored and discarded safely and appropriately.
- Routine medicines were stored securely in locked cabinets and medicine fridges. Staff carried out weekly medication expiry and stock checks to ensure that medicines were reconciled correctly.
- The clinic had arrangements with a local pharmacy provider to supply medicines used for the care and treatment of patients.
- Controlled drugs were not kept on site and these were ordered for delivery on the day the surgical procedure took place. Controlled drugs were disposed of safely in line with the clinic's management policy.

Surgery

- Medicines that required storage at temperatures below 8ºC were stored in medicine fridges. Fridge temperatures were checked daily and the daily log sheets showed medicines were stored at the correct temperatures.
- Medicines used during surgical procedures and given to patients to take home were prescribed by the consultant that carried out the surgical procedure.
- We looked at the medication and controlled drug log books and the medication records for five patients. Patients were given their medicines in a timely way, as prescribed, and records were completed appropriately.
- Medication management audits were carried out on a monthly basis. Audit records from April 2016 to August 2016 showed 100% compliance was achieved with the provider's medicine management policies and procedures.

Records

- Staff used paper based patient records and these were securely stored in each area we inspected.
- We looked at the records for five patients. These were structured, legible, complete and up to date.
- Patient records showed that nursing and clinical assessments were carried out before, during and after surgery and these were documented correctly.
- Patient records included information such as consent records, medical history reviews and risk assessments, such as for thromboembolism (VTE), and these were completed correctly.
- Patient records were kept on site and were accessible for follow up consultations. Medical notes made by consultants working under practising privileges were retained in the patient records.
- A monthly patient records audit took place to review clinical records for completeness. Records showed compliance was 65% in April 2016 and 56% in May 2016. Remedial actions were taken to improve the quality of records and this had led to improved compliance of 84% in August 2016 and 94% in September 2016.

Safeguarding

- Staff received training in the safeguarding of vulnerable adults as part of their induction followed by refresher training every three years.
- Records up to October 2016 showed that all eligible staff across the services had completed their safeguarding training.
- Staff were aware of how to identify potential abuse and report safeguarding concerns. Information on how to report safeguarding concerns within the organisation and externally was clearly displayed in the waiting area
- The clinic manager was the safeguarding lead within the clinic. The corporate provider also had a named safeguarding lead consultant and staff were aware of how they could seek advice and support from the safeguarding lead when needed.
- There had been no safeguarding incidents reported by the clinic between July 2015 and June 2016.

Mandatory training

- Staff received mandatory training in areas such as children and adults safeguarding, infection control, medicines management, fire safety awareness, health and safety, lone working, conflict management, food hygiene, equality and diversity, resuscitation and moving and handling training.
- The training was delivered either face-to-face or via e-learning.
- Records showed that 100% of staff had completed their mandatory training and the clinic's internal target of 80% compliance had been achieved.

Assessing and responding to patient risk

- Patients had an initial consultation to determine whether they were eligible to receive treatment at the clinic. As part of this process, patients with certain medical conditions were excluded from receiving treatment. For example, patients that were overweight (i.e. a body mass index (BMI) above 25) were considered unsuitable for liposuction procedures.
- Patients undergoing surgical procedures were treated under local anaesthetic or sedation (e.g. Midazolam). General anaesthetic was not used for any procedures carried out at the clinic.
- This meant the patients that were accepted for treatment were generally fit and healthy wih a low risk of developing complications during or after surgical treatment.
- All varicose vein patients underwent an ultrasound scan prior to treatment to determine if they were suitable to undergo this procedure.

- Patients were also assessed by the consultant on the day of surgery to identify if there had been any changes to their medical condition since their initial consultation and a decision was made whether treatment could commence.
- The clinic reported that there had been no cases of unplanned transfer of a patient to another hospital between July 2015 and October 2016.
- Staff were aware of the 'management of a collapsed / unwell patient and unplanned transfer policy' and understood the steps to follow if a patient became unwell during or after treatment.
- The policy stated that the consultant would be called in the first instance to assess the patient.
- If a decision was made to transfer the patient, the consultant would be responsible for ensuring the patient is appropriately prepared for transfer and an ambulance would be called to transfer the patient to a local acute NHS Hospital. Patient records would be made available to accompany the patient when transferred.
- The clinic manager told us an additional recovery nurse would be allocated if two or more patients were treated on the same day.
- We observed one theatre team undertake the 'five steps to safer surgery' procedures, including the use of the World Health Organization (WHO) checklist. The theatre staff completed safety checks before, during and after surgery and demonstrated a good understanding of the 'five steps to safer surgery' procedures.
- We looked at the records for five patients that had undergone treatment at the clinic and the WHO checklists were completed appropriately in each case.
- Completed World Health Organization (WHO) surgical checklist records were reviewed as part of the routine patient record audits. However, there was no specific audit in place to observe staff practice and adherence to the WHO checklist.

Nursing and support staffing

- The clinic had a sufficient number of trained nursing and support staff with an appropriate skill mix so that patients were safe and received the right level of care.
- The clinic manager told us they did not use a recognised acuity tool to determine staffing levels. All patients were admitted for planned day case procedures and patient acuity was determined during pre-operative assessment. This allowed the clinic manager to determine the staffing levels needed for the patient prior to their admission.
- There were seven staff in substantive posts and permanently based at the clinic. This included the clinic manager and two registered nurses that worked part-time hours. They were supported by the patient coordinator, the lead receptionist, an additional part-time receptionist and a laser therapist.
- Cover for staff sickness or leave was provided by the existing team or by utilising staff from the provider's Leeds clinic. The clinic manager confirmed agency staff were not used frequently and if required, they tried to use staff that had worked at the clinic before so they were familiar with the clinic's procedures.
- Records showed the use of bank and agency nurses in theatres area was lower than the average for other independent acute hospitals during most of the period between July 2015 and June 2016.
- The only exception was during the three months between January and March 2016 where bank and agency staff usage was 100%.
- The clinic manager confirmed there was a staffing shortfall during this period. This had been addressed through the recruitment of the two theatre nurses. One of the nurses commenced employment in March 2016 and the other commenced employment in August 2016.
- The clinic manager confirmed there were no outstanding nursing or support staff vacancies at the clinic. Records showed agency staff underwent induction and their qualifications and training was checked prior to commencing work at the clinic.

Medical staffing

- The clinic did not have any substantive medical staff based on site.
- Surgical procedures were carried out by a team of seven consultant surgeons that were mainly employed by other organisations (such as in the NHS) in substantive posts and had practising privileges with the hospital.
- Five of the seven consultants carried out regulated activities that were within the scope of our inspection.
- The consultants were responsible for their individual patients during their stay at the clinic and the subsequent post-operative follow up visits.

Surgery

- The theatre team (for liposuction or veins procedures) consisted of a consultant surgeon, an operating department practitioner (ODP) and a scrub / recovery nurse.
- The ODP was self-employed and worked exclusively with the consultant that carried out vaser-liposuction procedures.

Emergency awareness and training

- There was a contingency policy and business continuity plan that listed key risks that could affect the provision of care and treatment. Staff were aware of how to access this information when needed.
- There were clear instructions for staff to follow in the event of a fire or other major incident.
- Staff also had guidelines in place for dealing with medical emergencies. The consultants and ODP had completed advanced life support (ALS) training. The theatre nurses had completed intermediate life support (ILS) training and the remaining staff were trained in basic life support.
- The clinic manager told us there had been no incidents where a patient required resuscitation during the past 12 months.

Are surgery services effective?

Evidence-based care and treatment

- Patients received care according to national guidelines such as National Institute for Health and Clinical Excellence (NICE), Royal Colleges' guidelines and General Medical Council (GMC) guidelines for doctors who offer cosmetic interventions.
- Staff used standardised care pathways for vaser liposuction, varicose vein removal and hair transplant procedures that were based on national guidelines.
- The care pathways were benchmarked against national guidelines and developed through corporate provider committees such as the clinical outcome and patient safety committee and the medical advisory committee (MAC) and cascaded to staff at the clinic.
- Policies and procedures reflected current guidelines and staff told us they were easily accessible in electronic and paper format.

Pain relief

- Patients undergoing surgical procedures were given a local anaesthetic (e.g. Lidocaine) or a sedative (such as Fentanyl or Midazolam) to minimise pain and discomfort during their procedure.
- Patients were given pain relief medication (such as co-codamol) following their discharge from the clinic. Patients were also given an information leaflet to take home which provided information on how to manage pain symptoms following discharge from the clinic.
- Patient records showed that patients received the required pain relief and they were treated in a way that met their needs and reduced discomfort.
- The patients we spoke with told us they received good support from staff and they were given appropriate medication to manage their pain symptoms during and after their treatment at the clinic.

Nutrition and hydration

- Patients with specific nutritional needs were assessed as part of the pre-operative assessment process. Patients with medical conditions such as diabetes were excluded from receiving treatment.
- Patients undergoing liposuction procedures were given written information about starve times prior to commencing treatment. Patients were advised not to eat solid food for up to six hours and drink water for up to two hours prior to undergoing treatment.
- Patients were also advised on the types of fluids or food they could take within the first 24 hours after treatment.
- All patients were admitted for day case procedures at the clinic and staff provided refreshments and a light pre-prepared meal (such as a sandwich) following their procedure.
- Where treatment took longer than a few hours (such as hair transplant procedure), staff were able to offer patients additional meals during the day.
- Staff took into account patients with specific cultural needs and were able to provide food based on their preferences, such as vegan, halal or kosher food.
- Patients told us they were offered a choice of food and drink and spoke positively about the quality of the food offered.

Patient outcomes

- The clinical governance lead told us that performance data had been submitted to the Private Healthcare Information Network (PHIN) in September 2016 in accordance with legal requirements regulated by the Competition Markets Authority (CMA).
- The services did not participate in other national audit programmes as a way to compare and benchmark patient outcomes, such as performance reported outcomes measures (PROMs).
- The clinical governance lead told us they planned to participate in and submit data to the national varicose vein procedure PROMS by March 2017.
- The clinic collated performance data for each individual consultant involved in surgical procedures. The information did not specify patient outcomes but was used to compare individual consultant performance in areas such as number of consultations, procedures, follow up appointments carried out as well as the number of complaints, clinical incidents and cancelled procedures reported for each consultant.
- A patient outcomes audit by a consultant that carried out liposuction procedures showed their patient complication rate was two out of 310 (0.6%) for procedures carried out between January 2015 and August 2016.
- There had been no cases of unplanned patient readmissions within 28 days of discharge between July 2015 and June 2016.

Competent staff

- Newly appointed staff underwent an induction process and their competency was assessed prior to working unsupervised. Theatre staff underwent competency based induction training for up to six weeks and their competency was assessed by the clinic manager.
- Staff told us they received annual appraisals. The clinic reported that 100% of staff had completed their appraisals at the time of our inspection.
- Consultants working at the hospital were employed under practising privileges (authority granted to a physician or dentist by a hospital governing board to provide patient care in the hospital). Practising privileges were reviewed every three years by the corporate provider's medical advisory committee (MAC). This included a review of appraisals and scope of practice and checks for any reported incidents related to the individual consultant.
- Records showed there were seven consultants that carried out treatments at the clinic and their practising privileges had been reviewed. There were no consultants with any outstanding queries relating to their practising privileges.
- We spoke with a consultant who told us they submitted information such as appraisal records, General Medical Council (GMC) revalidation, indemnity certificates and Disclosure and Barring Service (DBS) checks to the clinic on an annual basis.
- Records showed all the consultants working under practicing privileges had undergone appraisal within the last 12 months. In most cases, the appraisal was carried out by the NHS organisation where the consultants were employed and a copy was kept on file at the clinic.
- The corporate provider had appointed a Responsible Officer whose role included overseeing revalidation and appraisal processes. A consultant that was not directly employed by an NHS organisation received appraisal by an independent medical appraiser that had been nominated by the responsible officer.
- The operating department practitioner's staff file was kept on site and showed evidence that their professional registration, indemnity insurance, disclosure and barring service (DBS) checks and training (e.g. advanced life support training) were current and in place.

Multidisciplinary working

- There was effective daily communication between multidisciplinary teams within the clinic. Patient records showed that there was routine input from nursing and medical staff.
- Staff told us they had a good relationship with consultants working under practicing privileges.
- There was daily communication between the patient coordinator, clinic manager and consultant surgeons so patient care could be coordinated and delivered effectively.
- There was cross-site working between clinic staff and staff from the provider's Leeds clinic.
- There were service level agreements in place with a number of external organisations to support processes such as equipment maintenance, domestic services, sterilisation of medical devices and laboratory support for MRSA screening and blood tests.

- There was a service level agreement with an external private hospital where some additional cosmetic surgery procedures were carried out.

Access to information

- Staff used paper based patient records and these were securely stored on site at all times. Clinical notes were kept with the patient records. Staff could also upload the patient records onto an electronic patient administration system. This meant that staff could access all the information needed about the patient at any time.
- The clinic reported that 100% of patients seen within the past three months had all the relevant medical records available.
- Staff told us they could access policies and procedures, up to date national best practice guidelines and prescribing formularies when needed.
- The clinic used standardised care pathway records for individual procedures and these were readily available. These were developed at corporate level and staff from the clinic had input in the development of these care pathways.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Staff had the appropriate skills and knowledge to seek verbal informed consent and written consent before providing care and treatment to patients.
- The consultants sought written consent from patients undergoing surgery during the initial consultation process. Written consent was also obtained a second time before the patient underwent surgical treatment.
- Staff also sought consent from patients for the use of digital images.
- All patients were allowed a minimum 14 day 'cooling off' before commencing any treatments.
- Patient records showed that written and verbal consent had been obtained from patients and that planned care was delivered with their agreement. Consent forms showed the risks and benefits were discussed with the patient prior to carrying out a surgical procedure.
- Where patients lacked the capacity to provide informed consent, staff made decisions about whether treatment could be provided and sought input from the patient's representatives and other healthcare professionals, such as the patient's general practitioner (GP).
- Patients with certain mental health conditions (e.g. depression, anxiety or risk of self-harm) were excluded for treatment at the clinic.

Are surgery services caring?

Compassionate care

- Patients were treated with dignity, compassion and empathy. We observed staff providing care in a respectful manner. Patient's privacy and dignity was maintained in the theatre and recovery areas.
- We spoke with six patients. All the patients said they thought staff were kind and caring and gave us positive feedback about ways in which staff showed them respect and ensured that their dignity was maintained. The comments received included: "brilliant experience, very happy with the service", "all expectations were fulfilled" and "staff were approachable and supportive"
- Staff carried out monthly patient satisfaction surveys during post-operative follow up appointments and the feedback was used to look for improvements to the service. The survey results from June 2016 to October 2016 were based on 44 responses.
- The survey feedback was positive with all the patients responding that they were either satisfied or very satisfied with the care and treatment they had received.

Understanding and involvement of patients and those close to them

- Patients underwent initial consultations with the patient coordinator and the consultants carrying out the procedure and individual patient preferences were taken into account as part of this process.
- Patients told us they were kept fully informed and staff were clear at explaining their treatment to them in a way they could understand. The comments received included: "staff were very thorough and explained everything" and "surgeon was informative, all questions were answered and was told what could go wrong with the procedure".
- Patients also spoke positively about the information they received verbally or in the form of written materials. They told us they received information that was specific to their treatment.

Emotional support

Surgery

- Patients told us the staff were calm, reassuring and supportive and helped them to relax prior to undergoing treatment. One patient commented that "staff were supportive, calming and helped to calm their nerves".
- We observed the theatre staff providing positive support and reassurance to a patient undergoing treatment on the day of the inspection.
- The patient coordinator acted as the main contact for patients throughout the treatment process. The coordinator carried out initial consultations with patients and was available to accompany patients during their surgical procedure and follow up consultations.
- During consultations patients were offered a chaperone (such as the patient coordinator) or patients were invited to have a friend or relative present.
- The consultants reviewed patients' emotional state as part of the pre-operative assessment process. Where patients were identified as needing counselling support, they were referred to their general practitioner (GP) so they could access the appropriate support or treatment needed.

Are surgery services responsive?

Service planning and delivery to meet the needs of local people

- The clinic only provided cosmetic services for private fee-paying adult patients over the age of 18 years. All patients were admitted for planned day case procedures. The services did not provide overnight accommodation for patients.
- As part of the pre-operative assessment process, patients with certain medical conditions were excluded from receiving treatment at the clinic.
- This included patients that were pregnant, had mental health problems (e.g. depression, anxiety or self-harm history) or had other underlying health issues (e.g. heart disease, stroke, diabetes or cancer).
- There were two treatment rooms and two theatres. One theatre was dedicated for hair transplant procedures and the other theatre was mainly used for liposuction procedures. One of the treatment rooms was used for varicose vein procedures.
- The initial consultation process allowed staff to plan for the patient in advance so they did not experience delays in their treatment when admitted to the clinic.
- There was regular communication between the clinic manager, patient coordinator and the consultant carrying out the procedure so that required resources (such as staff and equipment) could be arranged.

Access and flow

- Most patients accessed the services via self-referral. When a patient made an initial enquiry about the services offered at the clinic, a consultation appointment was made with the patient coordinator. Patients were given verbal and written information about the types of treatments offered.
- There was sufficient capacity to provide care and treatment for patients undergoing surgery. The clinic was open during weekdays and three Saturdays per month (from 10am until 4pm).
- Patients were then reviewed by the surgeon responsible for carrying out the procedure. As part of this consultation, a review of the patient's medical history was carried out to determine whether they were suitable to undergo surgical treatment at the clinic.
- Patients that were eligible and had agreed to undergo surgery at the clinic received a further consultation with the patient coordinator. The coordinator provided information about the procedure and relevant fees and discussed the patient's individual preferences.
- Most patients underwent surgery within four to six weeks of their initial consultation. Patients undergoing varicose vein or liposuction procedures were routinely admitted and discharged within four hours on the day of surgery.
- The clinic reported they had cancelled one procedure for a non-clinical reason in the last 12 months. This patient was offered an alternative date within 28 days of the cancellation.
- Patient records showed staff had completed a discharge checklist that covered areas such as medication given to the patient to take home. Discharge letters were not routinely sent to a patient's GP unless there was a specific reason and patient permission had been obtained.
- Patients that were discharged from the clinic were given a 24-hour contact number so they could speak with a nurse as part of the aftercare process. The nurse had contact details for all the consultants and they could be contacted if required.

Surgery

- Patients that had undergone vaser liposuction surgery were given a follow up appointment with a nurse within two days of the procedure. Patients with a drain were followed up by the consultant the day after surgery.
- Patients were given a post-operative follow up appointment with the consultant six weeks after the procedure and further follow ups were carried out if required. Records showed patients had been offered follow up appointments and they were seen by a consultant within specified timelines.
- The proportion of patients that did not attend (DNA) their initial consultations or follow up appointments was approximately 14%. Where a patient did not attend their planned appointment, staff contacted the patient to arrange an alternative date. In most cases patients did not attend these appointments through their own personal choice.

Meeting people's individual needs

- Information leaflets about the services were readily available in all the areas we visited. Staff told us they could provide leaflets in different languages or other formats, such as braille if requested.
- Staff could access a language interpreter if needed.
- The clinic only provided cosmetic services for private fee-paying adult patients over the age of 18 years.
- The clinic manager and head of regional operations told us if there was a surgical procedure error caused by the service they would offer as many follow up appointments as needed free of charge to resolve the issue.
- The pre-operative assessment process identified patients with dementia or learning difficulties and this allowed the staff to determine if they could accommodate these patients' needs or whether they should refer them to another service that could meet their needs.
- As part of the pre-operative assessment process, patients with certain medical conditions were excluded from receiving treatment at the clinic.
- The clinic was not accessible for patients with limited mobility. The treatment rooms and theatre areas could only be accessed by walking either up or downstairs and there was no lift in the building.
- The provider reported that the clinic was based in a listed building and this limited any building improvements that could be carried out. However, patients were made fully aware about accessibility to the clinical areas during their pre-operative consultations.

Learning from complaints and concerns

- Information leaflets describing how to raise complaints about the service were visibly displayed in the areas we inspected.
- Patients told us they had been given information on how to raise a complaint. Staff understood the process for receiving and handling complaints.
- The complaints policy stated that complaints would be acknowledged within two working days and investigated and responded to within 20 working days for routine complaints.
- Where the complaint investigation had not been completed within 20 working days, staff were required to notify the complainant explaining the reasons for the delay.
- Where patients were not satisfied with the response to their complaint, they were given information on how to escalate their concerns with the Care Quality Commission (CQC) and the Independent Healthcare Advisory Bureau (IHAS).
- The clinic received seven complaints between July 2015 and August 2016; six complaints were for clinical reasons (e.g. patient not satisfied with procedure) and one complaint related to an appointment cancellation.
- Six of the complaints had been resolved and responded to within the clinic's 20-day target. One complaint raised in August 2016 was still being investigated and the reasons for the delay had been explained to the complainant.
- Information about complaints was discussed during routine team meetings to raise staff awareness and aid future learning.

Are surgery services well-led?

Vision and strategy for this core service

- The provider's statement of purpose was; "our ultimate goal is patient satisfaction, we strive to achieve this by providing a service of consistently good quality, in line with both professional and ethical and national guidelines".

- Information relating to this had been shared with the staff working at the clinic.
- The private clinic business plan 2016/17 listed five performance objectives to be achieved over the next year. This included a continued focus to develop and grow core treatments such as liposuction, hair transplant and varicose vein removal procedures, continuous improvement of clinical standards and achieve five star customer service and improved online positive reviews.

Governance, risk management and quality measurement

- There was a monthly clinic meeting where information on performance, complaints, incidents and audit results was shared with staff.
- The clinic manager also attended the operational clinic manager meetings that took place every three months and involved the clinic managers from the provider's other locations.
- There was a clear governance structure in place with committees for medicines management, risk / health and safety, clinical outcome and patient safety, policy and procedure and infection prevention and control reporting into the corporate provider's quality and governance committee and medical advisory committee (MAC).
- The clinic manager logged identified risks on the clinic risk register. We saw the the risk register listed key risks and was up to date and reviewed on a regular basis, with oversight from the clinical governance lead (corporate).
- Routine audit and monitoring of key processes took place across the clinic to monitor performance against objectives. The clinical governance lead coordinated most of the audit activity and maintained the clinic's audit schedule.

Leadership / culture of service related to this core service

- The overall lead for the services was the clinic manager, who reported to the head of regional operations.
- The clinic manager from the Leeds clinic was the registered manager with the Care quality Commission. This was an interim arrangement and the Manchester clinic manager was in the process of applying to become the registered manager for this clinic.
- The Leeds clinic manager fulfilled the duties as the registered manager for the Manchester clinic and was present at this clinic for one or two days per month. There was daily communication between the clinic manager (Manchester) and the registered manager to ensure the services were managed effectively.
- The clinic reported there had been no staff sickness for nurses working in theatres between July 2015 and June 2016.
- The clinic manager confirmed that there was a period during the past year where staff turnover was high. The clinic manager was appointed in February 2016 and in the 12 months before this there had been three clinic managers in post.
- The appointment of the current clinic manager had led to improved and stable leadership at the clinic. There had been no staff turnover since the clinic manager was appointed in February 2016.
- All the staff we spoke with were highly motivated and positive about their work. The staff were complimentary about the clinic manager and told us the culture within the clinic had improved since February 2016.

Public and staff engagement

- Staff routinely engaged with patients to gain feedback about the services. This was also done formally through monthly patient feedback surveys. Survey responses showed patients were very positive about the care and treatment they received.
- The services also engaged with the public though ad hoc public events and open evenings. There were two open evening events held in April and July 2016 to promote the services delivered by the clinic.
- Staff told us they received good support and regular communication from the management team. The head of regional operations was responsible for a number of the provider's other clinics and had daily telephone calls and weekly visits to the clinic. The clinic manager also had a monthly conference call with the provider's managing director.
- Staff engagement took place through routine clinic meetings, weekly newsletters and through other general information and correspondence that was displayed on notice boards and in staff rooms.

- The senior management team also engaged with staff through events such as the 'national summer party' and the 'annual national Christmas party' meetings across the ward and theatre areas. Staff spoke positively about the visibility and level of engagement they received.

Innovation, improvement and sustainability

- The clinic manager told us they carried out treatments using modern and innovative equipment and technology. For example, the vaser liposuction procedure used ultrasound and radio frequency technologies and was less invasive than standard liposuction. This resulted in less scarring and quicker healing times for patients.
- The services planned to implement an electronic incident reporting system and an implementation meeting was scheduled for November 2016.
- All the staff we spoke with were confident about the sustainability of the service. The appointment of the clinic manager in February 2016 and the appointment of two permanently employed clinic nurses had led to an improved work and leadership culture and a reduction in staff turnover rates and agency staff usage.

Outstanding practice and areas for improvement

Areas for improvement

Action the provider SHOULD take to improve
Action the provider SHOULD take to improve

- The provider should participate in local and national audit programmes as a way to compare and benchmark patient outcomes, such as performance reported outcomes measures (PROMs).
- The provider should take appropriate actions to monitor staff practice and adherence to the World Health Organization (WHO) surgical checklist.