Arogya Connected Health LTD

Manchester Private Hospital

Inspection report

New Court
Windsor Street
Salford
M5 4HB
Tel: 01615078822
www.manchesterprivatehospital.uk

Date of inspection visit: 02 March 2023 to 17 March 2023
Date of publication: 10/05/2023

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

Ratings

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

Summary of findings

Overall summary

Our rating of this location improved. We rated it as good because:

- The service had enough staff to care for patients and keep them safe. Staff had training in key skills, understood how to protect patients from abuse, and managed safety well. The service used systems to identify and prevent surgical site infections. Staff assessed risks to patients and acted on them. They managed medicines well. The service managed safety incidents well and learned lessons from them.
- Staff provided good care and treatment, gave patients enough to eat and drink, and gave them pain relief when they needed it. Managers monitored the effectiveness of the service and made sure staff were competent. Staff worked well together for the benefit of patients and supported them to make decisions about their care. Key services were available seven days a week.
- Staff treated patients with compassion and kindness, respected their privacy and dignity, took account of their individual needs, and helped them understand their conditions. They provided emotional support to patients, families and carers.
- The service planned care to meet the needs of local people and took account of patients' individual needs. People could access the service when they needed it and did not have to wait too long for treatment.
- Leaders ran services well using reliable information systems and supported staff to develop their skills. Staff understood the service's vision and values, and how to apply them in their work. Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. Staff were clear about their roles and accountabilities.

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Surgery	Good	

Summary of findings

Contents

Summary of this inspection

Background to Manchester Private Hospital

Manchester Private Hospital is a private cosmetic surgery service in Salford, Manchester. The service provides a range of surgical cosmetic procedures including liposuction, breast augmentation, rhinoplasty and abdominoplasty. The service is owned and operated by Arogya Connected Health LTD. The service offers appointments to private fee-paying adult patients only. The service does not provide services for children. The service opens seven days a week dependent on demand. Manchester Private Hospital has had a registered manager in place since changing their registration in April 2020.

The hospital is located on the ground floor of premises shared with other businesses. Facilities include an operating theatre, a minor operations room, recovery area, a five bedded ward, two individual ensuite rooms, patient changing rooms and two consultation rooms. There is a reception/waiting area, staff room, and staff and patient toilets.

We previously inspected this service in January 2020 and rated it as overall requires improvement.

How we carried out this inspection

We carried out a comprehensive inspection to assess the provider's compliance with fundamental standards of safety and quality. We looked at key questions of the safe, effective, caring, responsive and well-led domains. The team that inspected the service comprised of two CQC Inspectors and two specialist advisors with an inspection manager providing support off site.

We reviewed specific documentation, interviewed key members of staff including the provider director, registered manager, clinical services manager, nursing, operating theatre and administrative staff.

We spoke with six patients about their experience of care in the service. We reviewed six sets of patients' medical records.

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

Areas for improvement

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

Action the service SHOULD take to improve:

- The service should ensure that equipment is labelled to show when it was last cleaned.
- The service should continue to monitor and take appropriate actions to improve venous thromboembolism (VTE) assessment compliance.
- The service should continue to monitor and take appropriate actions to improve national early warning scores (NEWS2) compliance.

Summary of this inspection

- The service should ensure that all patient records are legible so that anyone reading them can understand and comprehend them.
- The service should ensure that information is clearly displayed and available for patients regarding how to raise a concern or a complaint.

Our findings

Overview of ratings

Our ratings for this location are:

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

Good

Surgery

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

Is the service safe?

Good

Our rating of safe improved. We rated it as good.

Mandatory training

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

Staff received and kept up to date with their mandatory training. Mandatory training was delivered through e-learning modules with some face to face training modules.

The service had a mandatory matrix that identified which training modules were classed as mandatory for each staff role.

Overall mandatory training compliance for clinical staff was 96.5%. Overall training compliance for non-clinical staff was 89.3%.

The mandatory training was comprehensive and met the needs of patients and staff. Training modules included Mental Capacity Act, basic life support, infection prevention and control, information governance, sepsis awareness and awareness of mental health, dementia and learning disability.

Managers monitored mandatory training and alerted staff when they needed to update their training.

Safeguarding

Staff understood how to protect patients from abuse and the service worked well with other agencies to do so.
Staff had training on how to recognise and report abuse and they knew how to apply it.

Staff received training specific for their role on how to recognise and report abuse. All hospital staff had completed level two safeguarding adults and children training. Clinical staff and the registered manager had completed level three safeguarding adults and children training. The registered manager was the safeguarding lead for the service.

Staff could give examples of how to protect patients from harassment and discrimination, including those with protected characteristics under the Equality Act.

Good

Surgery

Staff knew how to identify adults and children at risk of, or suffering, significant harm and worked with other agencies to protect them. The service had reported two safeguarding incidents in the past 12 months.

Information relating to safeguarding topics such as female genital mutilation (FGM) and domestic violence were displayed in the hospital reception area.

Staff knew how to make a safeguarding referral and who to inform if they had concerns. There was a safeguarding referral form and the safeguarding policy provided key contact details.

Cleanliness, infection control and hygiene

The service used systems to identify and prevent surgical site infections. Staff used equipment and control measures to protect patients, themselves and others from infection. They kept equipment and the premises visibly clean.

Clinical areas were clean and had suitable furnishings which were clean and well-maintained. The service had flooring that could be easily cleaned.

Cleaning records were up to date and demonstrated that all areas were cleaned regularly. The service outsourced the deep clean of its facilities to a third party. We saw evidence that this had been recently completed.

Staff followed infection control principles including the use of personal protective equipment (PPE). We observed staff wearing uniform that was 'bare below the elbow' and they adhered to infection control procedures, such as hand washing and using hand sanitisers when entering and exiting clinical areas. We witnessed staff using PPE effectively.

There were sufficient hand washing facilities and hand gel dispensers throughout the hospital. Handwashing posters were displayed above all wash basins in the hospital.

The service carried out monthly hand hygiene and infection prevention and control audits. Hand hygiene audit results showed 100% compliance for the six months before our inspection. Infection prevention and control audit results showed an average of 95% compliance for the same reporting period.

Staff worked effectively to prevent, identify and treat surgical site infections. Since March 2022 the service had reported 21 surgical site infections. The surgical site infection rate was around 2%. We saw evidence of surgical site infections being investigated thoroughly.

Surgical instruments were sterilised by a registered third party. We reviewed the storeroom where surgical instruments were kept and saw that this was clean and tidy.

Staff cleaned equipment after patient contact, however equipment was not labelled to show when it was last cleaned.

The service was unable to provide evidence of a legionella safety certificate. However, a legionella risk assessment had been completed during the inspection period and the risk was detailed on the provider risk register.

The service had a comprehensive policy for infection prevention and control.

Good

Surgery

Environment and equipment

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

The service had suitable facilities to meet the needs of patients and their families. The hospital was located on the ground floor of the building. The reception area contained chairs for patients and carers and a reception desk. Two consultation rooms were accessed from this area.

The design of the environment followed national guidance. The theatre had a ventilation system with an air filter installed. We saw that the clinical environment in the theatre and recovery were appropriate for the level of surgery undertaken at the hospital.

Patients were cared for on a ward with five beds and there were two private single rooms with ensuite facilities. All patients had a call bell next to their bed. We observed that patients could reach call bells and staff responded quickly when called. The patient rooms were next to each other, and the doors closed to ensure privacy and dignity.

There were fire extinguishers throughout the premises, and these had been tested appropriately. Fire safety training was also included as part of mandatory training and staff had completed this.

Staff carried out daily safety checks of specialist equipment. We saw evidence of theatre staff completing equipment checklists. We saw evidence of completed portable appliance testing checks, as well as copies of current equipment maintenance and servicing records which were all complete.

The service had a designated resuscitation trolley. We saw evidence of daily checks that were completed. The trolley had a seal in place and contained the appropriate equipment. This ensured that staff had access to the right equipment, in the event of a significant patient emergency. Resuscitation trolley checks were audited monthly, and the service had achieved 100% compliance for the six months before our inspection.

The service had enough suitable equipment to help them to safely care for patients. For example, the surgical beds were in good condition, staff told us that they had enough PPE, and oxygen and suction was available at each bed in the ward and the two private rooms.

Staff disposed of clinical waste safely. The service had a service level agreement in place for the disposal of clinical waste. This was disposed of through its dirty utility room into locked bins for removal by a third-party provider.

Assessing and responding to patient risk

Staff completed and updated risk assessments for each patient and removed or minimised risks. Staff identified and quickly acted upon patients at risk of deterioration. The service made sure patients knew who to contact to discuss complications or concerns.

Patients had a pre-operative assessment prior to their procedure. The assessment considered factors such as age, substance misuse, allergies and medical problems including psychological difficulties before deciding whether the surgery was appropriate. The hospital admission policy outlined actions that would be taken if a patient presented with such conditions.

Good

Surgery

Staff followed the hospitals patient journey standard operating procedure which covered all necessary steps from the pre-operative assessment stage to the day of surgery and through to discharge. All patients received a phone call 24 hours prior to their procedure to ensure all pre-operative checks had been thoroughly completed.

The lead anaesthetist and surgeon would decide on whether a patient would be appropriate for surgery if concerns were identified at the pre-operative assessment.

Staff knew about and dealt with any specific risk issues. For example, we saw evidence in patients notes that risk assessments for venous thromboembolism (VTE) had been completed. VTE assessment compliance was audited monthly, and results showed an average of 73% compliance for the past six months. The clinical services manager told us they had identified gaps in compliance and actions had been implemented.

Staff used the nationally recognised national early warning scores (NEWS2) tool to identify deteriorating patients. We checked patients' NEWS2 charts and found them to be filled in correctly. NEWS2 compliance was audited monthly, and results showed an average of 80% compliance for the past six months. The clinical services manager told us that audits had identified gaps in recording patients' temperatures when they were in recovery.

The use of the World Health Organisation (WHO) five steps to safer surgery checklist was embedded in practice and we saw that staff used this in theatre. WHO checklist audit results showed an average of 93% compliance for the past six months.

We observed two surgical procedures including the initial full team brief, and the sign in and sign out procedures. All staff were engaged with the team brief and introduced themselves. All patients were discussed individually with conversations about the type of procedure, the equipment required and any implants. There were discussions about past medical history and any allergies.

The anaesthetists provided by the hospital had advanced life support training, while all other clinical staff had intermediate life support training.

Staff were aware of escalation protocols for deteriorating patients. Staff explained how they would support a patient whose condition deteriorated. Nursing staff would escalate for support from the resident medical officer (RMO) who was on site and an on call anaesthetist and surgeon if required. Staff explained that the provider would call the emergency services to arrange for transfer to the local NHS hospital, this was also outlined in the emergency transfer of patients to NHS facility policy.

Staff were aware of the process if a patient had to return to theatre overnight. There were standard operating procedures for 'unplanned readmissions and returns to theatre' and 'out of hours returns to theatre'.

The service had a policy for the management of sepsis. Information about sepsis was also displayed in the staff room including the sepsis six (an initial resuscitation bundle designed to offer basic intervention within the first hour of sepsis being suspected).

Patient discharge letters included information such as symptoms to look out for and a 24 hour telephone number if they had concerns or needed advice post discharge.

The service held contact details for all consultants in case they needed to be contacted outside of their usual hours. Staff told us that the consultants were responsive to calls, even outside of these hours.

Good

Surgery

Staffing

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

The service had enough clinical staff to keep patients safe.

The registered manager and clinical services manager accurately calculated and reviewed the number of suitably trained staff needed for each shift in accordance with national guidance. Staffing rotas were planned for three weeks in advance. Since our last inspection the service had not cancelled any clinics due to staffing levels.

The number of suitably trained staff matched the planned numbers. Staffing levels in theatre were in line with Association for Perioperative Practice guidelines for procedures under local anaesthetic and those under general anaesthetic.

There were three nursing vacancies out of 16 at the time of our inspection. One staff member had left the service in the past six months. From the 05 September 2022 to the 19 March 2023 the service reported 20 sickness absence episodes for both clinical and non-clinical staff.

From the 05 September 2022 to the 19 March 2023 bank staff had collectively completed 174 shifts. For the same reporting period agency staff had completed 10 shifts.

Managers made sure all bank and agency staff had a full induction and understood the service. The clinical services manager had a very thorough process in place to monitor bank and agency staff competencies.

We saw records and qualifications that assured the surgeons, anaesthetists and other theatre staff had the right skills, training and experience to provide the right care and treatment to patients undergoing surgical procedures. In total, there were 17 active surgeons and 10 anaesthetists who worked at the hospital under practicing privileges.

Consultants provided evidence of mandatory training prior to joining the service. The hospital had evidence of each consultants' validation of professional registration.

The service ensured RMO cover was available for out of hours response whenever needed.

Records

Staff kept detailed records of patients' care and treatment. Staff recorded all cosmetic implants on the Breast and Cosmetic Implant Registry (BCIR). Records were stored securely and easily available to all staff providing care, however they were not always clear.

The service kept a mix of electronic and paper records. Each patient was registered on the hospital's database. From the initial patient enquiry to the day of surgery all records were electronic. On the day of surgery, the electronic sections of the record were printed and the patient record become paper based from this point onwards.

Paper files were stored securely in locked filing cabinets within the manager's office (which was separate from the reception area of the hospital).

Staff recorded all cosmetic implants on the Breast and Cosmetic Implant Registry (BCIR). We also saw that traceability stickers had been placed in the records we reviewed that involved breast surgery.

Good

Surgery

Patient records were audited monthly and results showed an average of 88% compliance for the past six months.

We reviewed six patient records during our inspection. The records were comprehensive and included documents such as consultation forms, medical questionnaires, consent forms, operation notes and discharge summaries. However, in two of the records we reviewed we identified concerns regarding the legibility of consultants handwriting. In addition, some records did not include consultants' GMC stamp.

We were told there were plans in place for all patient records to be electronic by December 2023.

Medicines

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

The hospital had a contract in place with a pharmaceutical company to supply medicines.

Staff followed systems and processes to prescribe and administer medicines safely. Staff stored and managed medicines and prescribing documents in line with the provider's policy.

Staff reviewed each patient's medicines regularly and provided advice to patients and carers about their medicines.

Staff carried out weekly checks on controlled drugs and medicine stocks to ensure that medicines were reconciled correctly. We looked at a sample of controlled drugs and found the stock levels were correct, and the controlled drug register was completed correctly.

Staff recorded the minimum and maximum temperature of medicines stored and staff knew how to report any temperatures outside normal ranges as per the provider policy.

The service completed monthly medicines management and controlled drugs audits. Medicines management audit results showed 100% compliance for the past six months. Controlled drugs audit results showed an average of 98% compliance for the same reporting period.

Staff had access to MHRA medicines alerts, and the registered manager had signed up for email alerts.

Incidents

The service managed patient safety incidents well. Staff recognised and reported incidents and near misses. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support. Managers ensured that actions from patient safety alerts were implemented and monitored.

Staff knew what incidents to report and how to report them. Staff reported incidents on the hospitals electronic incident reporting system. Staff could also report incidents using a paper copy of the incident report form.

Staff raised concerns and reported incidents and near misses in line with the provider policy.

From March 2022 to February 2023 the service reported 176 incidents. Incidents were broken down by category and out of the 176 reported incidents, 14% related to 'other', 13% related to 'cancelled surgeries' and 11% related to 'intraoperative delays' and 'documentation errors' or 'communication issues'. There had been no never events reported by the service in the previous 12 months.

Good

Surgery

Staff understood the duty of candour. Staff had completed duty of candour training and could explain its principles and would give patients and families a full explanation if things went wrong.

We saw evidence that incidents were discussed at team meetings and quarterly clinical governance meetings (medical advisory committee). Incident information was also displayed in the staff room.

There was evidence that changes had been made as a result of feedback. For example, all clinical staff had recently completed NEWS2 training following a patient safety incident.

Is the service effective?

Good

Our rating of effective improved. We rated it as good.

Evidence-based care and treatment

The service provided care and treatment based on national guidance and evidence-based practice. Managers checked to make sure staff followed guidance. The service met cosmetic surgery standards published by the Royal College of Surgeons.

Care and treatment were delivered to patients in line with Professional Standards for Cosmetic Surgery, National Institute for Health and Care Excellence (NICE) and Royal Colleges guidelines to ensure effective and safe care.

The service had developed standard operating procedures for a number of surgical procedures, including liposuction. This set out the standard of care to be expected and the roles and responsibilities of staff.

We were told that the clinical services manager completed monthly checks for any updates to national guidance. We saw evidence of updates to provider policies and standard operating procedures being discussed at clinical governance meetings.

Staff protected the rights of patients subject to the Mental Health Act and followed the Code of Practice.

Nutrition and hydration

Staff followed national guidelines to make sure patients fasting before surgery were not without food for long periods.

There were appropriate processes in place to ensure patients' nutrition and hydration needs were met. Patients were given fasting instructions during their pre-operative assessment. Patients were also asked to arrive at hospital at a set time for their appointment (rather than at the beginning of the day) to ensure that they did not go long periods without food.

Water and hot drinks were available to patients and their families in the waiting room and staff offered refreshments.

Most patients had day procedures. They were provided with drinks and snacks where necessary. Patients who required inpatient stays were provided with food and were given a choice of meals.

Good

Surgery

Pain relief

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

Staff assessed patients' pain using a recognised tool and gave pain relief in line with individual needs and best practice. Patients received information to take home that informed them what they should do if they felt pain after their procedure.

Patients received pain relief soon after requesting it. Patients we spoke with told us staff gave them pain relief medicines when needed and their pain symptoms were managed appropriately.

Pain control was audited monthly and results showed an average of 71% compliance for the past six months. The clinical services manager told us that audits had identified gaps in recording pain scores particularly when patients were being discharged from the hospital.

Patient outcomes

Staff monitored the effectiveness of care and treatment. They used the findings to make improvements and achieved good outcomes for patients.

The service had a clinical audit programme in place, and we saw evidence that audit results were shared at team meetings and quarterly clinical governance meetings.

The service monitored clinical activity including rates for new cases, return to theatre, revision surgery and surgical site infections. From March 2022 to February 2023 the service had carried out 1047 new surgical cases. During this period, there had been 11 returns to theatre and 45 revision surgeries. The majority of revision surgery related to rhinoplasty.

The service collected data from patients using Q-PROM questionnaires to help review the effectiveness of surgical procedures provided. Patient satisfaction survey results and comments were discussed at the quarterly clinical governance meetings to identify any areas for improvement.

However, the service did not participate in relevant quality improvement initiatives, such as national clinical audits, benchmarking, research or trials.

Competent staff

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

The clinical services manager had a thorough process for checking staff members were competent for the role they were being employed. The service had implemented staff competency checklists which enabled staff to self-assess their level of skills and experience.

Managers supported staff to develop through yearly, constructive appraisals of their work. We saw evidence of five completed appraisals for clinical staff. All had agreed action plans and were thorough. Records confirmed that around 64% of clinical staff had completed their appraisals. However, this was because some staff members had not worked at the service for longer than a year.

Staff had the opportunity to discuss training needs with their line manager and were supported to develop their skills and knowledge. For example, one staff member had completed a nurse prescribing course.

Good

Surgery

The service had a staff recruitment (fit and proper persons employed) policy which outlined a list of criteria that staff must have before being considered to become an employee. These included a Disclosure and Barring Service Check (DBS), evidence of relevant qualifications for the role applied for and references.

Clinical staff were registered with their professional governing bodies. The provider had a comprehensive policy covering the arrangements for surgeons and anaesthetists employed under practising privileges. All new surgeons and anaesthetists employed under practicing privileges had to be approved by the providers' clinical governance group.

Multidisciplinary working

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

Staff held daily safety huddle meetings to discuss patients and improve their care. Good teamwork and communication were evident during our observation of clinical practice. There was good communication between the clinical and non-clinical staff.

All staff members we interviewed told us they felt supported by colleagues and managers. Minutes from staff and governance meetings showed that attendance was a broad mix from the various multi-disciplinary teams at the hospital.

Seven-day services

Patients could contact the service seven days a week for advice and support after their surgery.

Key services were available 24 hours a day, seven days per week depending on demand. Staff routinely contacted patients within 24 hours after their surgery and patients had the ability to contact a member of the clinical team out of hours if they had any concerns after surgery.

Health promotion

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

The service provided patients with post-operative information to help manage their after care and recovery. Patients told us they were happy with the information they received before and after procedures.

There were numerous leaflets and information folders in the hospital that provided advice to patients. These included information about breast cancer as well as contact details for a mental health support group.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

Staff supported patients to make informed decisions about their care and treatment. They followed national guidance and ensured that patients gave consent in a two-stage process with a cooling off period of at least 14 days between stages. They understood how to support patients.

Staff understood how and when to assess whether a patient had the capacity to make decisions about their care.

Staff gained consent from patients for their care and treatment in line with legislation and guidance. We reviewed six records and saw that sufficient time had been allowed for the cooling off period. The records showed that the risks and benefits of surgery had been discussed with the patients, as well as other options, including not having surgery.

Good

Surgery

Staff could provide examples of when they had referred the patient back to their GP for a formal mental health assessment as they were concerned about the patient's ability to consent to surgery.

The service completed a monthly consent audit and results showed 100% compliance for the past six months. Consent and mental capacity formed part of mandatory training which was up to date for all staff.

The service had a comprehensive consent policy that detailed the steps to be taken to check patients had the capacity to consent.

Is the service caring?

Good

Our rating of caring stayed the same. We rated it as good.

Compassionate care

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

Staff were discreet and responsive when caring for patients. Staff took time to interact with patients and those close to them in a respectful and considerate way.

Patients spoke positively about the quality of care they had received and how they were treated during their appointment, they did not feel rushed, they said staff were respectful of their time, and they were given enough time to ask questions at any stage.

During our inspection we observed staff introduce themselves, explained their roles, provided details of the procedure and welcomed any questions.

Staff followed policy to keep patient care and treatment confidential. Side room doors were closed when providing care and treatment and we saw nursing and surgical staff spoke with patients in private to maintain confidentiality.

Staff understood and respected the personal, cultural, social and religious needs of patients and how they may relate to care needs.

Emotional support

Staff provided emotional support to patients, families and carers to minimise their distress. They understood patients' personal, cultural and religious needs.

Staff gave patients and those close to them help, emotional support and advice when they needed it. Staff understood the emotional and social impact that a person's care, treatment or condition had on their wellbeing and on those close to them.

Staff supported patients who became distressed in an open environment and helped them maintain their privacy and dignity. Patients told us they were supported with their emotional needs and were able to voice any concerns or anxieties.

Good

Surgery

Understanding and involvement of patients and those close to them

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

The reception area contained profile information about each consultant at the hospital including their professional qualifications and the NHS trust they were primarily based at. These profiles were available to patients prior to their surgery and helped them make an informed decision about whether to proceed with surgery.

Staff made sure patients and those close to them understood their care and treatment. The quotation for the cost of the cosmetic procedure was discussed prior to the surgery and terms and conditions explained by the patient coordinator.

Staff talked with patients, families and carers in a way they could understand, using communication aids where necessary.

Patients and their families could give feedback on the service and their treatment and staff supported them to do this. Information on how to provide feedback was displayed on notice boards.

Patients gave positive feedback about the service.

Is the service responsive?

Good

Our rating of responsive stayed the same. We rated it as good.

Meeting people's individual needs

The service was inclusive and took account of patients' individual needs and preferences. Staff made reasonable adjustments to help patients access services. There was a system for referring patients for psychological assessment before starting treatment, if necessary.

All patients were private and accessed the service by choice. There were public transport links to the hospital. There was also free parking. The service had disability access to the building.

All patients would go through a thorough consultation process which included seeing the consultant surgeon virtually and face to face, with support from nursing staff as needed. All patients were offered a second, or more, consultations to discuss the procedure again and answer any questions. The consultation process also indicated whether patients had any additional needs or support requirements.

The service provided psychological support to patients. As part of the pre-operative assessment process, all patients were required to complete a patient health questionnaire (PHQ9).

All appointments were offered a chaperone for support.Information about chaperones was displayed in the reception area.

Good

Surgery

All staff had completed equality and diversity training. The service worked with a variety of patients. The service did not intentionally exclude any patients unless they met the clinical risk exclusion criteria.

We were told that patients could request to receive care and treatment from same sex healthcare professionals.

The service had access to a telephone interpretation service to communicate effectively with patients whose chosen language was not English. In addition, the service had a hearing loop installed in the reception area.

We saw documentation available in alternative formats. For example, there was braille patient information documents in the reception area.

Access and flow

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

People could access the service when they needed it and received care promptly and patients could access the service at weekends to suit their own availability.

The first patient was typically prepared and ready for theatre at 8:00am. There was a staggered admission for patients to avoid them having to wait long for their procedures to start.

Data was collected to gain an overview of theatre start times and patient flow. This data was reviewed at the clinical governance meetings which enabled managers to identify any themes when surgical lists overrun and take appropriate action to prevent future occurrences.

Managers monitored 'did not attend' (DNA) rates for pre-operative appointments, surgery and follow up appointments. Staff followed the hospitals 'managing DNA appointments' standard operating procedure. From March 2022 to February 2023 the service reported 1243 DNA appointments.

Managers monitored any cancelled appointments to keep these to a minimum. Patients would be contacted to rearrange their appointments in case of any cancellations. When patients had their appointments cancelled at the last minute, managers made sure they were rearranged as soon as possible.

Managers and staff planned each patient's discharge as early as possible. Consultants provided follow up care for patients when they were discharged and were available for advice where this was needed, and in case patients had any concerns.

Outpatient appointments were scheduled to allow staff enough time to complete their clinical duties.

Learning from complaints and concerns

The service treated concerns and complaints seriously, investigated them and shared lessons learned with all staff. The service included patients in the investigation of their complaint.The service had a system for referring unresolved complaints for independent review. However, it was not always easy for people to raise concerns about care received.

The hospital had a complaints policy which highlighted the stages of the complaints process and the rights of patients to take their complaint to the Independent Sector Complaints Adjudication Service (ISCAS).

Good

Surgery

The hospital did not keep individual complaint files. Each complaint was instead logged on a complaint tracker which recorded the type of procedure the patient had, the consultant's name, and complaint issue. We reviewed the tracker and saw that each complaint had been assigned to an investigator with progress and outcome (when completed) logged. There was a section to record any lessons that had been learned from each complaint.

Between March 2022 to February 2023 the hospital had received 41 complaints and 56% of these related to surgical outcomes. The hospital had processes in place to monitor surgical outcomes and ensure patients received appropriate follow up care.

Managers investigated complaints and identified themes. Complaints was a standing agenda item at the quarterly clinical governance meetings. The outcomes from complaints was shared at the hospital staff team meetings so that staff could learn and improve patient safety and experience.

Staff completed an e-learning module regarding complaints management. However, during our inspection we found a written complaint from a patient in an unlocked storage cupboard in the minor operating room. We were told that a staff member had intentionally placed the written complaint in the storage cupboard so they could discuss this with the surgeon involved. We saw evidence that this complaint had been investigated and the complaint was removed from the storage cupboard.

The service displayed information about how to provide feedback in patient areas. The provider website provided details of how to raise a complaint. However, we did not see information displayed about how to raise a complaint in the hospital.

Is the service well-led?

Good

Our rating of well-led improved. We rated it as good.

Leadership

Leaders had the skills and abilities to run the service. They understood and managed the priorities and issues the service faced. They were visible and approachable in the service for patients and staff. They supported staff to develop their skills and take on more senior roles.

The provider director was based at the location and had a close day to day working relationship with staff in the service and met regularly with the registered manager and clinical services manager to discuss the service.

The service had a senior leadership team which included the provider director, registered manager, clinical services manager, and head of sales. The ward staff, theatre staff and outpatients lead were managed under one service line by the clinical services manager.

Staff knew the management arrangements and their specific roles and responsibilities, and the service had a clear staff organisational chart. Staff told us the managers were visible and approachable. All the staff were positive about the management of the service and said that they were supported to develop both personally and professionally. The managers and staff were passionate about the service and providing patients with a safe, quality experience.

Good

Surgery

Vision and Strategy

The service had a vision for what it wanted to achieve and a strategy to turn it into action. The vision and strategy were focused on sustainability of services. Leaders and staff understood and knew how to apply them and monitor progress.

The service vision was 'safe, quality care within a small friendly environment' and the mission was 'to seek excellence in all surgical activity, aspiring to provide premier patient centred services to our valued patients in a safe, caring, and friendly environment and to nurture an environment in which all stakeholders thrive'.

The service vision and mission statement were underpinned by values, goals and objectives.

Senior managers told us the aim for the organisation was to provide high and safe quality care for patients and look after their staff. Senior managers were focussed on key risks such as recruitment and retention, maintaining staff health and wellbeing and delivery of key performance standards.

The service vision, mission and values were displayed in the hospital staff room, however we received a mixed response from staff in relation to their understanding of these.

Culture

Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. The service promoted equality and diversity in daily work, and provided opportunities for career development. The service had an open culture where patients, their families and staff could raise concerns without fear.

Staff we spoke with were highly motivated, patient focussed and spoke positively about working at the hospital. They told us there was a friendly and open culture and that managers were visible and approachable.

Staff told us they received regular feedback to aid future learning and that they were supported with their training needs by the managers. Staff told us they received good training and learning opportunities. Staff felt confident to raise issues with managers and felt managers responded positively when concerns were shared.

The service was open in its communications with patients and had a system to provide patients with clear information regarding terms and conditions, including the amount and method of payment of fees.

The hospital had an equality and diversity policy and whistleblowing policy.

Governance

Leaders operated effective governance processes. Staff at all levels were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service.

The service had a business strategy document which clearly outlined the roles and accountabilities of staff within the hospital. The document showed that all roles and accountabilities aligned to six key priorities. These were; patient safety, clinical effectiveness, efficient processes, satisfied patients, exceeding expectations and organisational growth.

Staff told us they had regular team meetings where they had opportunities to meet and voice their opinions, raise issues or concerns and share learning. Minutes of the most recent meetings were displayed in the staff room, as were the most recent audit results.

Good

Surgery

There were quarterly clinical governance meetings in place to discuss governance and risk. The role of the clinical governance meeting was to agree the protocols for clinical audits and outcome measurements. Incidents, complaints and patient satisfaction levels were also discussed at this meeting, along with training requirements. The meeting was chaired by a senior member of the hospital with staff members from all areas attending.

The hospital had a system to monitor the competency of the consultants that worked at the organisation. Using information stored on an electronic system, and paper files, the hospital could demonstrate that it had collected relevant information for consultants including details of professional registration, indemnity insurance, disclosure and barring service checks and references.

The hospital had a governance policy in place which outlined the governance procedures.

The service had a policy matrix which listed all provider policies and included review dates. We saw evidence of updates to policies and standard operating procedures being discussed at staff meetings.

Management of risk, issues and performance

Leaders and teams used systems to manage performance effectively. They had plans to cope with unexpected events. They identified and escalated relevant risks and issues but actions to reduce their impact were not always effective.

The service had a risk register and each risk had a description of the impact along with the rating and likelihood. However, the large number of risks on the register made it difficult to effectively scrutinise and manage. There were 61 risks on the services register that had been open since 2019. We were told that the risk register was reviewed at the quarterly clinical governance meetings.

The hospital had developed an audit programme that looked at 12 key areas including completion of National Early Warning Scores, hand hygiene, consent, WHO surgical safety checklist, pain relief and patient records. The results of these audits were discussed in the clinical governance meetings and team meetings.

There was monitoring of patient outcome measures (QPROMs), “did not attend” rates, clinical activity and surgical site infections. This enabled the hospital to clearly identify areas of strength or weakness, or where targeted improvements could be made.

The service had a major incident plan, which included specific actions to take to continue to deliver clinical services following an unplanned disruption in service. The plans included specific scenarios (such as loss of power, fire or building restriction), and actions for staff to take in managing this disruption efficiently.

Information Management

The service collected reliable data and analysed it. Staff could find the data they needed, in easily accessible formats, to understand performance, make decisions and improvements. The information systems were integrated and secure.

Staff completed information governance training as part of their mandatory training and compliance was 100% at the time of our inspection.

Good

Surgery

There was a privacy information document displayed in the reception area for patients to read. This included information about the hospital's responsibilities under the General Data Protection Regulation. There was also information displayed in the two consultation rooms.

We did not identify any concerns in relation to the security of patient records during the inspection. Computers were available and staff access was password protected. Staff had access to the service's electronic system for access to policies, procedures, incident management and complaints logs.

The service was not submitting data to external organisations, for example the Private Healthcare Information Network.

Engagement

Leaders and staff actively and openly engaged with patients. They collaborated with partner organisations to help improve services for patients.

Staff collected patient feedback after every appointment. We saw evidence that patient feedback was discussed at quarterly clinical governance meetings and team meetings.

The service completed regular staff surveys to collect feedback from staff. The results were discussed at team meetings to identify areas for improvement. Staff also told us that they felt able to raise concerns or share ideas with leaders when needed.

Learning, continuous improvement and innovation

All staff were committed to continually learning and improving services.

All staff were committed to continual learning and actively engaged with the appraisal and professional registration process. The service had engaged with local training providers. The registered manager told us the service was not involved in any clinical research. We did not see any evidence that the service participated in any accreditation schemes.