The Surrey Park Clinic

Quality Report

2 Stirling House
Stirling Road
Surrey Research Park
Guildford
GU2 7RF
Tel: 01483 454016
Website: www.thesurreyparkclinic.co.uk

Date of inspection visit: 17 October 2016
Date of publication: 03/02/2017

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

Ratings

Overall rating for this location	**Requires improvement**
Are services safe?	**Requires improvement**
Are services effective?	**Not sufficient evidence to rate**
Are services caring?	**Good**
Are services responsive?	**Requires improvement**
Are services well-led?	**Inadequate**

Mental Health Act responsibilities and Mental Capacity Act and Deprivation of Liberty Safeguards

We include our assessment of the provider's compliance with the Mental Capacity Act and, where relevant, Mental Health Act in our overall inspection of the service.

We do not give a rating for Mental Capacity Act or Mental Health Act, however we do use our findings to determine the overall rating for the service.

Further information about findings in relation to the Mental Capacity Act and Mental Health Act can be found later in this report.

Summary of findings

Overall summary

The Surrey Park Clinic is operated by The Surrey Park Clinic (IHG) Ltd. Facilities include one treatment room for minor outpatient surgical procedures , a pre and post surgical rest room, three consulting rooms and a pharmacy for outpatient dispensing.

The service provides outpatient services including minor outpatient surgical procedures and ultrasound scans, mostly for adults but including 40 children and young people aged 13 - 18 (July 2015 – June 2016). We inspected outpatient services and include services for children and young people within this core service report because of the very low number of children and young people attending as patients.

We inspected this service using our comprehensive inspection methodology. We carried out the inspection on 17 October 2016. We rated the service overall as requires improvement. However, caring was good, and leadership was inadequate because of the lack of formal governance structures and clinical oversight.

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.

The main service provided by this service was outpatients. We rated this service as requires improvement overall.

We found areas of practice that require improvement:

- Senior staff who investigated incidents and complaints had not been trained in root cause analysis which meant that investigations were not always sufficiently robust.
- Measures taken to prevent incidents recurring were not always successful, indicating that the reason for the incident occurring had not been adequately understood.
- Staff did not understand their responsibilities under the duty of candour and we saw examples where the service had failed to discharge their responsibilities under this duty.
- There were limited audits within the service to assure managers that staff were following the correct pathways and policies which kept patients safe, for example there were no regular hand hygiene audits.
- Although patient records were mostly stored securely, complete contemporaneous records were not available as consultant notes were not stored on site.
- Staff did not all have the required level of safeguarding training for both adults and children and young people.
- The service had levels of bank staffing which were consistently worse than the average rate for other independent services.
- The clinic's policies and procedures were nearly all outside of their review date, which meant that staff might not have worked to the relevant and current evidence-based guidance, standards, best practice and legislation.

We found areas of practice that were inadequate:

- The service did not have a formal clinical governance committee or medical advisory committee to review clinical practice and address clinical issues, and there was no clinical risk register to log and monitor risks.
- The clinic owner and general manager, who were both non-clinical staff, took responsibility for the granting and reviewing of practicing privileges. The absence of a consultant or doctor to advise on these processes meant it might have been difficult for the senior management team to assess the competencies and suitability of doctors applying for practicing privileges.
- There had been repeated incidents where a patient had been informed of another patient's test results which was a breach of the Data Protection Act and indicated that the service had failed to understand why this had happened.
- The service did not have access to interpreters and used family members instead. This meant the clinic might not have had assurance all patients who did not speak English understood, or felt involved in, all

Summary of findings

aspects of their care. Staff, including members of the senior management team, did not appear to understand that using family members to interpret was not best practice.
- There was no registered manager at the time of the inspection and the service had failed to take any action to remedy this. However, the general manager responded promptly immediately after the inspection and submitted an application.

We found areas of good practice in relation to outpatient care:

- Equipment was correctly labelled with details of service dates and we saw evidence of daily checklists for the resuscitation trolley.
- We saw documentation of patient allergies and evidence of antibiotic cover in the patient records we examined.
- The service had an on-call rota to enable them to see patients out of hours should they have any complications following labiaplasty.
- There were multi-disciplinary team meetings each month demonstrating a coordinated approach to patient care.
- Patient feedback on the service received at the clinic was consistently positive, with many commenting on the degree to which staff gave them privacy and time to make decisions.

Following this inspection, we told the provider that it must take some actions to comply with the regulations and that it should make other improvements, even though a regulation had not been breached, to help the service improve. We also issued the provider with three requirement notices that affected outpatients. Details are at the end of the report.

Professor Edward Baker

Deputy Chief Inspector of Hospitals

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Outpatients and diagnostic imaging	Requires improvement 	**Do not include in report** ☐ Outpatients was the main activity of the service. We rated this service as requires improvement because although it was caring, it required improvement for safety and responsiveness to people's needs and was inadequate for well-led. • Investigations into incidents were not sufficiently thorough which meant that there was no assurance that any changes in practice would prevent recurrence. • Staff did not understand their responsibilities under the duty of candour and this meant there were no assurances that the service would be open and transparent with patients if things went wrong. • Patient records were incomplete as consultants brought their own records and did not always leave a copy in the service. • There was no formal clinical governance structure and no medical advisory committee to oversee clinical practice. • Although there were no nursing vacancies, there was a high reliance on bank nurses and health care assistants, with only one full time permanent nursing post with overall clinical responsibility. • The service relied on patient satisfaction questionnaires to assess patient outcomes rather than clinical audit. However, • all the areas we visited were visibly clean and tidy and all reusable equipment was labelled to indicate that it was clean. • Clinical and non-clinical waste was correctly separated, and sharps bins were managed appropriately to minimise risk of harm to patients and staff. • Documentation was clear, legible and correctly signed with patient care pathways and documentation of allergies in all notes.

Summary of findings

- Patient feedback was consistently positive about the care they received from staff.

Summary of findings

Contents

Requires improvement

The Surrey Park Clinic

Services we looked at
Outpatients and diagnostic imaging

Summary of this inspection

Background to The Surrey Park Clinic

The Surrey Park Clinic is operated by The Surrey Park Clinic (IHG) Ltd. The service opened in 2005 to provide specialist female health care. It is a private hospital in Guildford, Surrey. The service primarily serves the communities of Surrey and only sees patients who are privately funded. It also accepts patient referrals from outside this area. The hospital is registered to provide the following regulated activities:Diagnostic and screening procedures; Surgical procedures; Treatment of disease, disorder, or injury.

The hospital has not had a registered manager in post since July 2015. At the time of the inspection, this was pointed out and the general manager submitted an application to register with the CQC shortly after the inspection.

Our inspection team

The team that inspected the service comprised a CQC lead inspector,and two specialist advisors with expertise in radiography and leadership of women's services. The inspection team was overseen by Elizabeth Kershaw, Inspection Manager.

Information about The Surrey Park Clinic

We inspected one core service at the hospital which covered all the activity undertaken. This was outpatients and diagnostic imaging. We reviewed a wide range of documents and data we requested from the provider. This included policies, staff records and results of surveys and audits. We placed comment boxes at the hospital before the inspection which allowed staff and patients to provide us with their views.

During the inspection, we visited all the clinical areas of the clinic. We spoke to ten staff including registered nurses, health care assistants, reception staff, medical staff, ultrasound department practitioners, and senior managers. We spoke to one patient. We also received 25 'tell us about your care' comment cards which patients had completed before our inspection. During our inspection, we reviewed ten sets of patient records and we observed care in the outpatient and imaging department.

There were no special reviews or investigations of the hospital ongoing by the CQC at any time during the 12 months before this inspection. This was the service's first inspection under the updated CQC ratings methodology.

In the reporting period July 2015 to June 2016 there were 2,120 outpatient total attendances, including 56 minor surgical procedures. Of these, 100% were non-NHS-funded. There were no inpatient or day case episodes of care recorded at the service in the reporting period and no overnight stays.

In 2015-16, the most common reasons for outpatient attendances were scans (87%), blood tests (8.7%) and cervical smears (1.8%). Labiaplasty formed 0.9% of attendances.

Four physicians and three sonographers worked at the clinic under practising privileges at the time of the inspection. Two other consultants had terminated their

Summary of this inspection

employment at the service over the course of the year. Four doctors carried out between 10 – 99 episodes of care between July 2015 - June 2016, and two carried out 100 or more.

The Surrey Park Clinic employed one registered nurse, 0.2 whole time equivalent health care assistants and six receptionists and administrative staff, as well as having its own bank staff.

From July 2015 to June 2016 , there were no Never events. Never events are serious incidents that are wholly preventable and have the potential to cause serious patient harm or death. There were eight clinical incidents of which seven were rated as moderate harm. This is similar to the rate of incidents of other independent acute providers we hold this type of data for, but the proportion of moderate harm is substantially higher (87.5% compared to 7.8%). There were no serious injuries.

There were no reported incidences of serious infection such as Methicillin-resistant Staphylococcus aureus (MRSA), Methicillin-sensitive staphylococcus aureus (MSSA), Clostridium difficile (c.diff) or E-Coli.

There were 14 complaints, none of which were referred to the Ombudsman or ISCAS (Independent Healthcare Sector Complaints Adjudication Service).

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?

Requires improvement

We rated safe as requires improvement because:

- The proportion of incidents rated as moderate harm was worse than the rate for other independent acute hospitals.
- Staff who investigated incidents had not been trained in root cause analysis, which meant the investigation may not fully identify the reason for the incident, or correctly identify how to prevent any recurrence.
- Staff did not fully understand the duty of candour and did not always discharge their responsibilities under this to patients when things went wrong. This was a breach of a regulation. You can read more about it at the end of this report.
- There was no regular hand hygiene audit so managers could not be assured that all staff were compliant with the policy.
- Patient records were incomplete as consultant records were held by the consultant without a copy in the patient record.
- Staff did not have the correct level of safeguarding adults and safeguarding children training. This meant that staff did not all have the appropriate level and frequency of training to be able to identify and act upon safeguarding concerns.
- Staffing levels were heavily reliant on bank staff and there was only one permanent full time nurse to monitor compliance with clinical governance and patient safety.

However,

- Adverse events were a standard agenda item in team meetings and we saw evidence of discussions in minutes.
- All areas were visibly clean and tidy, with cleaning charts and stickers providing evidence of appropriate cleaning.
- All electrical devices were labelled with the date of their most recent safety test and service, so staff could be assured they were safe to use.
- Patient records included individual care pathways and documented history of allergies.

Are services effective?

Not sufficient evidence to rate

Are services effective?

We inspected, but did not rate, effective.

Summary of this inspection

- Almost all of the clinic's policies were outside their review date, some by over two years. This meant staff might not have worked to the relevant and current evidence-based guidance, standards, best practice and legislation.
- The service used patient satisfaction audits to measure outcomes. Patient satisfaction results can be very subjective and may not always provide a robust tool for measuring outcomes.
- Consultant files showed gaps in the documentation required to support practising privileges at the service, which meant the clinic might not have had assurances all medical staff at the clinic were competent and fit to carry out their role.

However,

- Patients who attended for labiaplasty and participated in their audit reported that their pain was well controlled during the procedure.
- We saw evidence of a good induction process for a bank healthcare assistant, with all areas signed and dated and evidence of continuing professional development.
- There was a coordinated approach to patient care with monthly multi-disciplinary team meetings.
- There was an on call rota to provide out of hours cover for patient who experienced problems following labiaplasty, and appointments were available at a range of times to meet the needs of the patient.

Are services caring?

Good

We rated caring as good because:

- Staff took care to protect a patient's confidentiality when speaking to them at reception and on the telephone.
- Patient feedback was consistently positive about the kind and respectful treatment they had received.
- Patients commented that they felt staff looked after them "as a whole person" and addressed their needs quickly and effectively.

Are services responsive?

Requires improvement

We rated responsive as requires improvement because:

- In the absence of the lead nurse, laboratory results were checked and followed up either by a health care assistant or a member of the administration team. Non-clinical staff may not have had appropriate knowledge or training to be able to action results appropriately.

Summary of this inspection

- The service did not have access to interpreters and used family members instead.It was not possible to have assurance that all information had been correctly communicated to the patient.

However,

- Patients could access appointments quickly and at a time to suit them.
- There was clear information available on how to make a complaint, and all complaints were responded to within 28 days.
- The service actively sought feedback from patients and changed practice in response to this.

Are services well-led?

Inadequate

We rated well-led as inadequate because:

- There had been no registered manager since the previous owner changed roles over a year before the inspection. This was a breach of a regulation. You can read more about this at the end of this report.
- There was no up to date statement of purpose for the service nor a specific set of values. Information that was available referred to the previous owner and registered manager who had left the role over a year ago.
- There was no formal clinical governance structure and no minuted meetings to review governance.
- There was no medical advisory committee to oversee clinical practice and ensure that clinical care met the highest standards of safety and quality.
- Practicing privileges were granted and reviewed by staff who were not clinical.
- There was no formal risk register to identify and monitor risks.
- These governance isses were a breach of regulation. You can read more about this at the end of this report.
- There were tensions within the service relating to consultant behaviour which the management team were working to change.

However,

- The general manager submitted an application to be registered manager shortly after the inspection.
- There were plans to establish a MAC by the end of 2016 and they had started the process of recruiting a lead clinician to chair this.
- The management team was making progress in several key areas, and was working to update policies and patient pathways.

Summary of this inspection

- The service took steps to get patient feedback and made service improvements as a result of this.

Detailed findings from this inspection

Overview of ratings

Our ratings for this location are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Outpatients and diagnostic imaging	Requires improvement	Not rated	Good	Requires improvement	Inadequate	Requires improvement
Overall	Requires improvement	Not rated	Good	Requires improvement	Inadequate	Requires improvement

Requires improvement

Outpatients and diagnostic imaging

Safe	Requires improvement
Effective	Not sufficient evidence to rate
Caring	Good
Responsive	Requires improvement
Well-led	Inadequate

Are outpatients and diagnostic imaging services safe?

Requires improvement

We rated safe as requires improvement.

Incidents

- The service reported eight clinical incidents and 11 non-clinical incidents in July 2015 – June 2016. The rate of clinical incidents was similar to the rate of other independent acute hospitals. However, the service assessed seven of the eight incidents (87.5%) as moderate harm. The service classed the remaining incident (12.5%) as low harm. The proportion of moderate harm incidents (87.5%) was much worse than the rate of moderate harm incidents for other independent acute hospitals (7.8%).
- Staff reported incidents by completing a paper form and submitting this to the senior nurse or clinic manager. The senior nurse or clinic manager investigated incidents and produced a report of their findings. However, neither member of staff had training in root cause analysis (RCA) investigations. A lack of RCA training may have meant the service did not fully identify the causes of incidents and learn lessons to avoid recurrences.
- Staff told us the senior nurse and clinic manager discussed learning from incident investigations at team meetings. We saw evidence of this in team meeting minutes and saw that adverse events were a standard agenda item.
- However, we reviewed incidents and saw that there were several recurrences of incidents involving staff sending blood results to the wrong patient. Although senior staff had investigated the incidents and made changes to practice which all relevant staff followed, there were further recurrences of this type of incident. Measures the management team introduced involved administrative staff not covering telephone calls at the same time as sending out blood results to allow them to concentrate and reduce the potential for error. Recurrences suggested that the measures introduced were not sufficiently robust.
- Most staff we spoke to were unsure of what duty of candour (DoC) under the Health and Social Care Act (Regulated Activities Regulations) 2014 meant, or their responsibilities relating to it. The DoC 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 them with reasonable support.
- We saw an example where a patient received another patient's blood result via email. Staff asked the patient who received the wrong result to delete it from their email account. However, the service failed to discharge their duty of candour and inform the patient the result belonged to.
- Due to the largely elective nature of the services provided, there were no specific mortality and morbidity meetings. The clinic manager, general manager, and senior nurse had informal governance meetings and met to discuss any concerns as and when they arose.
- The service reported no patient deaths or never events in July 2015- 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. Any never event reported could indicate unsafe care.

Cleanliness, infection control and hygiene

- All clinical staff we saw were "bare below the elbows" to allow effective handwashing. Gloves were available to protect staff during procedures such as blood taking, and we saw staff using gloves appropriately. However, the service did not routinely audit hand hygiene procedures to monitor staff compliance with the clinic's hand hygiene policy. This meant managers may not have had assurances all staff followed the clinic's hand hygiene procedures to minimise the risk of infections.
- The service reported no incidences of meticillin-resistant Staphylococcus aureus (MRSA), Clostridium difficile or meticillin-sensitive Staphylococcus aureus (MSSA) in July 2015 – June 2016. The hospital also reported no cases of Escherichia coli in the same period.
- The clinic reported no surgical site infections following labiaplasty in July 2015 – June 2016. The clinic performed 56 labiaplasty procedures during this period. Labiaplasty is an outpatient surgical procedure to reduce the size of the labia (the folds of skin either side of the vaginal opening).
- All areas we visited were visibly clean and tidy. We saw that all reusable items, including the scan machine, had "I am clean" stickers. This showed staff had cleaned these items ready for the next patient. We also saw cleaning charts, which provided evidence of weekly deep cleaning for the treatment room.
- We saw wash hand basins available in the treatment rooms and clinic rooms that were compliant with the Department of Health's Health Building Note 00-09: Infection control in the built environment. We saw staff wash their hands and use hand gel appropriately before and after patient contact.

Environment and equipment

- The clinic had carpets throughout, with the exception of the treatment room, bathrooms and sluice. Carpets may be difficult to clean in the event of a spillage. We also saw fabric curtains and upholstered chairs in the consulting rooms, which may also be difficult to keep clean. The Department of Health's Health Building Note (HBN) 00-09: infection control in the built environment states "Spillage can occur in all clinical areas, corridors and entrances" and "in areas of frequent spillage or heavy traffic, [carpets] can quickly become unsightly". However, we saw carpets were visibly clean and free from stains. We saw a receipt showing the carpets had a steam clean the day before our visit.
- We saw that the ultrasound machine was recently serviced. This was the only piece of imaging equipment the clinic had. The machine had a label showing the date of the last service and the date the next service would be due. This provided assurances the machine was safe to use.
- We saw the clinic had labelled all electrical devices with the dates of the most recent test. We saw that the inspection light, the adjustable treatment couch and the desk light in the treatment room had all been tested for electrical safety within the last month. This provided assurances they were safe to use.
- We checked the resuscitation trolley and saw evidence of a daily checklist, which staff completed with no omissions. All medication and single use equipment was within the recommended use by dates. We saw that all medication was sealed and stored safely.
- We saw correct segregation of clinical and non-clinical waste. This was in line with HTM 07-01, Control of Substance Hazardous to Health, and the Health and Safety at Work Regulations. We saw that staff had labelled sharps bins and that no sharps bins were overfull. This was important to prevent injury to staff and patients from sharp objects such as needle sticks.

Medicines

- The clinic had a pharmacy on-site, with a part-time pharmacist and two full-time dispensing assistants. Pharmacy hours were 10am - 4pm, Monday - Friday. The pharmacist worked eight hours a week, and doctors dispensed medication when the pharmacist was not on-site. The pharmacist was available for advice over the telephone when she was not on-site.
- We saw copies of the most recent British National Formulary (BNF) available in clinic rooms. These provided doctors with guidance on the safe prescribing of medicines.
- The pharmacist pre-packed medication for consultants to dispense outside of these hours, for example, during Saturday clinics. We saw the secure out-of-hours cupboard used to store these drugs.

- The pharmacist described the clinic's system for labelling drugs, which ensured staff removed and safely disposed of drugs before they expired. We checked drug stocks and saw that there were no expired drugs. This provided assurances the labelling system was robust.
- The clinic stored private prescription forms (FP10s) securely in a cupboard behind the clinic reception. We checked the clinic rooms, and saw there were no FP10s inside clinic rooms when the rooms were not in use. This prevented unauthorised access to FP10s.
- The clinic did not hold any controlled drugs (CDs). CDs are medicines liable for misuse that require special management.
- We examined five records for patients who had labiaplasty. We saw documentation of allergies and evidence of antibiotic cover in all records.

Records

- We requested the notes for a specific patient, and staff told us they were not available as the patient was under the care of a visiting consultant. Staff were able to provide limited records from the clinic's electronic patient management system. However, these records were not complete or contemporaneous. This was contrary to best practice guidance and meant it may be difficult for staff to provide continuity of care.
- The clinic stored patient files inside a locked records room only accessible by staff. This helped protect the security of personal and confidential patient data. However, we saw an incident report describing how a patient took home another patient's records. The incident investigation identified that staff left the notes after the first patient left the clinic. The second patient then placed their magazine on top of the notes and accidentally took them away. A sonographer told us the service subsequently introduced two notes baskets for pending and completed appointments to avoid a recurrence. We saw this system in use on our visit.
- Clinic data showed that staff saw no patients without medical records in the three months before our visit. To mitigate any risk of notes not being available, the clinic also held electronic records on a computerised patient management system. Only staff with valid login details could access electronic records. This ensured that only those staff that legitimately needed to access personal and confidential data for the purposes of patient care could do so.
- Visiting consultants also brought their own records. Visiting consultants booked patients via their secretary and arranged transfer of notes to the clinic on the day of the patient's appointment. If a visiting consultant did not bring their patient's records, the administrative team arranged for relevant information to be faxed or sent to the clinic.
- We checked the practicing privileges folders for four consultants. In three out of the four files, we saw evidence of registration with the Information Commissioners Office (ICO). The Data Protection Act 1998 requires every organisation that processes personal information to register with the ICO, unless they are exempt. However, for the fourth consultant, we checked the ICO's data protection register and saw evidence of current registration.
- We reviewed the records for ten patients and saw an appropriate standard of documentation. We saw staff had signed and dated all entries in line with best practice guidance.

Safeguarding

- Clinic data showed 78% of staff had up-to-date safeguarding vulnerable adults level one training at the time of our visit. The clinic's safeguarding policies stated all staff should have annual safeguarding training. NHS England's Safeguarding Policy (2015) recommended that all clinical staff should have a minimum of level two safeguarding training. Therefore, the training provided did not meet the national recommendation. This meant not all staff had the appropriate level and frequency of training to enable them to appropriately recognise and respond to safeguarding concerns.
- The clinic did not routinely treat children, but sometimes saw adolescents for human papilloma virus (HPV) vaccinations as an outpatient procedure. HPV is a virus associated with cervical cancer. The senior nurse had safeguarding children level three training, and the clinic had a registered children's nurse as bank staff that provided vaccinations for children and young people under the age of 18. The registered children's nurse had also trained to safeguarding level three. This system ensured only safeguarding level three trained staff cared for children under the age of 18 in line with the national intercollegiate guidance, "Working together to safeguard children" (March 2015).
- However, clinic data showed 78% of staff had up-to-date safeguarding children level one training at the time of

our inspection. The national intercollegiate document, "Working together to safeguard children" (March 2015) stated, "All non-clinical and clinical staff that have any contact with children, young people and/or parents/ carers" should have level two safeguarding children training. The intercollegiate document specifically listed "nurses working in adult acute/community services" and "all other adult orientated secondary care health care professionals" as needing level two training. This meant not all staff had the appropriate level of safeguarding children training to enable them to appropriately recognise and respond to safeguarding concerns.

- The service did not have a policy for female genital mutilation (FGM). This meant staff might not have known how to report FGM in line with mandatory reporting requirements.
- We reviewed the clinic's policies for safeguarding vulnerable adults and safeguarding children. We saw that these policies had been due for review since September 2013. This meant the policies might not have reflected the most up-to-date guidance. For example, we saw that the safeguarding children's policy referred to the 2010 national intercollegiate guidance "Working together to safeguard children". However, an updated 2015 version of this guidance was publicly available.
- However, staff we spoke to demonstrated awareness of safeguarding and their responsibilities for raising concerns. Staff were able to identify the senior nurse as the clinic's safeguarding lead and could describe the process for raising concerns. A member of staff showed us the clinic's safeguarding folder, which contained addresses and contact numbers for raising concerns to the relevant local safeguarding authority (LSA). We saw the "safeguarding adults alerts/concerns" forms the safeguarding lead could use to report concerns, along with associated guidance. The clinic had not reported any safeguarding concerns in July 2015- June 2016.

Mandatory training

- Clinic data showed the following training completion rates at the time of our inspection for all staff: equality and diversity- 62.5%; fire awareness- 56.3%; infection prevention- 83%; manual handling- 68.8%; and basic life support- 68%. These figures included all clinical and non-clinical staff, as well as bank staff.
- In addition, data showed 100% of clinical staff completed phlebotomy training in September 2015 – August 2016. This data included bank nurses and healthcare assistants (HCAs).
- Data showed the senior clinic nurse completed immediate life support training in 2015-16. One designated member of staff completed an external emergency first aid at work course as part of their mandatory training in the same period. Three designated staff completed fire warden training in the same period. All of these courses had 100% compliance rates as all designated members of staff completed them in September 2015- August 2016.

Assessing and responding to patient risk

- We reviewed five sets of patient notes for patients who had labiaplasty. We saw individual care pathways in all sets of notes, which included documentation of allergies and medical history.
- In all sets of notes, we saw documentation of a negative pregnancy test before the labiaplasty procedure. This was in line with National Institute for Clinical Excellence (NICE) guideline NG45: Routine preoperative tests for elective surgery.
- As part of the patient care pathways, we saw staff had monitored patients while they recovered from labiaplasty and recorded routine observations such as blood pressure and temperature. This allowed staff to detect any deterioration in a patient's condition and escalate appropriately. Staff said they would call for an emergency ambulance if a patient became acutely unwell, but that they had never needed to do this.
- The service had an on-call rota to enable them to see patients out of hours for any complications following labiaplasty, such as excessive bleeding. One nurse and one consultant was on-call each day. We saw evidence in the clinic meeting minutes from 21 June 2016 that the on-call staff effectively responded to a situation involving a patient who was bleeding following a procedure.

Nursing staffing

- At the time of our visit, the service had one whole-time equivalent (WTE) nurse and 0.2 WTE HCAs. There were no nursing or HCA vacancies. We spoke to the senior clinic nurse, who felt this level of staffing was sufficient for the size and activity of the clinic.

Requires improvement

Outpatients and diagnostic imaging

- However, there were high levels of bank staff use. Data showed the rate of bank HCA use varied between 28.0% and 50.0% in July 2015 – August 2016. Bank HCA use was consistently worse than the average bank and agency rate for other independent acute hospitals, which ranged from 7.6% to 11.3% in the same reporting period.
- The rate of bank nurse use varied between 0% and 33% in July 2015 – August 2016. The average rates of bank and agency nurse use for other independent acute hospitals ranged from 9.8% to 12.9% in the same period. In four months of the reporting period, the rate of bank nurse use was worse than the average for other independent acute hospitals. In the remaining eight months of this period, the rate was the same as, or better than, the average rate of bank and agency nurse use for other independent hospitals.
- However, the clinic only used bank staff and never used staff from agencies. Bank staff who worked regular shifts were more likely to be familiar with the clinic's environment, policies and ways of working than agency staff.

Medical staffing

- The clinic had four doctors with practising privileges at the time of the inspection. These were either consultants or GPs with a special interest in women's health. Patients attended pre-booked appointments with a named doctor or consultant. This ensured there were always sufficient doctors on-site.

Emergency awareness and training

- The clinic manager told us the research park where the clinic was located had a designated team to respond to business continuity incidents such as loss of power. The clinic manager knew how to contact the team and said they were very responsive.
- We saw the clinic's "emergency plans for major utilities failure" policy. This stated the manager would contact the research park maintenance team, which was what the clinic manager told us. However, it also stated the registered manager would contact the relevant utility company, and the policy had been due for review since 2011. This meant there might have been confusion in the event of a continuity incident as to who was responsible for contacting the relevant utility companies.
- As the clinic did not provide surgery under general anaesthetic, there was no emergency generator to provide an uninterrupted power supply.
- We saw clear signage of fire exits in the clinic. Three members of staff were designated fire wardens to oversee the evacuation process in the event of a fire. Records showed all three had updated their training in this area in September 2015 – August 2016.

Are outpatients and diagnostic imaging services effective?

Not sufficient evidence to rate

We inspected, but did not rate, effective.

Evidence-based care and treatment

- We reviewed the clinic's policies and procedures, and found nearly all were outside their review date. These included the clinic's consent and information governance policies, which had been due for review since July 2015. The clinic's hand hygiene policy had been due for review since June 2014, and their patient-centred care policy had been due for review since April 2015. This meant staff might not have worked to the relevant and current evidence-based guidance, standards, best practice and legislation.
- The clinic offered the harmony test for pregnant women. The harmony test was a blood test, which tested fragments of baby's DNA present in the mother's blood to screen for three genetic conditions caused by inheriting extra chromosomes. There were Down's syndrome, Edward's Syndrome and Patau Syndrome. Several studies have shown the harmony test could more accurately detect these conditions, and at an earlier stage in pregnancy (from 10 weeks), than more commonly used methods, such as the combined test. The combined test involved a blood test and a scan at around 11 to 14 weeks of pregnancy to predict the likelihood of these conditions.

Pain relief

- Patients having labiaplasty had local anaesthetic to provide pain relief during the procedure. After their procedure, the consultant prescribed oral pain relieving medications such as codeine for patients to take home to provide pain relief during the recovery period.

- We reviewed the clinic's labiaplasty audit data from January 2016 – September 2016.This audit recorded patients' views of their care collated from patient survey. All 10 patients who completed the survey reported their pain was well-controlled during the procedure. All said they experienced less pain than they expected, and three said they felt no pain at all.

Nutrition and hydration

- The clinic did not provide meals as patients were never there for any great length of time. For example, patients usually went home within two hours after labiaplasty. The clinic provided a range of teas, coffees and drinking water in their waiting room to allow patients and visitors to stay hydrated.

Patient outcomes

- The clinic used patient satisfaction audits to measure outcomes. The clinic carried out patient satisfaction and labiaplasty audits on a yearly basis, with data collated monthly. Patient satisfaction results can be very subjective and may not always provide a robust tool for measuring outcomes. This was because these audits had no scope for benchmarking or comparison to similar services.
- However, due to the nature of the services offered, there were no national audits the clinic could participate in.
- The clinic's ultrasound scanning service did not participate in the Imaging Services Accreditation Scheme (ISAS). ISAS is a UK assessment and accreditation programme designed to help ensure diagnostic imaging services give their patients consistently high quality services.
- The clinic reported one unplanned return to theatre within 28 days following labiaplasty in July 2015 – June 2016. The clinic treated 56 patients for this procedure during the same period, which gave a return to theatre rate of 1.79%. This rate was not high in comparison to the private and voluntary hospitals data collection for the same period. The reason for the return to theatre was excessive bleeding, which led to haematoma. A haematoma is a solid swelling of clotted blood. The consultant and senior nurse managed the situation effectively, and the patient made a full recovery.

Competent staff

- We saw the clinic's "application for practicing privileges" policy. However, this policy had been due for review and referred to the former owner, who no longer participated in the granting and reviewing of practicing privileges.
- The senior management team told us they interviewed consultants and doctors who wanted to apply for practicing privileges. They also requested a range of documentary evidence to support their application in line with best practice guidance. This included evidence of current registration with the General Medical Council (GMC), a CV, two written references, evidence of appropriate indemnity insurance, evidence of appraisal within the last 12 months, evidence of a UK passport or work permit, evidence of Hepatitis B immunity, registration with the Information Commissioner's Office (ICO), and a satisfactory Disclosure and Barring Service (DBS) check. Consultants supplied updated evidence yearly, including evidence of appraisal through their regular employer, mandatory training and insurance documents.
- We reviewed the competency folders for four consultants. In all four folders, we saw gaps on the practicing privileges checklist and the absence of required documents. These included the absence of written references for one consultant, the absence of appraisal evidence for another and the absence of a DBS or Criminal Records Bureau (CRB) check for two others. This meant the clinic might not have had assurances all medical staff at the clinic were competent and fit to carry out their role.
- The senior management team told us they searched the internet to find consultants working in the field and contacted them to ask whether they would like to apply for practicing privileges. There was no medical advisory committee (MAC) to oversee the granting and maintaining of practicing privileges. Instead, staff with non-clinical backgrounds managed this process. The absence of a consultant or doctor to advise on these processes meant it may have been difficult for the senior management team to appropriately assess the competencies and suitability of doctors applying for practicing privileges.
- We saw evidence of current registration with the Health and Care Professions Council (HCPC) for both sonographers who also worked as radiographers elsewhere. We saw evidence of current registration on

the College of Radiographers Public Voluntary Register of Sonographers for the third sonographer. Professional registration provided assurances staff were suitably qualified and competent to carry out their role.

- We also reviewed the competency folder for a bank healthcare assistant (HCA). This showed evidence of a robust induction process, with competency assessment in a range of areas including blood taking, consent, incident reporting, aseptic technique, and assisting with minor surgical procedures. We saw the HCA and their assessor had signed and dated all areas to provide evidence of competency. We also saw evidence of continuing professional development (CPD), including a phlebotomy certificate which showed evidence of refresher training.
- All nurses and HCAs, including bank staff, received an annual appraisal of work performance at the clinic. Clinic data showed 66% of staff received an annual appraisal in 2015. There was no set target, although the clinic's expectation was that all staff should have an annual appraisal. Data showed that only 13% of HCAs had an appraisal in 2015. Lack of appraisals may have meant the service did not address any potential staff performance issues.
- Sonographers and doctors had an annual appraisal with their regular employer. In three out of four consultant files we reviewed, we saw evidence of an appraisal within the last 12 months.

Multidisciplinary working

- The clinic had monthly multi-disciplinary team meetings involving nurses, sonographers, consultants, pharmacy and administrative staff. We saw evidence of meeting minutes over a three-month period.
- We saw that there was a coordinated approach to care. For example, HCAs saw patients to take blood on the same day as their consultant appointment. This avoided patients making unnecessary journeys to the clinic.

Seven day services

- The clinic had a 24-hour, seven-day on-call rota to provide out-of-hours consultant and nurse cover for any patients who experienced problems following labiaplasty.
- The clinic offered Saturday morning appointments for patients who were unable to attend on weekdays.

Access to information

- Staff had access to paper copies of all the policies and procedures they needed to do their jobs in the clinic rooms. They also had a nursing manual providing guidance. Staff knew how to access these documents. Staff also had access to national guidelines and other evidence-based sources of information via the internet.
- The clinic stored patient records securely inside a locked patient records room. The clinic also used an electronic patient management system, which all staff could access.
- Women having pregnancy scans brought their handheld pregnancy records with them to their appointment. This allowed sonographers to record their findings and to share this information with other relevant medical professionals involved in their care, such as midwives. A sonographer told us it was a booking condition that all pregnant women who had attended a booking appointment with their midwife and received a handheld record must bring this with them for their scan.
- With patient consent, the clinic sent copies of blood results to patient's GPs, as well as directly to the patient. This enabled the GP to arrange ongoing care where this was appropriate, for example, if the results revealed a viral infection. Staff told us that if a patient had not provided consent, they would strongly encourage them to inform their GP so that they could access appropriate care and support.
- Sonographers told us that with the woman's consent, they contacted her GP or midwife and sent copies of ultrasound images if they detected any abnormalities. In a potential emergency, such as an ectopic pregnancy, sonographers contacted the local NHS hospital and arranged immediate ongoing care.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- We reviewed five sets of notes for patients who had labiaplasty. All had a completed consent form, which the patient and consultant signed and dated to ensure its validity. We also saw evidence the consultant had discussed potential risks associated with the procedure with all patients.
- However, we noted that patients having labiaplasty completed their consent forms on the day of the procedure. This was not in line with current guidance from the Royal College of Surgeons "Good Surgical

Practice 2014", which stated staff should "obtain the patient's consent prior to surgery and ensure that the patient has sufficient time and information to make an informed decision".

- Staff obtained and documented verbal consent for minor procedures such as blood taking and ultrasound scans. We observed staff obtain verbal consent before taking a patient's blood. This was in line with the clinic's consent policy.
- We saw the clinic's patient registration forms, which specifically asked patients if they consented to the sharing of information about their care with their GP. In several sets of notes we reviewed, we saw that the patient did not consent to the clinic communicating with their GP. In all cases, we saw staff had respected the patient's wishes and did not send any communications to the GP.
- The clinic had a specific consent form for children and young people under the age of 16. We saw a copy of this form. The parent provided consent, and there was a space for the young person to sign to acknowledge their treatment if they wanted to. This was in line with best practice guidance to enable children to feel involved in decisions about their care and treatment.
- The guidance notes on the children and young people's consent form were in line with Gillick competence. Gillick competence is a test in medical law to decide whether a child younger than 16 years is competent to consent to medical examination or treatment without the need for parental permission or knowledge. The guidance stated, "Everyone aged 16 or more is presumed to be competent to give consent for themselves unless the opposite is demonstrated". We saw clear guidance about Gillick competence available to staff obtaining consent.
- Due to the nature of the services provided, which were mostly for younger, pregnant or menopausal women, staff told us they had never had a patient who lacked capacity. Staff told us that due to the age group of the patients they treated, no patients living with dementia had received treatment at the clinic.
- However, staff who received mandatory training in-house did not receive training in the Mental Capacity Act (2005). This meant that not all staff had the relevant training to allow them to assess the capacity of a patient to consent to care or treatment.

Are outpatients and diagnostic imaging services caring?

Good

We rated caring as good.

Compassionate care

- We reviewed 25 patient comment cards from patients who had used the service in 2016. All reported positive experiences of care from clinic staff. Some of the comments included, "the staff have all been exceptionally kind", "all staff have been professional and respectful at all times", and "the entire team are professional, kind, caring and empathetic".
- After booking in on arrival at reception, staff invited patients to wait in a separate waiting area. This enabled patients to speak to the receptionist privately if they needed to. Medical secretaries took patient telephone calls in their office rather than the reception area. This allowed patients to speak privately over the telephone and maintained patient confidentiality by preventing any patients in the reception area overhearing private conversations. In the clinic's patient satisfaction survey 2015, we saw that 100% of patients who responded (43 patients) felt staff gave them the privacy, time and attention they expected.
- We observed kind and caring interactions from staff during patient care. For example, a HCA apologised to a patient and adjusted the patient's tourniquet when the patient reported discomfort. After adjusting the tourniquet, the HCA checked the patient was comfortable before continuing with the procedure.
- Staff told us they always offered patients a chaperone of the same gender as the patient before any intimate procedures, such as trans-vaginal scans or cervical smears. We saw that this was in-line with the clinic's chaperone policy. The policy also stated all children and young people under the age of 18 must have a chaperone accompany them for any procedure or consultation.

Understanding and involvement of patients and those close to them

- In the comment cards we reviewed, five patients made positive comments around staff understanding and

involving them in their care. These included, "I felt I was listened to and my needs were responded to", "[staff] listened to all health concerns and addressed them quickly/effectively", and "you are looked after as a 'whole person' and symptoms are recognised and understood".

- Patients had a named consultant. We saw evidence from clinic data that the service informed patients if their named consultant was not available, for example, if they gave up their practicing privileges, and offered an alternative.
- We saw clear information on the clinic's website detailing the expected reporting times for different blood tests. Staff we spoke to were aware of turnaround times and gave this information to patients verbally.
- Nurses and consultants completed charge sheets, which patients took to the receptionist to settle any additional costs and book their next appointment before they left. We saw patients leave the clinic informed about their next steps. For patients who had labiaplasty, administrative staff automatically booked a follow-up consultation 10 days after the scheduled procedure at the time the patient booked their procedure. This allowed patients to plan ahead for their post-surgical care.
- We saw posters displayed in both the female and male toilets signposting people suffering from domestic abuse to support organisations.

Emotional support

- We saw from the labiaplasty records we reviewed that consultants understood the patients' reasons for surgery and emotional impact of treatment. For example, many patients wanted the procedure to improve their confidence. We saw consultants discussed the risks and benefits of treatment to allow patients to make informed choices.
- All 10 patients who participated in the clinic's labiaplasty audit in January 2016 – September 2016 were pleased with the outcome of the procedure. One patient described the emotional impact of treatment as "life changing in terms of my self-confidence". Two patients made specific positive comments relating to emotional support from staff. These were, "staff made me feel at ease when I was nervous" and "the clinic has been fantastic and very supportive throughout".
- We saw further positive comments around emotional support from patients who participated in the 2015 patient satisfaction survey. These included, "excellent and supportive experience….at a difficult time" and "the consultant was very supportive and explained everything thoroughly".
- Sonographers told us they contacted women's midwives or GPs to arrange ongoing emotional support for women and their partners who received bad news during a pregnancy scan. All sonographers at the clinic also worked in the NHS and had experience of breaking bad news.

Are outpatients and diagnostic imaging services responsive?

Requires improvement

We rated responsive as requires improvement.

Service planning and delivery to meet the needs of local people

- The service did not treat any NHS-funded patients. Patients either funded their treatment themselves, or claimed medical insurance.
- The clinic did not have a pathology laboratory on-site. We saw a service-level agreement (SLA) for provision of accredited laboratory services through another local independent hospital. The laboratory sent both electronic and hard copies of results back to the Surrey Park Clinic. The clinic subsequently emailed results to the patient, or discussed them at their follow-up appointment if applicable.
- The SLA stated the laboratory would telephone the clinic to alert them of any clinically significant result. Clinic staff also told us the laboratory did this. The lead nurse was checked laboratory results and followed up on any positive results or anomalies. A HCA or a member of the administrative team covered this role in the lead nurse's absence. This meant staff with no clinical background sometimes took responsibility for checking and sending patient results. Non-clinical staff may not have had appropriate knowledge or experience to identify clinically significant results and arrange appropriate follow up.
- The only type of imaging service the clinic provided in-house was ultrasound. However, the clinic referred patients to another local independent hospital for X-ray imaging services such as bone density scans.

- The clinic was located in a research park and free car parking was available for patients. The clinic was also a short walk from local bus routes.
- The waiting room was clean and had sufficient comfortable seating. There was a hot drinks machine with a selection of teas and coffees, as well as drinking water. There was free wireless internet access, and magazines for patients to read while they waited.

Access and flow

- Patients self-referred to the clinic and most booked their first appointment over the telephone. Patients could usually get appointments quickly and at a time to suit them. The clinic often had same day appointments available for blood tests. The clinic was open on Saturday mornings for patients unable to attend on weekdays.
- We saw that clinics generally ran on time. One clinic ran late on the day of our visit, and we saw that staff kept patients informed about the delay. We saw the consultant apologise to the patient for the delay they experienced.
- We saw the clinic's admission and discharge policy, which outlined clear acceptance criteria for minor procedures such as labiaplasty and intra-uterine device (IUD) insertion for contraception. The policy stated the clinic only accepted adults aged 18 and over for these procedures. However, we saw from patient notes that a 17 year old had one of the procedures listed earlier in 2016. Senior managers advised this was an exceptional case. The clinic had since applied the policy more rigorously and told patients to wait until after their 18th birthday before having any minor procedure at the clinic. We reviewed the clinic's procedure register and saw evidence the clinic had not treated any other young women under the age of 18 for labiaplasty since this case.

Meeting people's individual needs

- The service did not have access to interpreters, either for face-to-face translation or via a language line. Staff gave us two examples of cases where family members translated for a patient who did not speak English. One member of staff said they "hoped [the relative] had explained everything correctly". This meant the clinic might not have had assurance all patients who did not speak English understood, or felt involved in, all aspects of their care. Staff, including members of the senior management team, did not appear to understand that using family members to interpret was not best practice.
- The clinic did not provide dementia awareness training for any of its staff. However, due to the types of services provided, most patients were under the age of 65 and therefore at lower risk of dementia. The patient satisfaction survey 2015, which took a snapshot of patient demographics, showed that 38 out of the 43, or 88.4% of, patients who responded were under 65. Staff told us no patients living with dementia used the service.
- There was lift access to enable wheelchair users to access the clinic. There was also a wheelchair-accessible toilet immediately outside the door into the clinic. The clinic shared this toilet with another organisation, and patients could gain access by asking the receptionist for the key

Learning from complaints and concerns

- We reviewed complaint responses and saw that not all responses fully addressed and apologised for all issues raised. For example, one complaint contained two issues- a delay in test results and the late running of a clinic. We saw that the response acknowledged the delay in results and offered an explanation and financial compensation. However, the response did not apologise, or give an explanation, for the issue of the late-running clinic.
- Clinic data showed the service received 14 patient complaints received in July 2015 - June 2016. We reviewed complaint themes and saw that most complaints related to either finance (five complaints) or information (five complaints).
- An appropriate member of senior staff in the relevant area investigated complaints with oversight from the senior nurse. The senior nurse sent out the final written responses to complaints following agreement with the general manager. The clinic owner also telephoned all patients who felt they did not receive a satisfactory level of service.
- We saw clear information about how to complain displayed in the clinic reception. The clinic's complaints policy stated they aimed to acknowledge all formal written complaints within five days and send a response within 28 days. Clinic data showed that they met this target for 100% of complaints in July 2015 – June 2016.

Requires improvement

Outpatients and diagnostic imaging

- The service actively sought patient feedback through patient satisfaction questionnaires. We saw questionnaires available in the waiting room for patients to complete. We saw some learning from patient satisfaction questionnaires. For example, the patient satisfaction survey 2015 identified that 32% of patients waited longer than 10 minutes for their appointment. Of these, staff only kept 50% informed about delays. One of the learning objectives for 2016 was to ensure staff kept patients informed of any delays. We observed that this happened during our visit.

Are outpatients and diagnostic imaging services well-led?

Inadequate

We rated well-led as inadequate.

Vision and strategy for this this core service

- The clinic did not have a specific written set of values. When we asked staff what they thought the values were, all answers related to providing a high standard of patient care. Answers included, "commitment to first class patient care", "patients come first", and "patient welfare". These responses aligned with the clinic's aims and objectives as part of its statement of purpose, which stated the clinic aimed to "provide the highest quality of care to its patients by being at the forefront of advancements within the field of female health". However, the statement of purpose needed review as it referred to the former registered manager who left this role over a year before our visit.
- Members of the senior management team told us the clinic's short-term strategy was to increase the number of consultants and offer additional services such as testing for breast cancer genetic markers. Long-term, the clinic planned to expand and offer satellite clinics in other locations.

Governance, risk management and quality measurement

- The clinic did not have a formal clinical governance committee. Health care assistants (HCAs) and bank nurses reported to the senior nurse, who was the clinic's governance lead. The pharmacy manager and sonographers also reported to the senior nurse. The senior nurse reported to the general manager, who did not have a clinical background. The general manager reported to the clinic owner, who again had a non-clinical background.
- As there were no formal clinical governance committee meetings, the senior nurse met with the general manager and the clinic manager (who was responsible for the administrative team) to review governance issues. These meetings took place as needed rather than at any given frequency. We asked to see copies of the minutes, and senior staff were unable to provide any, as they did not record minutes of these meetings.
- The clinic did not have a medical advisory committee (MAC). In most independent acute hospitals, an MAC provides a formal organisational structure to promote the safety and high quality of clinical services and ensures that only competent medical practitioners deliver them. Specialist consultants sit on MACs to provide specialist advice and assurance to executive teams.
- As there was no MAC, the clinic owner and general manager, who were both non-clinical staff, took responsibility for the granting and reviewing of practicing privileges. The absence of a consultant or doctor to advise on these processes meant it might have been difficult for the senior management team to assess the competencies and suitability of doctors applying for practicing privileges. When we asked the owner how he obtained assurances around the standards of clinical care, he said, "I trust in the consultants to get it right". However, the clinic told us they planned to establish an MAC by the end of 2016 and were trying to recruit a retired consultant to lead the MAC.
- When we spoke to the senior nurse, she demonstrated awareness of the risks we identified when we asked what was on her "worry list". These included information governance, carpets, and the lack of formal governance structure and MAC. However, the clinic did not have a clinical risk register, only a "health and safety risk assessment register". This meant there was no formal system for the logging and monitoring of risk.
- There was an over reliance on patient satisfaction survey results as a measure of patient outcomes. We found management lacked understanding around patient outcomes. Whenever we asked how the service measured patient outcomes, senior staff all said it did

this through patient satisfaction reports and patient feedback. The service carried out an annual labiaplasty audit, and we saw that this again relied on patient feedback to measure service quality.

- However, the provider subsequently informed that us that at the beginning of 2017, a more formal governance structure was implemented and meeting minutes kept.

Leadership and culture of service

- The clinic changed ownership in 2014. The clinic told us "some staff found the changeover of management difficult as the previous owner was a strong character and is still visible in the clinic". Since then, the clinic recruited a new lead nurse in September 2015. We saw evidence the lead nurse was making progress in several areas, including putting care pathways and policies in place.
- The clinic had been without a registered manager for over one year before our visit. CQC wrote to the general manager advising her of the actions required to become the registered manager. However, we saw the clinic took no action to address this.
- We saw an example of an incident where senior staff failed to apply Duty of Candour (DoC) in line with the requirements of the Health and Social Care Act (Regulated Activities Regulations) 2014. We discussed DoC with a manager, who said it was important to keep patients informed following an incident but also that they should be "careful about what [they] tell [patients] and not tell them too much before the clinic investigates". This demonstrated the culture did not always encourage candour, openness and honesty.
- A member of staff gave us an example of senior managers taking action to address inappropriate behaviour from a consultant. However, several members of staff told us there were still some issues with challenging behaviour from this consultant. This meant inappropriate staff behaviour might not have been fully addressed.
- Despite these issues, staff spoke positively of the culture and said they felt supported by their managers. Staff said leaders were visible and approachable. Staff told us, and we saw for ourselves, that the owner and general manager had an "open door policy" for staff to raise concerns. Staff described the culture as "friendly", "lovely", and "nice".

Public and staff engagement

- We saw the service actively engaged to seek the views of patients through their patient satisfaction surveys and labiaplasty audits. We saw patient satisfaction questionnaires available in the waiting room for patients to complete.
- The clinic held monthly meetings for all staff. These meetings provided an open forum for all staff groups to have their say, and we saw that the meeting minutes reflected this.

Innovation, improvement and sustainability

- We saw the results of patient satisfaction questionnaires, and evidence the clinic made service improvements in response to patient feedback. This included having staff answer the telephones for an additional half hour in the mornings so that patients telephoning early could speak to a person rather than an answering machine. It also set targets for responding to patient contact, such as answering a telephone call within three rings and replying to an email within seven hours.
- The year before our visit, a senior nurse was recruited to provide the business with some clinical independence and expertise in the role of governance lead. The senior nurse introduced patient care pathways for different procedures. We saw copies of these in the patient records we reviewed. This ensured all staff followed the correct processes and kept accurate patient records.
- Senior staff and the clinic owner told us that the owner put extra money into the clinic during the quietest months of the year in July and August. This ensured financial pressures never compromised patient care.
- We were informed by the provider that a new organisation structure had been implemented following our inspection which ensured that clinical input worked alongside business strategy with a clinical presence on the senior management team.

Outstanding practice and areas for improvement

Areas for improvement

Action the provider MUST take to improve

- The provider must take immediate action to obtain registered manager status for an appropriate member of staff.
- The provider must take action to formalise governance arrangements.
- The provider must take action to ensure that clinicians with an appropriate level of specialist knowledge are involved in the granting and reviewing of consultants' practicing privileges.
- The provider must take action to ensure all staff understand and appropriately discharge the duty of candour.
- The hospital must take action to ensure flooring in clinical areas complies with the requirements of Health Building Note 00-09: Infection control in the built environment.

Action the provider SHOULD take to improve

- The provider should take action to measure and benchmark patient outcomes in a way that does not involve an over-reliance on patient satisfaction feedback.
- The provider should ensure that all clinical staff receive an appropriate level of safeguarding training in line with national intercollegiate guidance.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

The table below shows the legal requirements that were not being met. The provider must send CQC a report that says what action they are going to take to meet these requirements.

Regulated activity	Regulation
Diagnostic and screening procedures Surgical procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance **Regulation 17 (1) (2) (a)** **Systems or processes must be established and operated effectively. Such systems or processes must enable the registered person to assess, monitor and improve the quality and safety of the services provided in the carrying on of the regulated activity.** **Regulation 17 (2) (b)** **Systems or processes must enable the registered person to assess, monitor and mitigate the risks relating to the health, safety and welfare of service users and others who may be at risk which arise from the carrying on of the regulated activity.**

Regulated activity	Regulation
Diagnostic and screening procedures Surgical procedures	Regulation 20 HSCA (RA) Regulations 2014 Duty of candour **Regulation 20 (1)** **Registered persons must act in an open and transparent way with relevant persons in relation to care and treatment provided to service users in carrying on a regulated activity.**

Regulated activity	Regulation
Diagnostic and screening procedures Surgical procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment **Regulation 12 (2) (h)**

This section is primarily information for the provider

Requirement notices

The provider must assess the risk of, and prevent, detect and control the spread of infections, including those that are healthcare related.