The Private Clinic - Fitzroy Square

Quality Report

1 Fitzroy Square
London
W1T 5HE
Tel:02077250880
Website: www.theprivateclinic.co.uk

Date of inspection visit: 14 May 2019
Date of publication: 04/07/2019

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	Good
Are services safe?	Good
Are services effective?	Good
Are services caring?	Good
Are services responsive?	Good
Are services well-led?	Good

Overall summary

The Private Clinic - Fitzroy Square is operated by The Private Clinic of Harley Street Limited.

The hospital provides cosmetic surgery for privately funded patients over the age of 18 years of age. Facilities within the hospital include two operating theatres and three overnight patient beds.

We inspected this service using our comprehensive inspection methodology. We carried out the announced part of the inspection on 14 May 2019. We gave the provider 48 hours' notice to ensure that the hospital would be open on the day of our inspection.

To get to the heart of patients' experiences of care and treatment, we ask the same five questions of all services:

Summary of findings

are they safe, effective, caring, responsive to people's needs, and well-led? Where we have a legal duty to do so we rate services' performance against each key question as outstanding, good, requires improvement or inadequate.

Throughout the inspection, we took account of what people told us and how the provider understood and complied with the Mental Capacity Act 2005.

Services we rate

This was the first time we have inspected this service. We rated it as **Good** overall.

We rated the service 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. Staff assessed risks to patients, acted on them and kept good records of care and treatment. They managed medicines well. Staff collected safety information and used it to improve the service. The service generally controlled infection risk well. Staff knew how to report patient safety incidents and could tell us about 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 to carry out their role. 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 care. They provided emotional support to patients and those close to them.
- The service planned care to meet individual patient needs, and made it easy for people to give feedback. People could access the service when they needed it.
- 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. The service engaged well with patients to plan and manage services and all staff were committed to improving services.

However:

- Some of the service's systems and processes for identifying, reporting and reviewing patient safety incidents and risks to the service, were relatively new and not yet fully embedded into practice.

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

Nigel Acheson

Deputy Chief Inspector of Hospitals

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Surgery	Good 	Cosmetic surgery was the main activity of the hospital. We rated this service as good because it was safe, effective, caring, responsive and well-led.

Summary of findings

Contents

Good

The Private Clinic - Fitzroy Square

Services we looked at:
Surgery

Summary of this inspection

Background to The Private Clinic - Fitzroy Square

The Private Clinic - Fitzroy Square is operated by The Private Clinic of Harley Street Limited. The hospital opened in November 2016. It is a private hospital in central London. The hospital provides cosmetic surgery services to self-funded patients from across the UK. The service did not provide services to NHS-funded patients or patients under the age of 18.

The hospital provides a range of surgical cosmetic procedures including liposuction, breast augmentation and gynaecomastia (male breast reduction surgery).

Facilities included two operating theatres and a three-bedded first stage recovery area. The hospital had five patient admissions rooms, three of which could provide overnight accommodation, if required.

The hospital has had a registered manager in post since November 2016. At the time of the inspection, a new registered manager had recently been appointed and was registered with the CQC in October 2018.

The Private Clinic – Fitzroy Square did not provide any outpatient or consultation services at the hospital. Patients were seen for consultation, pre-assessment and follow-up post-procedure, at one of the provider's other CQC-registered locations. As these services did not take place on site at the hospital, we did not inspect these services during this inspection.

Our inspection team

The team that inspected the service comprised a CQC lead inspector, one other CQC inspector, and two specialist advisors with expertise in surgery. The inspection team was overseen by Terri Salt, interim Head of Hospital Inspection.

Information about The Private Clinic - Fitzroy Square

The hospital is registered to provide the following regulated activities:

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

During the inspection, we visited all clinical areas within the hospital, including the theatres, recovery and ward areas. We spoke with 13 staff including registered nurses, health care assistants, reception staff, doctors, operating department practitioners and senior managers. We spoke with three patients and two relatives. During our inspection, we reviewed seven sets of patient records.

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

Activity (March 2018 to February 2019)

- The hospital carried out 1,418 surgical cosmetic procedures (1,348 patients).
- There were 161 inpatient and 1,187 day case episodes of care recorded, all of which were privately funded. The service did not provide NHS funded services.
- The most common surgical procedures carried out were liposuction (597) and breast augmentation (430). Other procedures carried out included gynaecomastia (87), abdominalplasty (73) and mastopexy (70).

Summary of this inspection

There were 21 surgeons, 22 anaesthetists, and three resident medical officers (RMOs) working under practising privileges at the hospital. The service employed 20 registered nurses, two health care assistants and two receptionists, as well as having its own bank staff. The accountable officer for controlled drugs (CDs) was the registered manager.

Track record on safety

- No never events
- Clinical incidents: 22 'no harm', 1 'low' harm, no 'moderate' harm, no 'severe' harm, no deaths
- No serious injuries
- No reported incidences of hospital acquired Methicillin-resistant Staphylococcus aureus (MRSA),
- No reported incidences of hospital acquired Methicillin-sensitive staphylococcus aureus (MSSA)
- No reported incidences of hospital acquired Clostridium difficile (C.Diff)
- No reported incidences of hospital acquired E-Coli
- Six complaints

Services provided at the hospital under service level agreement:

- Pharmacy
- Sterile services
- Pathology
- Private Ambulance Service
- Recycling and Business Waste
- Clinical Waste
- Laundry
- Cleaning

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?

Good

This is the first time we have rated this service.

We rated safe as **Good** because:

- The service provided mandatory training in key skills to all staff and made sure staff completed it.
- Staff understood how to protect patients from abuse and the service worked well with other agencies to do so.
- The service generally controlled infection risk well.
- The design, maintenance and use of facilities, premises and equipment kept people safe.
- Staff completed and updated risk assessments for each patient and removed or minimised risks.
- 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.
- Staff kept detailed records of patients' care and treatment.
- The service used systems and processes to safely prescribe, administer, record and store medicines.
- The service used monitoring results well to improve safety. Staff collected safety information and managers used this to improve the service.

However:

- Although the service generally managed patient safety incidents well, systems and processes for reporting and reviewing incidents were relatively new and not yet fully embedded into practice.

Are services effective?

Good

This is the first time we have rated this service.

We rated effective as **Good** because:

- The service provided care and treatment based on national guidance and evidence of its effectiveness.
- Staff monitored the effectiveness of care and treatment. They used the findings to make improvements and achieved good outcomes for patients.
- Staff gave patients enough food and drink to meet their needs and improve their health.
- Staff assessed and monitored patients regularly to see if they were in pain.
- The service made sure staff were competent for their roles.

Summary of this inspection

- Doctors, nurses and other healthcare professionals worked together as a team to benefit patients.
- Key services were available seven days a week to support timely patient care.
- Staff gave patients practical support and advice to lead healthier lives.
- Staff supported patients to make informed decisions about their care and treatment. They followed national guidance to gain patients' consent.

Are services caring?

Good

This is the first time we have rated this service.

We rated caring as **Good** because:

- Staff treated patients with compassion and kindness, respected their privacy and dignity, and took account of their individual needs.
- Staff involved patients and those close to them in decisions about their care and treatment.
- Staff provided emotional support to patients and those close to them to minimise their distress. They understood patient's personal, cultural and religious needs.

Are services responsive?

Good

This is the first time we have rated this service.

We rated responsive as **Good** because:

- The service planned and provided services in a way that met the needs of the patients it provided services to.
- People could access the service when they needed it. Waiting times from referral to treatment and arrangements to admit, treat and discharge patients were in line with good practice.
- The service was inclusive and took account of patients' individual needs and preferences. Staff made reasonable adjustments to help patients access services. They coordinated care with other services and providers.
- It was easy for people to give feedback and raise concerns about care received. The service treated concerns and complaints seriously, investigated them and shared lessons learned with all staff.

Are services well-led?

Good

Are services well-led?

This is the first time we have rated this service.

We rated well led as **Good** because:

Summary of this inspection

- Managers at all levels had the right skills and abilities to run a service providing high-quality sustainable care.
- The service had a vision for what it wanted to achieve and workable plans to turn it into action, which it developed with input from staff and patients.
- Managers across the service promoted a positive culture that supported and valued staff, creating a sense of common purpose based on shared values.
- The service systematically improved service quality and safeguarded high standards of care by creating an environment for excellent clinical care to flourish.
- The service collected, analysed, managed and used information well to support all its activities, using secure electronic systems with security safeguards.
- The service engaged well with patients and staff to plan, manage and improve services.
- The service was committed to improving services by learning from when things went well or wrong, promoting training, research and innovation.

However:

- Although the service had systems and processes to identify risks, and plans to eliminate or reduce them, systems and processes for reviewing risks were relatively new and not yet fully embedded within the wider governance processes.

Detailed findings from this inspection

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

Are surgery services safe?

Good

This was the first time we have rated this service. We rated safe as **good.**

Mandatory training

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

- All staff were required to complete mandatory training which included: infection prevention and control, safeguarding, information governance, fire safety, basic life support (BLS) and immediate life support (ILS). Staff attended a one-day training course covering all the mandatory training modules and completed supplementary e-learning courses.
- All staff employed by the service, other than the two newly recruited staff, had completed all of their mandatory training.
- Staff compliance with mandatory training was monitored through the provider's central human resources (HR) team, who sent reminders to both the staff member and the hospital manager via email when training was due.
- The provider had sourced a specific sepsis training package for clinical staff, which they planned to include as part of mandatory training to improve awareness and identification of the deteriorating patient. This was in the process of being rolled out, with 73% of staff having completed this at the time of the inspection. The remaining staff were due to complete the training by June 2019.
- Doctors with practising privileges at the hospital were required to provide annual assurance of mandatory training completion, which was monitored by the provider's HR team, with oversight from the medical advisory committee.
- There were arrangements in place for supporting new staff at the hospital, including an induction and supernumerary period during which clinical competencies were assessed. Staff that we spoke to were satisfied with the induction process and how it prepared them for their role.

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**.**

- The service had policies and procedures in place to safeguard children and vulnerable adults at risk of abuse. The hospital's safeguarding adults policy had been updated in February 2018 and included information on female genital mutilation (FGM).
- All staff completed safeguarding adults and children training (levels 1 and 2) as part of their mandatory training.
- Staff we spoke with knew how to escalate safeguarding concerns and demonstrated understanding and awareness of safeguarding issues, including FGM.
- Although the hospital did not treat anyone under the age of 18 years of age, children occasionally visited the hospital with a family member. Whilst children were not allowed on the ward, staff had received the appropriate level of safeguarding children training to ensure they understood relevant safeguarding concerns.

- The hospital's registered manager was also the local safeguarding lead and was trained in level 4 safeguarding. Staff knew who their safeguarding lead was and told us they felt supported to identify and raise concerns.
- Guidance for staff on how to raise a safeguarding concern was visible on the staff noticeboard.
- The hospital had not reported any safeguarding concerns to the CQC in the 12 months prior to the inspection.

Cleanliness, infection control and hygiene

The service generally controlled infection risk well. Staff used equipment and control measures to protect patients, themselves and others from infection. They kept equipment and the premises visibly clean.

- The hospital environment and equipment was visibly clean, and staff followed infection prevention and control (IPC) policies and procedures. Staff used green 'I am clean' labels on equipment to indicate that it had been cleaned and was ready for use.
- Staff had access to appropriate handwashing facilities, hand gel sanitisers and personal protective equipment (PPE), including gloves and aprons. We saw that staff used these appropriately. Sanitising gel was available at the entrance to all clinical areas, including individual patient bed bays and theatres.
- The hospital had a comprehensive local audit schedule planned for 2019, which included IPC audits of sharps, clinical waste and the environment. The most recent audit results showed good compliance the hospital's IPC policies and procedures. Hand hygiene audit results for January and February 2019 showed 100% staff compliance with hand hygiene procedures. Staff were bare below the elbows in clinical areas in line with hospital policy.
- We saw clinical and domestic waste bins were available and clearly marked for appropriate disposal. Staff followed appropriate waste segregation procedures. Disposable curtains around patient beds, were in-date and visibly clean.
- Cleaning staff followed appropriate IPC procedures, including using specially designated colour coded mops to clean different areas. They followed a daily cleaning rota and maintained a record of which areas had been cleaned.
- The service's IPC committee met quarterly to review any issues around infection control, including audit results, surgical site infection (SSI) surveillance, incidents relating to infection control, and was responsible for reviewing IPC policies and guidelines, and responding to newly published guidelines and recommendations. The committee was chaired by a consultant microbiologist who was the service's infection control advisor and IPC lead. Locally, staff were supported by the hospital's IPC link nurse who was responsible for undertaking IPC audits, including the hand hygiene audit and providing feedback to staff.
- The hospital had systems and processes in place to identify and prevent surgical site infections (SSIs). Staff were required to report any cases of suspected SSI to the IPC lead, using a specially designed template. A quarterly audit was carried out to identify any suspected SSIs. Any suspected cases were reviewed and discussed by the IPC committee. The hospital had recorded three surgical site infections over 2,675 procedures performed between October 2017 and May 2019. This was an infection rate of 0.1%, which was better than the service's target of 1.5%.
- The hospital had not reported any cases of hospital-acquired MRSA. MRSA is a bacterium that can be present on the skin and can cause serious infection. The hospital had an MRSA screening policy, and staff screened all patients who satisfied the criteria for MRSA screening prior to admission. Healthcare workers and those patients with a previous history of infection or colonisation with MRSA were screened at the pre-assessment stage.
- The hospital's design and layout meant that staff regularly entered the theatre via the sluice, which was designated as a 'dirty' area, used for temporary storage of clinical waste removed from theatres. This was a potential infection control risk. Staff told us this was to prevent the risk of infection presented by opening the main theatre doors whilst a procedure was underway. Following the inspection, the service's IPC lead carried out a risk assessment of theatre access. They assessed the hospital's existing control measures as being adequate to reduce the risk of infection as long as staff movement between the two areas was kept to a minimum. The IPC lead recommended that going forward, staff must only use the sluice entrance to theatres in exceptional or emergency circumstances.

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.

- There was secure access to the hospital via the ground floor reception. All clinical areas were located on the lower ground floor, accessible by either lift or stairs. As the hospital shared the building with several other services, access to the lower ground floor via the lift was restricted. All patients were taken down in the lift by a member of staff, who accessed the clinical areas using a security code.
- In the event of an emergency, there were fire exits located on the lower ground floor, as well as appropriate access to allow a patient to be transferred on a trolley to an ambulance. Staff told us they had recently tested the hospital's fire evacuation plan.
- Staff carried out safety checks of surgical and anaesthetic equipment, including resuscitation equipment, to ensure they were readily available, safe and fit for purpose. Staff carried out daily safety checks on the anaesthetic machine and recorded these, in line with professional
- The hospital had a difficult intubation trolley with equipment, including a laryngoscope, needed to establish an airway in the event of a patient emergency. However, it did not include a fibreoptic laryngoscope as recommended by The Royal College of Anaethetists (RoCA) Guidelines. Nursing staff told us the anaesthetist had identified this and there were plans to acquire one.
- The hospital outsourced medical device maintenance and servicing to a third-party provider. Documentation showed that an annual service of all equipment had been carried out in May 2018, which included electrical safety testing. Following the inspection, the hospital provided evidence that all equipment had undergone annual service and maintenance checks in May 2019.
- Decontamination and sterilisation of instruments was outsourced to an external provider, under a service level agreement, and managed in a dedicated facility off-site. Staff told us that there were no issues with this arrangement and processes were in line with national guidance, such as the Department of Health Technical Memorandum on decontamination.
- We observed that sharps management complied with Health and Safety (Sharp Instruments in Healthcare) Regulations 2013. The hospital's infection control link nurse carried out regular sharps audits to check that staff were following the correct process for disposal of sharps.
- The hospital had recently introduced a new bunion removal procedure which required the use of X-ray equipment. A mobile C-arm was used by the surgeon to see images of the bones within the patient's foot during the procedure. A mobile C-arm is a medical imaging device that is based on X-ray technology. The hospital had relevant policies and procedures in place, including a radiation protection policy, which incorporated Employer's Procedures for IR(ME)R 2017 and local rules for staff.
- The hospital's head of medical services was the appointed radiation protection supervisor (RPS). Three deputy RPSs had also been appointed. There was an appointed radiation protection advisor (RPA) and two medical physics experts (MPEs). Emergency contact details for both the RPA and MPEs were included within the local rules document. Staff had received training in radiation safety, local rules, use of equipment and PPE.
- The hospital's head of clinical services carried out a quarterly health and safety review to provide assurance that any environmental hazards had been risk assessed and appropriate emergency procedures were in place. The most recent review in March 2019 had not identified any issues other than highlighting that additional checks of radiation safety should be incorporated into the next review.

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 hospital ensured that only patients who could be safely cared for were admitted for surgery. The hospital had a documented patient selection criteria, which included a list of specifically excluded conditions and risk factors, as well as those that required an additional review by either the surgeon or anaesthetist to confirm suitability. For example, patients who were pregnant, had type 1 diabetes or a body mass index (BMI) of over 40 were considered not suitable for surgery.
- All patients underwent a pre-operative assessment to assess their suitability for surgery. This took place at one

of the provider's other clinic locations. A nurse reviewed the patient's general health and medical history and carried out tests to assess whether the patient was fit to have surgery. Patients identified as having additional risk factors, such as a BMI over 35, were also seen by an anaesthetist to check whether it was safe for them to have a general anaesthetic or sedation.

- The American Society of Anaesthesiologists (ASA) physical status classification system is a system for assessing the fitness of patients before surgery, with grade three indicating a patient with severe systemic disease, and grade four indicating a patient with severe systemic disease that is a constant threat to life. The treatment of patients of ASA grade three and above was also not permitted.
- The service undertook emotional and mental health screening as part of pre-operative assessment process to identify psychologically vulnerable patients. This included a review of the patient's psychiatric history and a questionnaire about body image.
- Hospital staff were able access records of the pre-operative risk assessments, which were documented in the patients' medical records and were available on-site on the day of admission. All paper records were then scanned into the hospital's electronic records system to ensure they were accessible to all staff.
- Staff carried out appropriate patient risk assessments and safety checks on admission and procedures would not go ahead if there was a risk to patients' safety. In the 12 months prior to our inspection, 38 patients had their procedure cancelled on the day of surgery. The main reasons included the patient being unwell, having an infection or otherwise being unfit for surgery on the day (for example having high blood pressure). One patient had their procedure cancelled as they did not have a chaperone to escort them home post-procedure.
- The hospital had processes in place to ensure that patients were kept safe during their procedure. The service used the World Health Organisation (WHO) surgical safety checklist for patients throughout the perioperative journey, to prevent or avoid serious patient harm. By following the checklist, health care professionals can minimise the most common and avoidable risks endangering the lives and well-being of surgical patients. This was in line with national recommendations. We observed theatre staff used the WHO surgical safety checklist during procedures and all staff present were engaged appropriately in the process.
- After the procedure, all patients were transferred to the first stage recovery area, where they were monitored closely by recovery staff for up to two hours, before being moved to the second stage recovery area. Staff handovers from ward to theatre and recovery, included all necessary key information to keep patients safe.
- The hospital used the national early warning score (NEWS) to identify deteriorating patients. This is a basic set of observations such as blood pressure, respiratory rate, oxygen saturation, temperature and pulse rate, which are then used to calculate a score indicating the severity of a patient's acute illness. This system helped staff to identify patients who were deteriorating and provide them with increased support.
- Nursing staff we spoke with understood how to escalate patients appropriately and told us that they felt well supported by the consultants and resident medical officer (RMO). Out of hours, the RMO had access to support from an on-call medical team based at the local NHS trust. Most staff had received training in sepsis identification and management and knew where to find the hospital's sepsis policy and action guidance.
- Overnight patient care was provided by a registered nurse, healthcare assistant and RMO. Out-of-hours surgical cover was provided by an on-call team, providing a surgeon, anaesthetist and theatre team. The responsible surgeon and anaesthetist, who had performed the patient's procedure, were required to be available to attend the hospital within 30 minutes of being notified of emergency case.
- A minimum of three theatre staff were rostered on-call seven days a week. The on-call team included a qualified theatre nurse, an operating department assistant (ODP) and one other member of theatre staff. The on-call team were required to be on standby in the event that theatre staff had gone home where the surgeon, anaesthetist or RMO decided that a patient needed to return to theatre for emergency intervention. For example, for the removal of post-operative haematoma (solid swelling of clotted blood).
- The hospital had reported two unplanned returns to theatre in the 12 months prior to our inspection. Both were patients who had developed a haematoma following breast surgery. There had been no unplanned

patient transfers to other hospitals in the same reporting period. In response to an incident where there had been a delay in returning a patient to theatre, the hospital had created a documented emergency plan and carried out emergency scenario training, to ensure all staff knew what to do if a patient needed to return to theatre in an emergency.

- In response to an incident where an anaesthetist had left the hospital prior to the RMO starting their shift, it was agreed that there should always be a doctor available on site with the appropriate recovery experience to manage recovering patients. The medical advisory committee (MAC) had agreed that anaesthetists must remain on-site at the hospital until all patients were in second stage recovery and comfortable. The hospital manager was responsible for ensuring that RMO cover was in place when needed. Staff were able to arrange short notice RMO cover via an agency if required.
- The service had a service level agreement in place with the local NHS trust to ensure they could quickly escalate and transfer out any patient who deteriorated post-operatively and were too unwell to be cared at the hospital. The hospital's patient transfer policy set out the roles and responsibilities of staff in the case of an emergency. The policy stated that staff should contact the intensive care unit outreach registrar at the local NHS trust and provided a direct phone number. The hospital was located less than half a mile from the NHS hospital and therefore patients could be transferred quickly in the event of an emergency.
- The hospital had processes in place to ensure patients were assessed for their risk of developing complications following surgery, including venous thromboembolism (VTE). VTE is a condition in which a blood clot forms most often in the deep veins of the leg, groin or arm (known as deep vein thrombosis) and travels in the circulation, lodging in the lungs (known as pulmonary embolism). It is important that VTE assessments are undertaken prior to surgery so as to reduce the occurrence of an embolism. The hospital had reported one case of pulmonary embolism in the 12 months prior to our inspection. We saw that this incident had been investigated and action had been taken to raise staff and patient awareness of the risks and the preventative measures available.
- Most patients were day cases, which meant they were able to leave the hospital the same day as their procedure. Staff ensured that patients were always supported by a chaperone on discharge. This was discussed with the patient at both the pre-assessment and admission stages to ensure the patient was appropriately supported.
- Patients had access to a 24-hour telephone helpline, which was staffed by a registered nurse. If patients had any concerns following discharge from the hospital, they were encouraged to phone the helpline for advice. The nurse used a risk assessment tool to make decisions about when to escalate concerns to the responsible surgeon. Staff told us that all patients received a follow-up phone call the day after their procedure.

Nursing and support staffing

The service had enough nursing and support 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.

- Staffing levels in theatres complied with Association for Perioperative Practice (AfPP) guidance, which stated that scheduled operating lists required a minimum of two scrub practitioners, one circulating staff member, one registered anaesthetic assistant practitioner and one recovery practitioner per patient. There were two recovery nurses working in the first stage recovery area and one nurse and one health care assistant in the second stage recovery (ward) area.
- We observed the nursing handover of patients between different stages of recovery and found it to be comprehensive and clear, covering all necessary aspects of patient care.
- Managers regularly reviewed and adjusted staffing levels and skill mix, and gave bank and agency staff a full induction. The hospital manager monitored staffing requirements daily and staff rotas were planned six weeks in advance to ensure appropriate cover for theatre lists.
- At the time of our inspection, the hospital employed 20 nursing staff (including the registered manager), two healthcare assistants (HCAs) and two reception staff. Due to a recent expansion of theatre services, and increase in establishment, 50% of staff had worked at the hospital for less than 12 months.

- The hospital had an establishment of 17.55 full-time equivalent (FTE) registered nurses. At the time of our inspection, there was a vacancy of 3 FTE registered nurses.
- The hospital had an establishment of 5.35 FTE HCAs, and a vacancy of 2.35 FTE HCAs.
- Where patients required overnight care, this was usually provided by bank staff who worked at the nearby NHS trust. Staff told us this happened usually once or twice per week on average.
- Data provided by the hospital for the 12 months prior to February 2019 showed that sickness rates were generally very low, and no shifts were unfilled between December 2018 and February 2019. However, during this time the hospital had relied heavily on bank and agency staff to cover these shifts due to permanent staff vacancies. Between December 2018 and February 2019, 54 shifts were covered by agency staff, and 29 shifts by bank staff. However, staff told us that the use of agency staff had significantly reduced in the three months prior to our inspection due to successful recruitment of permanent staff.
- The hospital had recently recruited two additional nurses. The registered manager told us that staffing levels had recently been reviewed by the head of nursing to ensure all theatre lists were staffed as per AfPP recommendations for safe staffing. Recruitment to fill the remaining vacancies was on-going and we were told that funding for this had been agreed by senior management team. The service had recently reviewed staff benefits and pay as part of a reward and retention project in response to staff feedback.

Medical staffing

The service had enough medical staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment.

- There were 21 surgeons, 22 anaesthetists, and three resident medical officers (RMO) working under practising privileges at the hospital.
- The medical advisory committee (MAC) was responsible for approving practising privileges for medical staff. Medical staff with practising privileges had their appraisals and revalidation undertaken by their respective NHS trusts. There was a responsible officer who worked for the provider organisation who completed appraisals for those doctors without a substantive NHS post.
- The provider's central HR department monitored mandatory training, registration and insurance requirements for all doctors on practising privileges. The hospital manager received a monthly report with details of any issues or outstanding areas of compliance.
- Where patients required an overnight stay, we were told that the anaesthetist would stay on site until the RMO arrived to ensure there was always appropriate medical supervision. All RMOs were trained in advanced life support (ALS) and generally worked 6pm to 8am, unless pre-booked to start earlier. Occasionally, the hospital needed to use an RMO from an agency. They had a service level agreement with an established RMO agency service provider, who ensured all agency staff had completed the relevant required training.
- Nursing staff told us they generally felt well supported by the consultants and the RMOs. Out of hours, the RMO had access to support from an on-call medical team based at the local NHS trust.

Records

Staff kept detailed records of patients' care and treatment. Records were clear, up-to-date, stored securely and easily available to all staff providing care.

- Patient records were a combination of paper and electronic records. We reviewed seven sets of patient records and found them to be completed to a high standard.
- Clinic staff used paper-based patient records to record patients' consultation, assessment and operative records, as well as post-operative care and risk assessments. All patients having day surgery at the clinic were required to complete a pre-assessment medical questionnaire. This included questions about any recent surgery, medications, any treatment for any medical conditions and allergies. We saw pre-assessment checks and risk assessments were present in records we reviewed. We saw allergies and results from blood tests were recorded.
- All patients were required to have a face-to-face consultation with the surgeon who would be

completing their operation at least two weeks prior to the procedure. Records of the consultation were kept in the patient's paper file as well as being scanned into the electronic system for future reference.

- Paper patient records were kept in a locked cabinet when not in use and were transferred securely off-site at the end of the day to the provider's head office, where they were then scanned and kept electronically. The notes that were printed had a barcode to enable automated scanning and accurate filing.
- The hospital had a process to ensure that records in respect of cosmetic implants were included in the national breast and cosmetic implant register.details of the surgery, and any implant or injectable used.
- The head of medical services carried out a monthly records audit. They sampled six sets of patient records to review against clinical records standards. Audit results for April 2019 showed that although theatre records were consistently completed to a high standard, some information was missing from the records of the patient's initial consultation. For example, two out the six sets of records were missing some of the patient details, such as date of birth or address, a further two had no evidence of a copy of the consent being provided to the patient and two lacked the patient's signature on the consultation summary. Only one of six included a completed costings sheet with terms and conditions completed. There was also no evidence of what action had been taken to address these specific issues.
- The service had recognised the need to improve the quality of record-keeping and had developed a new audit tool based on the Royal College of Physicians generic medical record keeping standards. The new audit tool included a section for comments and recommendations. The hospital's audit plan showed this was due to be introduced in June 2019.

Medicines

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

- There was a service level agreement (SLA) in place with a local pharmacy for the supply of medicines. Senior staff told us that they liaised with the pharmacist weekly to maintain appropriate stock levels and conducted regular audits of any drugs in stock.
- The head of medical services completed a bi-monthly medicines management audit, which showed 100% compliance against agreed standards in March 2019.
- All drugs that we checked were within date. Controlled Drugs (CDs) were stored in locked cupboards, which a registered nurse held keys for, and were checked twice a day. Two qualified nurses checked drug stocks daily and a spot check of the CD register confirmed levels were correct.
- In response to a patient safety incident, the hospital told us they had removed all 10ml Fentanyl ampules and replaced them with 2ml ampules. This was to reduce the risk of staff error in record-keeping or administration of the correct dose. Fentanyl is a type of pain medication used during anaesthesia and is classified as a controlled drug.
- Medication fridge temperatures were monitored by staff, although ambient room temperatures where medicines were kept in a locked cupboard were not. Although there was sufficient ventilation to keep the storage area cool on the day of the inspection, staff had not carried out any specific checks to ensure medication kept in cupboards were stored at a safe temperature as recommended by manufacturers.
- Staff carried out both daily and weekly checks on the contents of the resuscitation trolley and hypoglycaemia recovery box. Medicines were in date and stored appropriately. Staff were able to describe safe disposal of medicines.
- In theatres, we observed medicines were safely stored and administered by staff. Staff stored intravenous (IV) fluids appropriately in accordance with manufacturer recommendations.
- Staff in theatres were aware that it was unacceptable to prepare substances for injection in advance of their immediate use, or to administer medication drawn into a syringe by another practitioner when not in their presence. This was in line with hospital policy. There were no drugs drawn up in advance during the list we observed.
- Medication administration records had patient allergies recorded. We saw in practice that a patient was wearing a red allergy band.
- The hospital had recently introduced a new antibiotic policy and developed an audit tool for antimicrobial prescribing, to assist in promoting standardisation of prescribing between surgeons. Microbiology advice was available from the service's IPC committee who was

chaired by the consultant microbiologist and IPC lead for the service. Audit outcomes and any issues around individual surgeon's practises were discussed at the medical advisory committee (MAC).
- The service's medication management policy had recently been updated and approved by the medication management committee, to ensure it met with professional standards for medicine management.

Incidents

Although the service generally managed patient safety incidents well, systems and processes for reporting and reviewing incidents were relatively new and not yet fully embedded into practice.

- Whilst staff were aware of their responsibilities to report incidents and knew about learning in response to incidents, there was further work to be done to embed a sustained culture of reporting and learning from incidents and near misses.
- Senior staff recognised that incident reporting was not yet fully embedded and the service was still developing a culture of reporting, and learning from, near misses. Whilst the hospital's electronic incident reporting system had been place for over 12 months, staff had recently raised concerns that they did not feel confident using the system. The service had responded by providing additional training and support to staff. Managers told us they were working with staff to help develop a wider understanding of the importance of incident reporting. Staff told us managers actively encouraged them to report incidents.
- Staff we spoke with knew how to report an incident and were aware of recent incidents and learning from these. We were told of an incident where a patient developed a blood clot after they were discharged. The service investigated the incident and learning was shared with staff. Staff showed us what had changed in the discharge documentation given to patients as a result of this incident. For example, there was now an information page on venous thromboembolism (VTE), or blood clots, given to all post-surgical patients on discharge. As a result of the incident we were told staff now measured all patients for compression stockings at the pre-assessment stage. This was used a prompt to remind staff to discuss VTE prevention measures with patients.
- There were no never events reported by the hospital since it opened in November 2016. A never event is a serious incident that is wholly preventable as guidance, or safety recommendations providing strong systemic protective barriers, are available at a national level, and should have been implemented by all providers. Each never event type has the potential to cause serious patient harm or death but neither need have happened for an incident to be a never event.
- The hospital had recorded 26 incidents between January and December 2018. Of these incidents, three were related to non-clinical issues. All were recorded as either 'no harm' or 'low' harm incidents. Data provided by the hospital following the inspection showed there were 17 incidents reported between April 2018 and January 2019. All were recorded as 'no harm'. This included a patient who experienced a delay in returning to theatre for removal of a haematoma which had been investigated using a root cause analysis framework to identify contributory factors and areas for improvement. The hospital's incident policy stated that only incidents graded moderate or above required investigated so it was therefore unclear whether all incidents had been correctly graded as 'no harm'.
- Data provided by the hospital after the inspection for January to May 2019, recorded 16 incidents, this demonstrated a small, but positive, increase in incident reporting.
- The provider had a system in place to ensure lessons were learned from incidents and improvements were made as a result. All incident reports were reviewed by senior staff and were subject to a risk-appropriate level of investigation. The service undertook root cause analysis investigations for any incidents graded moderate or above. There were no serious incidents reported by the service in the 18 months prior to our inspection.
- We reviewed three root cause analysis reports and found the quality of documentation and timeliness of the investigation to be variable. Although incident investigation reports identified root causes, highlighted contributory factors and made recommendations for improvement, they lacked a specific focus on learning. There was minimal information provided about the outcome of investigations and the specifics of any learning to be shared with staff. Whilst action plans to implement recommendations had been developed,

these were limited in scope and did not fully document the improvements staff told us had been put in place. This meant the service may have missed opportunities for further learning.

- Whilst senior staff discussed and reviewed individual patient safety incidents and relevant learning points at various governance meetings, there was limited evidence of analysis of incident trends to identify themes. This meant the service may have missed opportunities to identify and mitigate risks to patient safety.
- The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain 'notifiable safety incidents' and provide reasonable support to that person. This means providers must be open and honest with service users and other 'relevant persons' (people acting lawfully on behalf of service users) when things go wrong with care and treatment, giving them reasonable support, truthful information and a written apology.
- The provider told us there were no incidents during the reporting time that met the threshold for duty of candour, however they provided an example of where staff had apologised in person to a patient following a complaint about their care. Staff that we spoke with were aware of and could explain what duty of candour meant and their role in it. When things went wrong, staff apologised and gave patients honest information and suitable support.
- Although the service aimed to have an open and transparent culture, we found that incident investigation reports did not always demonstrate how duty of candour or 'being open' had been considered. We were not assured that the service was always fully open with patients when care or treatment could have been better.

Safety Thermometer

The service used monitoring results well to improve safety. Staff collected safety information and managers used this to improve the service.

- The NHS safety thermometer is an improvement tool to measure patient harms and harm-free care. It provides a monthly snapshot audit of the prevalence of avoidable harms in relation to new pressure ulcers, patient falls, venous thromboembolism (VTE) and catheter associated urinary tract infections. The hospital was not required to use the safety thermometer as it was a private healthcare provider. However, the hospital collected this information as part of their quality and safety performance monitoring and review process.
- Between March 2018 and February 2019, the hospital reported no falls, no pressure ulcers and no cases of catheter associated urinary tract infections. There was one reported case of venous thromboembolism (VTE), which had been investigated and had resulted in improvements in the service.
- Patient safety information was regularly reviewed at the provider's clinical governance and medical advisory committee meetings.
- Although the hospital did not actively share or display this information with patients and visitors, they did share feedback with staff via team meetings.

Are surgery services effective?

Good

This was the first time we have rated this service. We rated effective as **good.**

Evidence-based care and treatment

The service provided care and treatment based on national guidance and evidence of its effectiveness. Managers checked to make sure staff followed guidance.

- The hospital used evidence-based care pathways with clinical guidelines from established and recognised professional bodies. Staff had access to policies and care pathways guidance electronically. We saw that staff knew where to access policies and procedures.
- Policies we sampled included appropriate references to relevant national guidance, for example National Institute for Health and Care Excellence (NICE) and Association of Anaesthetists of Great Britain & Ireland (AAGBI) guidelines.
- The medical advisory committee (MAC) and patient safety committee reviewed and ratified all new policies, procedures and products to ensure they met with best practice recommendations and clinical guidelines. Updates in policies and procedures were shared with staff to ensure they were understood and followed.

- The hospital had processes in place to check that staff were following policies and guidelines. The hospital's audit programme had recently been reviewed and updated to audit clinical effectiveness, in line with professional standards and Association for Perioperative Practice (AfPP) guidance.
- The hospital was working towards full compliance with the National Safety Standards for Invasive Procedures (NatSSIPs) and had recently developed Local Safety Standards for Invasive Procedures (LocSSIPs) and introduced these into practice. This included posters reminding staff to 'stop before you block' to encourage staff to pause and double check the location of the procedure.

Nutrition and hydration

Staff gave patients enough food and drink to meet their needs and improve their health. Staff followed national guidelines to make sure patients fasting before surgery were not without food for long periods.

- Staff followed best practice guidance on fasting prior to surgery. Records showed checks were made to ensure patients had adhered to fasting times before surgery went ahead.
- Patients told us they were given advice about fasting, and how to prepare for surgery at the pre-assessment stage. They were then reminded again of fasting instructions by way of phone call or email around a week before surgery, and then again by a text message the evening before. Patients said they found these reminders helpful.
- Patients who experienced nausea or vomiting were prescribed anti-sickness drugs if required and saw that nurses regularly checked that patients did not feel sick.
- Patients were encouraged to have a drink of water two hours before arriving at the hospital for their procedure and were offered fluids as soon as they had recovered following surgery. Staff recorded hydration levels and fluid intake in patients' recovery notes.
- Patients' dietary preferences were documented at the pre-assessment appointment and recorded in patient notes. Menu options sent to overnight patients in advance so that they could pre-select their meals.

Pain relief

Staff assessed and monitored patients regularly to see if they were in pain. Staff responded quickly when patients were in pain and gave additional pain relief when needed.

- Patients told us that staff managed their pain well and that they received pain medication when they needed it. Recovery staff monitored and recorded patients' pain levels and gave additional pain relief to ease pain if required.
- Staff told us that all patients received a follow-up phone call the day after their procedure. During this phone call, patients were asked about their pain levels and for feedback on how well their pain was managed whilst in hospital.
- Patients had access to a 24-hour telephone helpline which was staffed by a registered nurse. If patients had any concerns about pain or other queries about other issues such as swelling, bruising or medication, following discharge from the hospital, they were encouraged to phone the helpline for advice. Staff on the helpline used a risk assessment tool to review the patient's symptoms and escalate appropriately.
- Staff measured patients' pain on a scale of one to five with one being no pain and five being unbearable and uncontrollable pain. Staff contacted the patient's surgeon for immediate review if patients reported pain levels above three.
- The results of the hospital's most recent pain audit (based on 46 patients) showed that of the 40% of patients who reported experiencing pain, 100% said that staff had made them aware of post-operative and staff did everything they could to manage patient pain.

Patient outcomes

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

- The hospital monitored patient outcomes in several ways, including participation in national audit programmes. All patients were asked to complete a patient reported experience measures (PREMS) form on discharge, to assess their experience of care during their stay at the hospital. PREMs results were reported by

individual consultant, and then reviewed by senior staff at both the clinical governance and patient safety committees to identify themes and areas for improvement.

- In line with the Royal College of Surgeons recommendations, the hospital had recently begun collecting and submitting data in relation to quality patient reported outcome measures (Q-PROMS). Collecting Q-PROMS involves asking patients to complete a standard set of questions to assess their health status before surgery, and again six months after surgery. This allows for a patient's own measurement of their health and health-related quality of life, and how this has been changed by having surgery. The data gathered from the use of Q-PROMs can be used in a variety of ways to empower patients, inform decision making and, where relevant, support quality improvement. As the service had only recently started submitting data, full results were not yet available; however the four responses that had been received showed patients were positive about their treatment and outcomes.
- Consultants asked patients for their consent to take photographers before and after surgery to provide a recorded of the outcome of their procedure. The hospital's website had a large range of 'before' and 'after' photographs, as well as a wide range of information on procedures, their risks and benefits and any alternatives available.
- The hospital complied with the Competition and Markets Authority (CMA) legal requirement to submit private patient episode data to the Private Healthcare Information Network (PHIN).
- The service recorded all post-operative complications, including suspected surgical site infections (SSIs), instances of delayed healing, complaints and revisions, on a central dashboard, which was used to monitor and review the performance of individual consultants. Data provided for October 2017 to December 2018 recorded a revision rate of 3.81% (against a target of 6%) and a patient complaint rate of 0.43% (against a target of 3%).
- The hospital had recorded three surgical site infections over 2,675 procedures performed between October 2017 and May 2019. This was an infection rate of 0.1%, which was better than the service's target of 1.5%.
- All patients having breast implants were given a copy of the breast and implant register document in their notes. These were then completed in theatre and brought to the manager's office following completion and added to the register.
- The hospital's audit programme had recently been updated to reflect the hospital's participation in the AfPP national audit programme based on the standards and recommendations for safe perioperative practice. A range of audits to assess clinical effectiveness were planned for 2019, including a review of swab count practices, fluid management and medicines management.

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 monitor the effectiveness of the service.

- Staff said they had access to opportunities for development, were supported by managers and felt competent to carry out their roles. New staff had an induction to the hospital and were supported to complete relevant training and competency assessments.
- The head of medical services told us that a full training needs analysis had recently been undertaken with funding approved for additional staff development. The hospital had a proactive approach to supporting staff development and had committed to AfPP membership for registered and non- registered clinical staff, to promote the delivery of safe, high-quality and effective patient care.
- There were 21 surgeons, 22 anaesthetists, and three resident medical officers (RMO) working under practising privileges at the hospital. The granting of practising privileges is an established process whereby a medical practitioner is granted permission to work within an independent hospital. Senior staff told us that they ensured professional registration, fitness to practice, and validation of qualification checks were undertaken for all staff working under practising privileges. Data provided by the service showed that all doctors with practising privileges at the hospital had in-date indemnity insurance at the time of the inspection.

- The medical advisory committee (MAC) was responsible for approving practising privileges for medical staff. Doctors applying for practising privileges at the hospital were required to provide an evidence log documenting the number and type of procedures performed. The medical director reviewed this information alongside other information including references and signed an approval document to confirm they were happy to grant practising privileges. The approval process included a scope of practice document which listed the procedures the doctor was competent to perform.
- The company's electronic patient management system was pre-populated with the agreed and signed off procedures for each doctor, which could not be overridden. Therefore, it was not possible for a surgeon to book a patient for a procedure unless they had previously been signed off as approved to perform this operation. All appropriate staff had access to the records of each doctor's scope of practice on the electronic patient management system.
- The medical director confirmed that all surgeons had attained the minimum number of credits required to demonstrate competence, as set out in the Royal College of Surgeons certification scheme, for the procedures they were approved to undertake.
- Most medical staff with practising privileges had their appraisals and revalidation undertaken by their respective NHS trusts. There was a responsible officer who worked for the provider organisation who completed appraisals for those doctors without a substantive NHS post. Data provided by the service showed that 78% of doctors with practising privileges at the hospital had an in-date appraisal at the time of the inspection.
- All staff who had been employed by the hospital for 12 months or more had received an appraisal.

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 told us that they enjoyed working with their colleagues and were complimentary about the support they received from one another. We observed good working relationships between all grades of staff and all professional disciplines.
- The clinic asked every patient for their consent to share post-operative information with their GP. This was to ensure the GP was aware of the procedure and post-operative treatment recommended.
- The medical director was in the process of reviewing speciality representation at the medical advisory committee (MAC) to improve team-working and consistency of practice between clinicians.

Seven-day services

Key services were available seven days a week to support timely patient care.

- The hospital was open six days a week. Theatre lists ran on Saturdays to offer more choice to patients. An on-call system operated for 24 hours after each operating list, which meant the same team would return in the case of emergency.
- Patients were able to contact staff for support at any time. They were given a telephone number to call following their procedure, which was staffed by a nurse 24 hours a day, seven days a week.

Health promotion

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

- Patients were provided with materials they could read that outlined their procedure at their pre-assessment appointment. On discharge, patients were provided with further information on how to look after themselves post-surgery.
- Patients told us they felt well-informed by staff about their care, from consultation to follow-up. Patients were knowledgeable about how to look after themselves after their procedure. They told us their discharge planning started early. They understood the importance of the venous thromboembolism (VTE) risk assessment, prevention and plans for VTE prevention when they were discharged home.

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 to gain patients' consent.

- The hospital had systems and processes to ensure staff gained informed consent from patients before carrying out procedures and treatments.
- Professional standards for cosmetic surgery state that surgeons who perform cosmetic surgery should ensure that consent is obtained in a two-stage process, with a cooling-off period of at least two weeks between the stages to allow the patient to reflect on the decision. All records we checked had evidence of the two-week cooling off period.
- We reviewed seven sets of notes with completed consent forms for surgical procedures. We saw consent records were legibly completed by the consultant undertaking the procedure and outlined risks and benefits, with evidence of these having been discussed with the patient.
- We saw that consent forms were signed again on the day of surgery, with patients given adequate time to consider their surgery between the consultation and the intended procedure date. Patients we spoke with told us they were given time to ask questions and felt fully informed about their procedures.
- The hospital followed best practice guidelines by carrying out a separate consent process for anaesthesia. This ensured the patient was fully aware of the risks of undergoing anaesthesia or sedation and had an opportunity to ask their anaesthetist questions.
- The hospital did not routinely accept patients for admission that were deemed to lack capacity regarding treatment decisions. Staff gave clear explanations about their responsibility in ensuring patients understood the treatment they had consented for and described the process they would follow if they had concerns.
- Staff received training on Mental Capacity Act 2005 (MCA) as part of their mandatory safeguarding training. The hospital's consent policy covered MCA and included a decision-making pathway document for staff to reference if required.

Are surgery services caring?

Good

This was the first time we have rated this service. We rated caring 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 proactive in maintaining patient's privacy and dignity. Staff were mindful when speaking to or about patients; for example, they did not talk about patient details in public areas or speak too loudly in patient rooms. Staff made sure patients were covered by blankets or sheets when being transported and made sure doors were closed, especially during intimate examinations. Nursing staff were trained as chaperones and were used regularly to support patients during intimate examinations and when photographs were taken.
- Patients said that staff always maintained their dignity and privacy. One patient told us the consultant asked their family member to leave before they took pre-surgery photos. The patient told us they felt their privacy had been considered and respected.
- Staff looked after patients in a kind and compassionate manner. Staff introduced themselves, explained their role and communicated in a clear manner. This ensured that patients understood what was happening and felt able to ask questions.
- Patients we spoke with said staff were "kind", "wonderful", and "excellent". Patients were very positive about all staff, from cleaners to nurses and consultants. One patient told us that all staff members they had met were "attentive and caring".
- All patients received an automated text message after they had left the hospital asking how likely they would be to recommend the service to family and friends. The hospital's friends and family (FFT) score was consistently positive, with 100% of patients recommending care between April 2018 and March 2019. The average FFT response rate was 24%. The hospital's patient response rate had improved over the previous 12 months and further work was on-going to encourage patients to provide feedback.
- In addition to the FFT, all patients were asked to complete a patient reported experience measures (PREMS) form on discharge, to assess their experience of care during their stay at the hospital. The hospital received 92 completed feedback forms in the six months prior to our inspection; this reflected an 18% response

rate. Responses to all questions were consistently positive. For example, of those that responded, 100% of patients said they felt treated with respect and dignity by staff.

Emotional support

Staff provided emotional support to patients and those close to them to minimise their distress. They understood patient's personal, cultural and religious needs.

- Staff told us that most patients came to the hospital excited about having their procedure. They recognised that many patients were also anxious about having surgery and they made sure patients always had enough time to ask questions. Patients told us they felt supported and reassured by staff and had an opportunity to discuss any worries or concerns.
- The service undertook emotional and mental health screening as part of pre-operative assessment process to identify psychologically vulnerable patients. This included a review of the patient's psychiatric history and a questionnaire about body image. Patients told us they appreciated the pre-operative assessment screening was a necessary part of the process to having the surgery, and that they felt well-supported emotionally by staff.
- The hospital had a service level agreement with a third-party counselling service, which allowed them to refer patients who were identified as requiring psychological support.
- Each patient was assigned a patient coordinator and given their phone number. This meant that patients could call if they had any questions and they required more support and information.
- Patients had their physical and psychological needs regularly assessed and addressed, including nutrition, hydration, pain relief, personal hygiene and anxiety. Staff told us how they spent time addressing patients' physical and psychological needs and we saw this in practice. For example, all patients we spoke with told us how their pain was addressed quickly, personal hygiene was attended to, hydration needs were met, and staff anticipated patient needs by bringing items to patients before asked. Staff were mindful of the different needs patients may have.

Understanding and involvement of patients and those close to them

Staff involved patients and those close to them in decisions about their care and treatment.

- Patients told us they were well-informed about their surgical procedures. Consultations and pre-operative assessment happened at one of the provider's other clinic locations sites. Patients told us they were given a lot of information about the procedure, including potential risks and complications and as well as alternatives available.
- Communication between staff and patients was good. Patients told us they felt well-informed each step of the way and were given enough time to ask questions. Staff ensured patients understood the importance of realistic expectations about their surgery and talked to patients about potential side-effects and complications.
- A patient we spoke with told us how they initially attended a free consultation at the service. During the consultation they were given a lot of different options and were able to ask questions about each option. Following consultation, patients are given a patient coordinator who could help to book appointments, answer questions and help with any other scheduling issues.
- As the service provided only cosmetic surgery, all patients were private and self-funding. Patients told us all discussions around cost and payment were dealt with sensitively by staff. For many of the service's surgical procedures, there was a flat rate fee. This information was available of the hospital's website, along with a comprehensive range of other information. A discussion around costs took place at the patient's initial consultation and was documented in their records. Patients told us they appreciated the transparency of information relating to cost.
- One patient told us their surgery was to be done in two parts. The consultant explained to them that the first surgery may give the patient the desired results, and insisted they wait to book the second surgery until they had seen results from the first surgery. The patient said this made them feel involved in their care and they appreciated they weren't pressured into a second surgery that they may not have needed.
- Patients were required to have a friend or family member to act as a chaperone to help the patient home after discharge. All family members we spoke with felt well-involved and told us that discharge instructions were clear and well-explained.

Good

Surgery

- Staff told us that all patients received a follow-up phone call the day after their procedure. This included a series of questions to assess the patient's experience of care and gain feedback on several areas including pain management, confidence in staff, discharge planning and how well patients felt supported throughout the process. The hospital manager told us that this feedback was shared with staff and used to improve the service provided to patients.

Are surgery services responsive?

Good

This was the first time we have rated this service. We rated responsive as **good.**

Service delivery to meet the needs of patients

The service planned and provided services in a way that met the needs of the patients it provided services to.

- The service offered a wide choice of procedures and choice of consultants, to best meet patient needs. Each patient was assigned a patient coordinator who helped with booking appointments, scheduling and facilitating any questions to consultants. This ensured that patients had access to a flexible service with a good amount of choice and continuity of care.
- The service's clinical areas were purpose-built and appropriate for the services being delivered. There was secure lift access from the reception area to the clinical areas.

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. They coordinated care with other services and providers.

- Staff worked hard to make the patient's experience as pleasant as possible. Staff recognised and responded to the holistic needs of their patients, from the initial referral before admission, to checks on their wellbeing after they were discharged from the hospital.
- Patient coordinators were allocated to each patient to ensure they had a dedicated point of contact throughout their patient journey.
- Patients had access to a 24-hour telephone helpline, which was staffed by a registered nurse. If patients had any concerns following discharge from the hospital, they were encouraged to phone the helpline for advice.
- The service had a system to remind patients of their surgeries and fasting instructions prior to surgery. Patients told us they found this system very helpful. They received a reminder email several days before their surgery and a text message the day before.
- A menu offering a wide choice of meals was provided to patients in advance of their stay, so they could select options which met their dietary requirements.
- The service offered translation services for patients where English was not their first language. They also provided a loop system to patients who were hard of hearing.
- The hospital was wheelchair accessible. Staff took patients down to the clinical areas on the lower-ground floor in the lift.
- Chaperones were available for patients who requested one during their stay.
- The service had a wide range of information available on their website for patients to access. This included a wide range of 'frequently asked questions' for each procedure offered, a detailed profile of each surgeon, patient reviews and 'before and after' photos. Patients told us the hospital's website was very informative and the online system was easy to use.
- Patients attending for a consultation were given a copy of information leaflets and procedure guides for the services they were interested in. Patients could also request a range of brochures via the website. These were available in other languages if required.

Access and flow

People could access the service when they needed it. Waiting times from referral to treatment and arrangements to admit, treat and discharge patients were in line with good practice.

- Patients self-referred to the service by phoning the service's customer contact centre, or emailing to enquire about treatment. A new surgery booking system

had recently been introduced to streamline the process and improve patient experience. Patients told us that accessing the service was easy and staff were responsive to their needs.

- The service did not audit patient waiting times for surgery. This was because all procedures were elective, and patients were able to choose their preferred dates. One patient told us they requested a specific day for surgery because of childcare needs and the service was able to accommodate this.
- Staff contacted patients 24 hours prior to their procedure, usually via text and phone call, to remind them of how to prepare for surgery. This included fasting arrangements and the requirement to have a chaperone accompany them to escort them home.
- Patients were asked to arrive at the hospital a minimum of one hour before their procedure. Procedure start times were staggered to minimise patient wait times on the day of surgery. Staff managed patients' expectations with regular updates on approximate wait times.
- In the 12 months prior to our inspection, 38 patients had their procedure cancelled on the day of surgery. The main reasons for cancellation included the patient being unwell, having an infection or otherwise being unfit for surgery on the day (for example having high blood pressure). One patient had their procedure cancelled as they did not have a chaperone to escort them home post-procedure. Only five cancellations were due to the surgeon being unavailable, three of which were due to the theatre list overrunning.
- The head of medical services held a weekly meeting to review theatre use, to ensure surgeons used theatre time productively and to minimise any delays to patients.
- Patients had access to their assigned patient coordinator before, during, and after their procedures. The hospital did not hold post-operative follow-up appointments. Instead, patients were seen at their local clinic, where they would see a nurse for a follow-up appointment within five to ten days of their procedure. A follow-up with the consultant surgeon took place four to six weeks later.

Learning from complaints and concerns

It was easy for people to give feedback and raise concerns about care received. The service treated concerns and complaints seriously, investigated them and shared lessons learned with all staff.

- The hospital received six complaints between March 2018 and February 2019. The service acknowledged all complaints within five working days and provide a full response within 20 working days.
- Whilst the hospital had received a low number of patient complaints, themes included poor communication and management of patient expectations. Staff also told us that waiting times on the day of the procedure had previously been an issue, but this had been addressed by staggering patient admission times.
- The hospital provided written responses to all formal complaints. Responses we reviewed showed that staff took concerns seriously and offered patients a sincere apology. Complaints responses included letting the patient know what action had been taken to improve services. For example, a new booking system had been introduced to make it easier for patients to book appointments.
- The head of medical services was responsible for overseeing the management of complaints in accordance with The Private Clinic complaints policy. Initially, staff would attempt to resolve all concerns raised by a patient while using the service. All formal complaints were made in writing to the head of medical services, or the most senior manager available on site.
- Complaints were recorded on the electronic incident reporting system and were a standard agenda item for discussion at the monthly hospital meeting, medical advisory committee (MAC), patient safety meeting and the clinical governance meetings. If the complaint was related to another hospital committee, such as IPC or health and safety, they would also be discussed there.
- The Private Clinic were members of the Independent Sectors Complaints Adjudication Service (ISCAS) and the Centre for Effective Dispute Resolution (CEDR). This meant that if a patient was not happy with the response to their complaint from the service provider, there was an external and independent service to further assist and support complainants.

Are surgery services well-led?

Good

This was the first time we have rated this service. We rated well-led as **good.**

Good

Surgery

Leadership

Managers at all levels had the right skills and abilities to run a service providing high-quality sustainable care.

- The hospital was managed locally by the head of medical services, who was also the location's registered manager. The head of medical services was a registered nurse and experienced theatre manager, with a background in NHS services. They were supported in their role by the provider's senior management team, which included the medical director and head of nursing.
- The head of medical services had received appropriate training for their role, including additional safeguarding training and training to help them understand the human factors that underpin the delivery of safe patient care. They attended a range of governance committee meetings including patient safety, medical advisory and infection control. They also attended a quarterly clinic managers' meeting with the head of nursing to ensure important messages from the provider's quality and governance meeting were shared and any local issues were escalated.
- Staff said they felt well-supported and felt confident in raising concerns. They were positive about the leadership of the service and told us their manager was approachable and visible within the hospital. Feedback from the latest staff survey supported this, with 100% of staff satisfied with support from their line manager and 90% of staff agreeing that their line manager took a positive interest in their health and well-being.
- Senior staff had responded positively to feedback raised via the staff survey and had acted to address staff concerns. They recognised that there was more work to do around improving communication, and improving the visibility of senior staff, within the organisation.

Vision and strategy

The service had a vision for what it wanted to achieve and workable plans to turn it into action, which it developed with input from staff and patients.

- The Private Clinic's mission statement was, 'to offer the safest, most effective cosmetic treatments, and to achieve the best possible results for our patients.' The organisation's ultimate goal was patient satisfaction and they strived to achieve this by, 'providing a service of consistently good quality, in line with both professional and ethical standards and national guidelines.'
- The service aimed to deliver this mission statement through five key aims, which were: providing the best medical expertise, delivering outstanding care, achieving patient satisfaction and excellent customer service and being committed to providing honest advice. The organisation's aims and values were shared on their website and within their patient information guides.
- Senior leaders told us that managing patient expectations and providing honest feedback was integral to the organisation's aim of being an ethical cosmetic service provider. The service's commitment to clear communication and honest and responsible advertising was demonstrated by the quality and range of information available to patients within procedure guides and on their website.
- The service aimed to be the best independent provider of cosmetic surgery procedures in London and aspired to be at the forefront of developing cosmetic and plastic surgery within the private sector. The medical director told us that they planned to achieve this by ensuring that the service only employed surgeons and anaesthetists who could demonstrate the highest standards of expertise. To achieve this they planned a review of all clinicians with practising privileges to reduce the number of surgeons and anaesthetists to only those who practised the most frequently.
- The hospital had long-term plans to improve services through the introduction of new and innovative techniques. For example, the hospital had recently introduced a new, less invasive, bunion removal procedure, which allowed quicker recovery for patients.

Culture

Managers across the service promoted a positive culture that supported and valued staff, creating a sense of common purpose based on shared values.

- Staff felt supported, respected and valued by their colleagues and managers, and were proud to work at the hospital. They told us there was an open culture, which was centred on the needs and experience of people who used the service.

- Staff we met were welcoming, friendly and helpful. It was evident that staff cared about patients and their colleagues, as well as the quality and safety of services they provided.
- Staff were actively involved in developing good safety practice and were encouraged to identify better and safer ways of working. The hospital's head of medical service held team meetings which provided staff with an opportunity to reflect, provide feedback and share learning. We saw examples of where staff had helped identify risks on the hospital's risk register and been involved in improving practice, for example around swab count technique.
- Senior staff had responded positively to staff survey results and had acted to address staff concerns. Staff said there had been a recent increase in focus on staff development and they were aware of learning opportunities available.
- Senior staff told us the hospital had a strong culture of challenging behaviours and practices to continue to improve patient experience and outcomes. Doctors who failed to meet standards expected by the service had their practising privileges suspended or removed. The head of medical services told us that the new medical director was writing to all surgeons and anaesthetists to remind them of expectations around behaviours.
- Staff told us that they felt confident to raise any concerns with their line managers. There was an up-to-date policy on raising concerns, which outlined how to escalate any issues. Senior staff told us that any errors were discussed openly and managed in a fair way, with an emphasis on learning, in order improve systems and processes that promoted safe care. The service planned to introduce a 'speak up' guardian, whose role would be to help staff to speak up about any issues in order to protect patient safety and improve the quality of care.

Governance

The service systematically improved service quality and safeguarded high standards of care by creating an environment for excellent clinical care to flourish.

- The service had effective structures, processes and systems of accountability to support the delivery of the organisational strategy and good quality, sustainable services. Staff at all levels were clear about their roles and responsibilities and understood what they were accountable for.
- Responsibility for the hospital's governance sat within the wider organisational governance structure. This included a range of clinical committees, each with defined roles and responsibilities. These included a clinical outcome and patient safety committee, a skills, knowledge and competence committee, a risk and health and safety committee, an infection control committee and a medication management committee.
- Governance committees were held quarterly and were responsible for receiving information from the hospital and other clinic locations, and reporting up to the clinical governance committee, which, in turn, reported to the senior management team via the main board and the medical advisory committee (MAC).
- The recent appointment of a new head of nursing and new medical director had coincided with a review of the organisation's governance structure and audit processes. The service had recently refreshed its governance structure and had developed an updated clinical governance framework. The framework clearly set out the duties of the organisation's governance committees in maintaining and improving quality, lines of reporting, accountability and reporting frequency.
- The hospital's audit programme had recently been updated to reflect the hospital's participation in the (AfPP) national audit programme based on the standards and recommendations for safe perioperative practice. A range of audits to assess clinical effectiveness were planned for 2019. Audit results, along with patient outcome data, complaints and incidents were discussed and reviewed at the relevant committees, including the MAC.
- Other recent governance changes included the re-introduction of the clinical outcome and patient safety committee and a review of the format and terms of reference (TOR) of the MAC. The recently appointed medical director was also the new MAC chair. He was in the process of refreshing and updating the TOR for the group, with the aim of improving oversight of specialities and standardising practice across the organisation.
- The hospital's head of medical services attended most of the governance committees, including the MAC and patient safety committee meetings. They also attended

the quarterly clinic managers meeting with the head of nursing to ensure important messages from the provider's quality and governance meetings were shared.
- The service had a process in place to ensure that all staff granted practising privileges at the hospital were fit to carry out their role. The MAC had oversight of the process and any new applicants were brought to the MAC for final approval.
- Whilst most policies we reviewed had been reviewed and updated recently, the hospital's practising privileges and recruitment policies were both past their review dates. Neither policy explicitly stated how frequently disclosure and barring service (DBS) checks should be reviewed.

Managing risks, issues and performance

Although the service had systems and processes to identify risks, and plans to eliminate or reduce them, systems and processes for reviewing risks were relatively new and not yet fully embedded within the wider governance processes.

- The hospital had a risk register which recorded specific local risks to the service. The hospital had identified 22 risks through a variety of sources, including feedback from staff, incident reporting and audit results. Risks included a range of concerns around staffing levels, staff training, equipment, infection control and storage space. The likelihood and impact of each risk had been assessed and an overall 'level of concern' recorded. All 22 risks were recorded as moderate concerns and therefore, according to the hospital's policy, responsibility for assurance on these risks sat with the governance committee.
- We were told that the senior management team carried out a monthly review of risks, and risks were also reviewed at the quarterly governance committee meetings. However, governance meeting minutes we reviewed did not have a specific agenda item on risk and there was no specific review of the risks recorded on the hospital's risk register.
- All risks recorded on the hospital's risk register had documented controls to mitigate the risk and actions required before the next review date. All actions were assigned to a responsible individual or team and had a timeframe for completion.
- The head of medical services told us that the hospital had previously used the electronic incident reporting system to record risk, but this had proved difficult to use. The decision had recently been made to create a separate hospital risk register to allow better oversight and review of local risks.
- The service had systems in place for measuring performance and providing information to help the board and teams to understand how they were doing. A refreshed audit programme had recently been introduced to provide assurance regarding the safety and the quality of care provided.

Managing information

The service collected, analysed, managed and used information well to support all its activities, using secure electronic systems with security safeguards.

- Although patient records were currently a combination of paper and electronic records, the service was working towards making more aspects of records electronic. This included plans to introduce an electronic pre-assessment tool for patients in 2019.
- The service also told us about planned improvements to further enhance security and protect patient confidentiality, including two-factor authentication for remote access to the computer network and end-to-end encryption of emails.
- There was a shared drive available to all staff, which contained links to current guidelines, policies and procedures. Staff knew how to access this, and the information contained within.
- Staff completed training on information governance and data protection as part of their mandatory training and were supported by the director of clinical services in their role as Caldicott guardian. A Caldicott guardian is a senior person responsible for protecting the confidentiality of people's health and care information and making sure it is used properly.
- The service had processes in place to capture, record and submit data to the Private Healthcare Information Network (PHIN) and the national breast and cosmetic implant register.

Engagement

The service engaged well with patients and staff to plan, manage and improve services.

Good

Surgery

- Patient feedback was gathered in several ways including the friends and family test (FFT), patient reported experience measures (PREMS), quality patient reported outcome measures (Q-PROMS) and complaints. Feedback and concerns were discussed at governance meetings and used to drive conversations around improvements in service delivery and patient experience.
- The service carried out an annual staff survey and used the results to identify areas for improvement and benchmark performance between locations. In the 2019 survey, 56% of staff had responded (compared to 70% of the organisation overall).
- Feedback from the staff survey was mainly positive, with many areas scoring 100%. For example, 100% of staff agreed with statement, 'I am able to make suggestions to improve the work of my team / department' and 100% stating they were aware of the organisation's values, mission and ethos.
- The hospital had developed a detailed action plan to address four key areas identified for improvement from the staff survey. This included reward and recognition, training, learning and development, communication and engagement, and perception of senior managers. Outcomes from the services' recent reward and retention project included changes to the pay and benefits offered to staff.
- Staff were encouraged to bring forward ideas and areas for improvement. For example, staff had identified a training gap around incident reporting. This was escalated to senior managers and added to the hospital's risk register. The service responded by providing additional training to staff.
- Senior staff recognised that closer teamworking and engagement between the hospital and the other clinic locations would benefit service delivery and staff well-being. Plans to develop this relationship were included within the staff survey action plan.

Learning, continuous improvement and innovation

The service was committed to improving services by learning from when things went well or wrong, promoting training, research and innovation.

- The service was working towards national accreditation by AfPP. Senior staff told us they hoped to be one of the first independent cosmetic surgery providers with independent assurance regarding the safety and quality of their services. Staff were supported and encouraged to apply for AfPP membership and given opportunities to attend additional training and AfPP events.
- The hospital was working towards full compliance with the National Safety Standards for Invasive Procedures (NatSSIPs) and had recently developed Local Safety Standards for Invasive Procedures (LocSSIPs) and introduced these into practice. This included posters reminding staff to 'stop before you block' to encourage staff to pause and double check the location of the procedure.
- The hospital had long-term plans to improve services through the introduction of new and innovative techniques. For example, the hospital had recently introduced a new, less invasive, bunion removal procedure, which allowed quicker recovery for patients. Without the need for screws, wires, pins or other implants, patients were able to walk almost immediately after recovery from surgery.

Outstanding practice and areas for improvement

Areas for improvement

Action the provider SHOULD take to improve

- The provider should carry out risk assessments to ensure medicines kept in cupboards are stored within the temperature range recommended by manufacturers.
- The provider should review the contents of the difficult airway trolley to ensure all appropriate equipment is available in line with good practice guidelines.
- The provider should ensure staff only use the sluice entrance to theatres in exceptional or emergency circumstances.
- The provider should ensure that all staff, including those on practising privileges, have an annual appraisal.
- The provider should ensure that systems and processes for reporting, managing and investigating patient safety incidents are applied consistently and understood by staff.
- The provider should ensure that there are robust arrangements for identifying, recording and managing and reviewing risks within the service.
- The provider should ensure policies for practising privileges and recruitment are reviewed and updated.