

Manchester Children's Clinic







Quality Report

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This report describes our judgement of the quality of care at this location. It is based on a combination of what we found when we inspected and a review of all information available to CQC including information given to us from patients, the public and other organisations

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?	Requires improvement	

Overall summary

Manchester Children's Clinic is operated by M C Medical Limited. The service has ward with one bed which is used for day-case patients only and a consultation room. There is one operating theatre and outpatient facilities.

The service provides surgery and outpatient services for children and young people up to the age of 18. We inspected the services for children and young people.

We inspected this service using our comprehensive inspection methodology. We carried out the announced part of the inspection on 11 November 2018.

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

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

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

Services we rate

We rated the service as **Good** overall.

Summary of findings

We found areas of good practice in services for children and young people:

- The provider ensured that all staff had completed mandatory training in key skills.
- Staff understood how to protect patients from abuse. Staff had training on how to recognise and report abuse and they knew how to apply it.
- The provider controlled infection risk well. Staff kept themselves, equipment and the premises clean. They used control measures to prevent the spread of infection.
- The service had suitable premises and equipment and looked after them well.
- Staff completed and updated risk assessments for each patient. They kept clear records and asked for support when necessary.
- The provider had enough staff with the right qualifications, skills, training and experience to keep people safe from avoidable harm and to provide the right care and treatment.
- Staff kept detailed records of patients' care and treatment. Records were clear, up-to-date and easily available to all staff providing care.
- The provider followed best practice when prescribing, giving, recording and storing medicines. Patients received the right medication at the right dose, at the right time.
- The service knew how to manage patient safety incidents. Staff knew how to recognise and report incidents and had received appropriate training. The provider had no clinical incidents in the reporting period from August 2017 to July 2018.
- The provider provided care and treatment based on national guidance and evidence of its effectiveness. Managers checked to make sure staff followed guidance.
- Staff assessed and monitored patients regularly to see if they were in pain. Suitable pain relief was given to ease pain.
- Managers monitored the effectiveness of care and treatment and used the findings to improve.
- The provider made sure that staff were competent for their roles. Managers made sure that staff had an up to date appraisal and had the required competencies to carry out their role.
- Staff of different kinds worked together as a team to benefit patients. Doctors, nurse and other healthcare professionals supported each other to provide good care.
- There was a thorough pre-operative assessment and consent process in place to ensure that patient risks were identified and patients who were not suitable for surgery in the facility were identified and signposted to receive surgery elsewhere.
- Staff cared for patients with compassion. Feedback from patients confirmed that staff treated them well and with kindness. Feedback about the service was 100% positive.
- Staff provided emotional support to patients to minimise their distress. Staff were reassuring to patients and their families and explained everything in a way that was easily understandable.
- Staff involved patients and those close to them in decisions about their care and treatment. Patients and their carers said that questions and queries were dealt with promptly and professionally, information was clear and easy to understand and good aftercare information was provided.
- The provider was a paediatric-only medical facility offering outpatient consultations for urinary incontinence, paediatric urology and day-case paediatric surgical procedures which met the needs of local children who needed non-urgent surgery.
- The service took account of patients' individual needs and was accessible to patients and carers with reduced mobility.
- People could access the service when they needed it. Patients could receive a pre-operative assessment and surgery within a few weeks.
- The service had received no formal complaints but had a clear complaints process in place and learned lessons from informal concerns.

Summary of findings

- Managers had the right skills and abilities to run a service providing high quality, sustainable care. Leaders were experienced and had the capability to make sure that a quality service was delivered and risks to performance were addressed.
- The service had workable plans for sustainability and growth of the business to deliver a wider service to paediatric patients.
- Managers promoted a positive culture that supported and valued staff, creating a sense of common purpose, based on shared values.
- The provider used a systematic approach to continually improve the quality of its services and safeguarding high standards of care by creating an environment in which excellence in clinical care would flourish. The service had clear governance roles and responsibilities that were divided between the chief executive (the consultant surgeon) and the registered manager (the clinic manager).
- The service collected, analysed, managed and used information well to support its activities, using secure electronic systems with security safeguards.
- The service engaged well with patients and staff to plan and manage appropriate services. Staff reported that they had been part of putting the business together and the views of patients and carers were always sought to drive improvements.
- There was a commitment to improving services by learning from things went well and when they went wrong, promoting research and innovation.
- Although there was an emergency procedure flowchart and policy for emergency procedures in the event of a deteriorating patient or cardiac arrest, the provider did not have pathways in place to recognise and manage the deteriorating patient in individual conditions, such as asthma or hypoglycaemia.
- The provider did not have a formal clinical and non-clinical incident recording system in place to identify trends and record incidents formally to enable learning.
- The provider did not make information accessible in a written or other format for patients and carers who had information or communication needs relating to a disability impairment or sensory loss in a way that they could read, receive and understand.
- The provider did not have a formal risk register in place to record risks identified, actions taken and plans to reduce risks.
- There was no named Level four safeguarding lead, either in the provider or the local authority, for staff to approach for more specialist advice when required.
- The medical advisory committee meeting minutes were brief and did not reflect whether the meetings were effective.
- There was a limited audit programme in place.

However:

We found areas of practice that require improvement in services for children and young people:

- The provider could improve their safeguarding policy by including the “PREVENT” government strategy on suspected radicalisation and contact information to better inform staff how to make a safeguarding referral to the local authority safeguarding team.

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

Ellen Armistead

Deputy Chief Inspector of Hospitals (North)

Summary of findings

Our judgements about each of the main services

Service

Services for children and young people

Rating

Good



Summary of each main service

Children and young people's services was the main activity of the service. Although the service carried out surgery and outpatient services, these activities were all for children and young people so we have reported all our findings in this main service section. We rated this service as good because it was safe, effective, caring, responsive and well-led.

Summary of findings

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Good 

Manchester Children's Clinic

Services we looked at

Services for children and young people;

Summary of this inspection

Background to Manchester Children's Clinic

Manchester Children's Clinic is operated by M C Medical Limited. The service opened in January 2017. It is a private clinic in Swinton, Greater Manchester. The clinic primarily serves the communities of the Greater Manchester area. It also accepts patient referrals from outside this area and abroad.

The clinic has had a registered manager in post since 30 January 2017.

Our inspection team

The team that inspected the service comprised a CQC lead inspector, and one other CQC inspectors. The inspection team was overseen by an Inspection Manager.

Information about Manchester Children's Clinic

The hospital has one ward and is registered to provide the following regulated activities:

- Surgical procedures
- Treatment of disease, disorder or injury
- Diagnostic and screening procedures
- Caring for children (0-18 years)

The provider is a small clinic, performing minor surgical procedures under general anaesthetic for patients from one to 18 years old. The provider only operates from one site where they also provide outpatient services to children and young people. The clinic only provides care for private patients who are insured or self-funding.

The facility generally only offers weekend clinics and theatre lists in order to ensure that patients miss the minimal amount of school and both parents can attend, where possible.

During the inspection, we visited the consulting room, ward, anaesthetic room, operating theatre and reception and waiting areas. We spoke with eight staff including a consultant paediatric surgeon, clinic manager, consultant paediatric anaesthetist, sister in charge, operating department practitioner, paediatric ward nurse, paediatric theatre assistant and personal assistant. We

spoke with one patient and three relatives. During our inspection, we reviewed 3 sets of patient records, reviewed policies and procedures, staff files and patient and relative feedback forms.

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

Activity (1 August 2017 to 1 July 2018)

- In the reporting period 1 August 2017 to 1 July 2018 there were 29 day case episodes of care recorded at the service; of these 100% were non-NHS funded.
- In the reporting period 26 (24%) day case and outpatients were aged nought to two years; 72 (66%) were aged three to 15 years and 11 (10%) were aged 16 to 17 years old.
- There were 80 outpatient total attendances in the reporting period; of these 13 were a first appointment and 67 were a follow-up appointment.

One surgeon and one anaesthetist worked at the clinic under practising privileges. Manchester Children's Clinic employed one receptionist/personal assistant. All other staff worked there as bank staff. The accountable officer for controlled drugs (CDs) was the consultant surgeon.

Summary of this inspection

Track record on safety

- No never events
- Clinical incidents - none with no harm, none with low harm, none with moderate harm, none with severe harm and none resulting in death
- No serious injuries

No incidences of hospital acquired Meticillin-resistant Staphylococcus aureus (MRSA)

No incidences of hospital acquired Meticillin-sensitive staphylococcus aureus (MSSA)

No incidences of hospital acquired Clostridium difficile (C.diff)

No incidences of hospital acquired E-Coli

No complaints

Services provided at the clinic under service level agreement:

- Clinical and or non-clinical waste removal
- Interpreting services
- Laundry
- Maintenance of medical equipment
- Pathology and histology
- Blood transfusion
- Pharmaceutical supplies

Summary of this inspection

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?

We rated it as **Good** because:

- The provider ensured that all staff had completed mandatory training in key skills.
- Staff understood how to protect patients from abuse. Staff had training on how to recognise and report abuse and they knew how to apply it.
- The provider controlled infection risk well. Staff kept themselves, equipment and the premises clean. They used control measures to prevent the spread of infection.
- The service had suitable premises and equipment and looked after them well.
- Staff completed and updated risk assessments for each patient. They kept clear records and asked for support when necessary.
- The provider had enough staff with the right qualifications, skills, training and experience to keep people safe from avoidable harm and to provide the right care and treatment.
- Staff kept detailed records of patients' care and treatment. Records were clear, up-to-date and easily available to all staff providing care.
- The provider followed best practice when prescribing, giving, recording and storing medicines. Patients received the right medication at the right dose, at the right time.
- The service knew how to manage patient safety incidents. Staff knew how to recognise and report incidents and had received appropriate training. The provider had no clinical incidents in the reporting period from August 2017 to July 2018.

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

- The provider could improve their safeguarding policy by including the "PREVENT" government strategy on suspected radicalisation and contact information to better inform staff how to make a safeguarding referral to the local authority.
- Although there was an emergency procedure flowchart and policy for emergency procedures in the event of a deteriorating patient or cardiac arrest, the provider did not have pathways in place to recognise and manage the deteriorating patient in individual conditions, such as asthma or hypoglycaemia.
- The provider did not have a formal clinical and non-clinical incident recording system in place to identify trends and record incidents formally to enable learning.

Good



Summary of this inspection

Are services effective?

We rated it as **Good** because:

- The provider provided care and treatment based on national guidance and evidence of its effectiveness. Managers checked to make sure staff followed guidance.
- Staff assessed and monitored patients regularly to see if they were in pain. Suitable pain relief was given to ease pain.
- Managers monitored the effectiveness of care and treatment and used the findings to improve.
- The provider made sure that staff were competent for their roles. Managers made sure that staff had an up to date appraisal and had the required competencies to carry out their role.
- Staff of different kinds worked together as a team to benefit patients. Doctors, nurse and other healthcare professionals supported each other to provide good care.

There was a thorough pre-operative assessment and consent process in place to ensure that patient risks were identified and patients who were not suitable for surgery in the facility were identified and signposted to receive surgery elsewhere.

Good



Are services caring?

We rated it as **Good** because:

- Staff cared for patients with compassion. Feedback from patients confirmed that staff treated them well and with kindness. Feedback about the service was 100% positive.
- Staff provided emotional support to patients to minimise their distress. Staff were reassuring to patients and their families and explained everything in a way that was easily understandable.
- Staff involved patients and those close to them in decisions about their care and treatment. Patients and their carers said that questions and queries were dealt with promptly and professionally, information was clear and easy to understand and good aftercare information was provided.

Good



Are services responsive?

We rated it as **Good** because:

- The provider was a paediatric-only medical facility offering outpatient consultations for urinary incontinence, paediatric urology and day-case paediatric surgical procedures which met the needs of local children who required non-urgent surgery.
- The service took account of patients' individual needs and was accessible to patients and carers with reduced mobility.

Good



Summary of this inspection

- People could access the service when they needed it. Patients could receive a pre-operative assessment and surgery within a few weeks.
- The service had received no formal complaints but had a clear complaints process in place and learned lessons from informal concerns.

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

- The provider did not make information accessible in a written or other format for patients and carers who had information or communication needs relating to a disability impairment or sensory loss in a way that they could read, receive and understand.

Are services well-led?

We rated it as **Requires improvement** because:

- The provider did not have a formal risk register in place to record risks identified, actions taken and plans to reduce risks although they were identifying and dealing with risks in an informal way.
- There was no named Level four safeguarding lead, either in the provider or the local authority, for staff to approach for more specialist advice when required.
- Incident management and feedback systems were not robust to ensure information was communicated to each staff member and opportunities to learn from incidents.
- The medical advisory committee meeting minutes were brief and did not reflect whether the meetings were effective.
- There was a limited audit programme in place.






However, we also found the following areas of good practice:

- Managers had the right skills and abilities to run a service providing high quality, sustainable care. Leaders were experienced and had the capability to make sure that a quality service was delivered and risks to performance were addressed.
- The service had workable plans for sustainability and growth of the business to deliver a wider service to paediatric patients.

Requires improvement



Services for children and young people

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

Are services for children and young people safe?

Good 

We rated the safe domain as **good** because:

Mandatory training

- The provider ensured that all staff had completed mandatory training in key skills.
- All the staff worked in substantive posts at a large NHS children’s hospital; the service allowed their mandatory training from their substantive posts to be transferable to Manchester Children’s Clinic.
- The clinic manager kept records of staff training and renewal due dates and ensured that they provided evidence that their training was up to date. All staff were up to date with mandatory training at the time of our inspection.
- Staff had undertaken training in their substantive posts in courses such as clinical basic life support, general data protection regulations, equality and diversity, health and safety, infection control, information security and manual handling.
- The clinic had a local induction for staff and this included ensuring that all staff were trained on the clinic evacuation procedure and fire safety.

Safeguarding

- Staff understood how to protect patients from abuse. Staff had training on how to recognise and report abuse and they knew how to apply it.

- The provider had a policy on safeguarding children and young people. The policy was in date and had been reviewed at regular intervals. The policy covered identification of a vulnerable child, types of abuse, signs of abuse, disclosure and referral.
- The policy did not cover the “PREVENT” government strategy, that was developed to assist in signposting organisations where there was a suspicion of an adult or child having been radicalised.
- Similarly, the policy did not include anything about female genital mutilation or child sexual exploitation. However, staff could describe what to do if they suspected that patient or carer had undergone female genital mutilation and if any family asked for female genital mutilation to be carried out on a child, staff knew that the police should be contacted immediately. Since our inspection, the policy had been updated to include a section on female genital mutilation.
- The policy also did not have the contact information boxes completed, although we saw that the local authority safeguarding team contact details were displayed in the clinic consulting room.
- All clinical staff and the manager were trained to level three in safeguarding children and young adults. Staff were required to produce up to date safeguarding training certificates which were transferable from their substantive posts. At the time of our inspection, all staff had the required training. There was no named Level four safeguarding lead, either in the provider or the local authority, for staff to approach for more specialist advice when required.

Services for children and young people

- Patients were always with a level three trained doctor or nurse and their parents. Chaperones were available on request and closed-circuit television operated on all floors in non-clinical areas of the facility for the protection of patients and staff.
- The practice clinical safeguarding lead was the consultant surgeon with the clinic manager as the deputy lead.
- The service had not made any safeguarding referrals within the reporting period, but had made one safeguarding referral since opening.

Cleanliness, infection control and hygiene

- The provider controlled infection risk well. Staff kept themselves, equipment and the premises clean. They used control measures to prevent the spread of infection.
- There had been no cases of Clostridium difficile or Escherichia coli infections at the service from August 2017 to July 2018.
- There had been no cases of methicillin-resistant Staphylococcus aureus or methicillin-sensitive Staphylococcus during the period August 2017 to July 2018.
- There were no surgical site infections recorded by the service from August 2017 to July 2018.
- The service had a biological substances infection control protocol. This covered measures to be taken by staff to limit the risk of infection from biological substances, including spillages, handling of pathology specimens, taking of blood, dealing with bleeding, handling of samples, taking swabs, decontamination and transportation of biological and clinical waste.
- The service had an infection control policy that set out the commitment to control the risk of infection within the building.
- Staff were provided with training on infection control as part of induction procedures and had access to relevant infection control policies. The training was repeated annually and covered training on hand decontamination, hand washing procedures, the use of personal protective equipment and the safe use and disposal of sharps.
- The ward, waiting areas and theatre areas were visibly clean and free from dust and clutter. A clinical staff member adhered to a cleaning schedule and completed cleaning checklists. We saw cleaning schedules covering the last two years. Cleaning of the facility took place the day before it was open and was cleaned once per week regardless of whether there was a theatre list booked. We saw that the toys in the waiting area were regularly cleaned during the day. Cleaned equipment was labelled with an "I am clean" sticker.
- Hand wash and hand gels were available for use throughout the building. There were bins for the disposal of clinical and non-clinical waste. Waste was appropriately separated and disposed of. The clinic had a service level agreement with a clinical waste company who safely disposed of clinical waste, sharps bins and sanitary bins. The waste collection bins outside the facility were clearly marked and were kept locked.
- Appropriate waste bags were in use in the theatre and were labelled with the location and date, in accordance with the Association of Perioperative Practice guidelines.
- The dirty sluice room was protected by a key pad to prevent unauthorised entry. Cleaning materials were locked away in cupboards.
- Staff wore personal protective equipment, such as disposal aprons and gloves whilst delivering care. All staff adhered to infection prevention control measures, such as being bare below the elbows. We observed that staff cleaned their hands before and after seeing a patient.
- Curtains around beds were clean and disposable. We saw that they were in date. Floors and chairs were clean and covered in a wipeable material. Disposable paper rolls were used on examination beds and there were foot-operated waste bins and universal cleaning wipes available in the clinic examination room.
- We saw that sharps waste bins were labelled correctly, were kept partially closed and were not overfilled.
- We observed that staff carried out hand hygiene in accordance with best practice. However, the service did not carry out hand hygiene audits.

Environment and equipment

Services for children and young people

- The service had suitable premises and equipment and looked after them well.
- The clinic was bright and decoration was in good order throughout. Rooms were spacious enough to carry out treatment safely and contained all the necessary equipment. Outpatient and pre-operative assessments took place on the ground floor, the theatre and anaesthetic room were on the ground floor and the recovery ward was on the lower ground floor.
- The clinic was secure with security shutters and two sets of locked doors at the entry and grills over windows to protect the premises when empty.
- Lines of observation from the reception desk to the waiting area were good.
- Equipment storage rooms were well ordered and tidy. A sample check of single use equipment showed that they were all within their expiry date. All trays of surgical instruments were single-use and disposable.
- The clinic had an equipment inventory maintenance schedule in place that showed that equipment servicing was carried out regularly both internally and by external contractors. These included the lift; waterproof call button; emergency lighting; clinical waste contract and laundry services agreement.
- A log book of equipment, such as drug fridges was kept and contained maintenance and servicing records of the equipment.
- All equipment appeared to be in good condition and full working order. Treatment beds were height adjustable. There was a set of calibrated weighing scales that were in good order.
- An emergency resuscitation trolley was available in the building and all contents were checked whenever the clinic was open, including an external defibrillator. There were various sized oxygen masks for children on the trolley.
- Suction oxygen was available in the ward area and was observed to be tested regularly and working. The cylinder was within its expiry date.
- Communication between staff throughout the building was aided by the use of Walkie-Talkies which were seen to work well to inform staff that a patient was ready to be moved to the ward from recovery, for example.

Assessing and responding to patient risk

- Staff completed and updated risk assessments for each patient. They kept clear records and asked for support when necessary.
- The provider only admitted patients for surgery that were considered low risk. Patients with co-morbidities or who would require surgery that would generally take more than an hour to perform were not admitted and were referred to an acute trust for surgery.
- A pre-operative questionnaire was completed for each patient before any agreement by the clinic to perform a surgical procedure and obtain the consent of the patient or parent. The questionnaire covered any recent illnesses or symptoms, allergies, whether the starving instructions had been properly followed and risk of methicillin-resistant *Staphylococcus aureus* (MRSA). If there was a risk of methicillin-resistant *Staphylococcus aureus* (if the child had been an inpatient in a hospital within the last six months) they were referred for screening before any surgery was carried out. The provider had a service level agreement with a laboratory who collected the swabs and carried out the screening.
- We observed a pre-operative check of the patient being carried out and saw that the child was weighed (with a witness to double-check the weight); the temperature of the child was taken, blood pressure and heart rate. In further check of the patient's condition was undertaken to ensure that the procedure was still required and there had been no changes since the previous consultation.
- The service had an emergency procedure flowchart and policy for emergency procedures in the event of a deteriorating patient or cardiac arrest in a patient. Staff were aware of the emergency procedure. All clinical staff on site were required to go to the location of the emergency and the clinical team decided as soon as possible whether to call an emergency ambulance so that the patient could be transported to a local NHS acute trust.
- Staff told us they had carried out emergency simulations of the deteriorating patient
- There were no separate pathways in place to recognise and manage individual conditions causing deterioration in the patient, for example, an asthma pathway or hypoglycaemia pathway.

Services for children and young people

- During our inspection we observed the theatre team using the World Health Organisation five steps to safer surgery checklist. From the five steps, we observed one briefing, which takes place before the patient is brought into theatre; one “sign-in” step which takes place before the patient is given anaesthesia and includes ensuring the patient identity is correct, the right site for surgery incision is marked, allergies are recorded and the risk of blood loss is discussed. We observed one “time-out” (or surgical pause) step which takes place before an incision is made when the team double check the patient identity and incision site and any likely surgical risks are discussed and the nurse confirms the sterility of instruments. We observed one “Sign-out” step. This is supposed to take place before any members of the team have left the theatre and includes recording the name of the procedure, counting the instruments, swabs and sharps used during the procedure to ensure all are present and nothing has been left inside the patient and any specimens have been properly labelled.
- We observed that the checklists were carried out in accordance with the guidelines to ensure the safety of the patient during surgery.
- The clinic kept a file of relevant patient safety and medication alerts issued by the Medicines and Healthcare Products Regulatory Agency via the web-based central alerting system.
- Patients were always in the presence of a clinical member of staff with basic paediatric life support training and the anaesthetist had advanced paediatric life support training. The anaesthetist was always on site when there were patients in the building. All clinical staff and the clinic manager had undertaken resuscitation training.
- There was an intensive care unit monitor on the ward so that patients could be closely monitored for signs of deterioration post-operatively.
- Patients and their parents were given an emergency telephone number to call following discharge where they could speak directly to the surgeon in the event of any suspected complications. Patients who were experiencing bleeding were advised to attend an emergency department at the earliest opportunity. For patients where the wound site was red the family was

asked to email photographs of the wound site which were then encrypted and shown to the surgeon so that he could decide on whether he needed to see the patient again or appropriate follow-up action.

- The emergency evacuation procedure and fire safety checklist were displayed in the clinic. The clinic had an emergency backup power supply in the event of power failure

Staffing

- The provider had enough staff with the right qualifications, skills, training and experience to keep people safe from avoidable harm and to provide the right care and treatment.
- The service had been set up by a consultant paediatric surgeon who was substantially employed by a large children’s acute hospital in Manchester. Surgical procedures were carried out by a team that comprised of the surgeon; a consultant paediatric anaesthetist; a sister in charge; an operating department practitioner, a paediatric theatre assistant and a paediatric ward nurse.
- Patients were cared for on the ward on a one-to-one basis.
- The clinical team were supported by the clinic manager and a personal administrative assistant.
- All the clinical staff and the clinic manager were substantially employed at a large children’s acute hospital in Manchester and worked at the clinic on a self-employed “bank” basis using practicing privileges. The personal administrative assistant was the only employee of the clinic and worked on a part-time basis, three days per week.
- The clinic held a file with all expiration of certificate to practice dates and indemnity insurance details for each clinical staff member working at the clinic. Each person underwent disclosure and barring service checks and up to date appraisals from their substantive employer were requested annually. The clinic manager ensured that all the clinicians had a current certificate to practice, indemnity insurance in place and that mandatory training and appraisal was up to date.
- The clinic would not conduct any surgery unless there was a full surgical team in place.

Services for children and young people

- To avoid the cancellation of a surgical list due to sickness or other absence, the consultant paediatric surgeon had access to a bank operating department practitioner, scrub nurse and ward nurse who could be brought in a short notice to cover absence on the usual team. All three also worked at the children's acute hospital with the rest of the team. They had undergone disclosure and barring checks and one had undertaken the Manchester Children's Clinic induction. If the ward nurse or operating department practitioner were needed to work in the clinic, we were advised that they would be brought in the day before to undergo their induction training. At the time of our inspection the additional staff had not been required to cover for the regular nurses or operating department practitioner.
- Outpatient clinics took place on Saturdays and were run by the consultant paediatric surgeon with support from the clinic manager.
- There were procedures in place for stock control, administration and storage of non-controlled drugs and a controlled drugs policy and procedures.
- The provider had a service level agreement with a local pharmacy for the supply of medicines, except hospital-only medicines that were supplied by the local NHS acute trust.
- The provider kept a good medicines stock control record and a spreadsheet showed those medicines that were within a month of their expiry date. The consultant surgeon had responsibility for ordering and the correct storage of medicines in the clinic. A monthly stock check and expiry date check was undertaken by the senior nurse and operating department practitioner.
- Medicines were stored in two lockable and dedicated cupboards that were secured in place. Stock was rotated in accordance with expiry dates.

Records

- Staff kept detailed records of patients' care and treatment. Records were clear, up-to-date and easily available to all staff providing care.
- The service used an electronic patient record system to store patient records and produce letters to GPs and referring clinicians. Letters were sent to GPs by encrypted email and also to the referring clinician.
- All paper records were scanned and stored against the electronic patient record then destroyed.
- There had been no instances when a patient record was not available at an outpatient appointment.
- We looked at three patient records on the system and saw that the system was secure, records were clear and there was a full past medical history and family history that was added to the record after the first consultation. We saw that the world health organisation (WHO) checklist had been completed where the patient had undergone surgery.
- Medicines that required storage at temperatures below eight degrees centigrade were appropriately stored in pharmaceutical grade lockable fridges with temperature monitoring equipment. Fridge and room temperatures were checked twice daily whenever there was a clinician on site (at least once per week) to ensure that temperatures had not gone out of range. We saw records of fridge temperature monitoring and no instances where the temperature had been out of range. Staff were aware of what to do if fridge temperatures went out of range.
- The provider had a service level agreement with the local NHS acute trust in the rare event that a patient would require a blood transfusion so stocks of blood were not kept on site.
- There was a medical oxygen cylinder stored securely in the ward area. This was within the supplier's expiry date and contained sufficient levels of oxygen for use in an emergency.
- Controlled drugs were stored in a locked cabinet in the theatre with the controlled drugs book. The cabinet was kept locked and a nominated clinician kept the key locked away. Controlled drugs were checked and recorded by two clinicians when the service was open.

Medicines

- The provider followed best practice when prescribing, giving, recording and storing medicines. Patients received the right medication at the right dose, at the right time.

Services for children and young people

- The anaesthetist was responsible for prescribing and administering all drugs within the minor procedure unit. The operating department practitioner double-checked all medications prior to administration.
- The anaesthetist was also responsible for prescribing all post-operative analgesia and take-home medicines.
- The ward nurse was responsible for administering post-operative prescribed medicines (usually analgesia). All medicines were checked by a second member of the medical team before being administered. If further pain relief was required, the nurse raised this with the anaesthetist or consultant surgeon.
- Patients who had known allergies or sensitivities (for example to Paracetamol) were given a red wristband on admission to remind staff to not administer drugs where the patient may sustain an adverse reaction.

Incidents

- The service knew how to manage patient safety incidents. Staff knew how to recognise and report incidents and had received appropriate training.
- The provider had reported no clinical incidents in the reporting period from 1 August 2017 to 1 July 2018.
- The provider had reported one non-clinical incident during the same reporting period and this was regarding a patient who had not received a follow-up telephone call within 48 hours of being discharged. The patient and their parents had received an apology for the oversight and there was increased diligence to ensure that all patients received the follow-up call at the right time.
- Staff we spoke with were all aware that incidents should be reported immediately to the clinical lead and clinic manager for appropriate action.
- The provider could describe other events that could have been formally recorded as non-clinical incidents but they had not done so. We spoke to the clinical lead and clinic manager who agreed that they would review what could be recorded as an incident to enable the identification of trends and enable learning. For example, the provider had received medication that was close to its expiry date and could have recorded this as a non-clinical incident.

- The provider could demonstrate that they had learned from incidents that had happened in other providers and had made changes to their own practices to minimise the risk of similar incidents happening in their own service. For example, they had introduced a question to the pre-operative checklist about whether a patient had been taking aspirin following an incident at another provider.

Safety Thermometer (or equivalent)

- The NHS Safety Thermometer is an improvement tool for measuring, monitoring and analysing patient harms and “harm free” care. It looks at risks such as falls, pressure ulcers, blood clots and catheter acquired urinary tract infections.
- The provider did not report safety thermometer information but reported that there had been no cases of acquired venous thromboembolism or urinary tract infections from 1 August 2017 to 1 July 2018. In addition, there were no reported instances of any clinical harm to a patient during the reporting period.

Are services for children and young people effective?

Good 

We rated the effective domain as **good** because:

Evidence-based care and treatment

- The provider provided care and treatment based on national guidance and evidence of its effectiveness. Managers checked to make sure staff followed guidance.
- The clinic manager was responsible for ensuring that policies and procedures were kept up to date and in line with national guidance. They were signed up to the notification service for the National Institute for Health and Care Excellence and updated any policies and procedures in accordance with updated national guidelines.
- We saw that clinical policies and procedures and care pathways reflected national guidance and were available for staff to review.

Services for children and young people

- Changed processes could be communicated to staff at team meetings and at the de-brief that took place at every surgical list. Care pathways for surgery and for recovery were based on national guidance, including from the National Institute for Health and Care Excellence and the Royal College of Surgeons.

Nutrition and hydration

- Staff gave patients enough food and drink to meet their needs.
- Patients were sent a dietary letter prior to their pre-operative consultation and it was established whether the patient was on formula milk and any food intolerances.
- Patients were given a sandwich, drink, ice-cream and fruit on the ward. Their choice of sandwich was established at the pre-operative assessment.
- Patients were admitted with minimal waiting times to surgery to minimise the length of time that they were “nil by mouth”.
- Patients were encouraged not to leave the facility until they had eaten something.

Pain relief

- Staff assessed and monitored patients regularly to see if they were in pain. Suitable pain relief was given to ease pain.
- Patients were assessed pre-operatively for the most appropriate post-operative pain relief and this was reflected in patient notes. Child-friendly pain assessment tools were used where appropriate. Patient records indicated that patients received the required pain relief and they were treated in a way that met their needs and reduced discomfort.
- If the ward nurse considered further pain relief, other than that already prescribed, was required they would seek advice from the anaesthetist or consultant surgeon.
- Patients and their carers were discharged with take-home pain relief medicines and information on how to manage pain symptoms. We observed that advice was given verbally to patients or their parents on discharge and were encouraged to contact the service if the pain relief was not effective.

- Surgical patients were contacted by the clinic manager within 48 hours after discharge and asked if their pain was at an acceptable level. Advice could be given by the consultant surgeon.

Patient outcomes

- Managers monitored the effectiveness of care and treatment and used the findings to improve.
- The provider did not participate in national audits or compare themselves with other services as there were no other similar services known to them within the area for comparison purposes.
- Post-operative monitoring of the patient took place within 24 hours of the patient being discharged with a follow-up telephone call to ensure that everything had gone well and to check whether the patient had any pain. Any contact with the patient and their parents was recorded on the patient record.
- Patients were given follow-up appointments to monitor outcomes at four weeks or six weeks after their procedure, dependent on what procedure they had undergone. A further follow-up appointment was given approximately two months after the first to ensure a positive outcome. Self-funding patient packages included two follow-up appointments in the price which encouraged patients to attend these appointments as there was no additional price.
- The provider carried out audits to measure patient outcomes at regular intervals.
- Two audits had been carried out on wound infections after surgery, in November 2017 and July 2018. Eighteen patients were audited for each audit. The audits found that 0% of patients had a post-operative wound infection. A third audit was planned for June 2019.
- An audit on adverse perioperative and immediate post-operative events had been carried out on patients treated between December 2017 and April 2018. Twenty-nine patients were identified. The audit found that 0% of patients had suffered adverse perioperative or post-operative events during the period. The next audit was planned for May 2019.
- An audit on post-operative contacts after discharge from parents using the emergency contact number was carried out for the period December 2017 to June

Services for children and young people

2018. The provider set a standard of less than two contacts in the first 48 hours after surgery. Of 30 patients identified during this period, the audit found that two calls had been recorded, both after a post-operative circumcision. The audit stated that both patients were managed conservatively to ensure a good outcome. The next planned audit for post-operative contacts was June 2019.

- No audits had been carried out on pain relief, the world health organisation (WHO) checklist, fasting times or hand hygiene.
- Data supplied by the provider showed that there had been no unplanned transfers of patients to other hospitals from July 2017 to June 2018 and no unplanned returns to the operating theatre within the reporting period.
- The data shows that there was one case of an unplanned readmission within 28 days of discharge. The manager told us that this related to a patient who had been advised to attend an NHS emergency department because of concerns about a wound bleeding.

Competent staff

- The provider made sure that staff were competent for their roles. Managers made sure that staff had an up to date appraisal and had the required competencies to carry out their role.
- Staff new to the service had to undertake an induction before being allowed to work at the clinic. Personnel files of all staff working at the clinic showed that all staff had undertaken the required induction and had read and understood relevant policies and procedures.
- The provider did not carry out appraisals with the medical staff working at the clinic but all staff were required to provide evidence that they had an up to date appraisal with their substantive employer. All medical staff and the clinic manager worked for the same NHS trust within the same speciality and there was confidence that the appraisal process there was sufficient to maintain the competencies of staff working in Manchester Children's Clinic. Records showed that all medical staff and the clinic manager had an up to date appraisal with their substantive employer.
- Additional staff training courses were not generally offered to medical staff working in the clinic but training

they had undergone with their substantive employer was recorded on each staff member personnel file. The clinic manager told us that additional staff training would be considered if a relevant training course could not be delivered by the substantive employer and would benefit the provider.

- The clinic personal administrative assistant had not yet received an appraisal at the time of our inspection but had only been in post for a few weeks. There were plans to provide training for them on use of the patient record system.
- The clinic manager was part of the institute of leadership and management accreditation scheme.
- The consultant paediatric surgeon was an international recognised expert for genital and urological paediatric and adolescent reconstruction and was the lead for postgraduate medical education at the acute children's hospital where they held a substantive post.
- The consultant paediatric anaesthetist was the clinical lead for anaesthesia at the acute children's hospital where they held a substantive post.

Multidisciplinary working

- Staff of different kinds worked together as a team to benefit patients. Doctors, nurse and other healthcare professionals supported each other to provide good care.
- There was effective communication between staff on the ward and in the theatre. All staff told us that they operated as closely-knit team to deliver the best care to patients. Surgical lists were discussed as a team before surgery so that patient care could be co-ordinated and delivered effectively.
- A de-brief of all staff took place after the list had been completed to gather feedback.
- The provider had service level agreements in place to work effectively with external services, for example, with a laboratory to provide blood tests and histology services; pharmacist services to provide non-hospital drugs to the provider and, where necessary, to the patient's home and with a local NHS acute trust to provide hospital-only medications and blood transfusion services.

Services for children and young people

- The provider worked with two private hospitals in the event that patients needed more complex surgery and/or access to scans and nuclear medicine services. Patients could also be referred for treatment at the NHS children's hospital, for example, if they required open bladder surgery or an overnight stay. The consultant surgeon from Manchester Children's Clinic would generally remain in charge of the patient if this was the case.

Seven-day services

- The service had no requirement to operate a seven-day service as the number of patients meant that the clinic only needed to run outpatient clinics on a Saturday with an operating list on a Sunday once or twice a month.

Consent, Mental Capacity Act

- Staff understood whether a patient had the capacity to make decisions about their care and how to ensure that consent had been obtained correctly, either directly from the patient, or from the parents.
- Staff demonstrated an understanding and application of Gillick competence. This is when children under 16 can consent if they have sufficient understanding and intelligence to fully understand what is involved in a proposed treatment, including its purpose, nature, likely effects and risks, chances of success and the availability of other options. We saw that a child that was old enough to understand what would happen was asked whether they had any questions as well as their parents and asked to, and signed their own consent form, along with their parents.
- Medical staff had all received training in the Mental Capacity Act and Deprivation of Liberty Safeguards, although no patients accepted into the service lacked mental capacity or were subject to deprivation of their liberty.
- The consultant paediatric surgeon was generally the clinician who sought consent from patients and/or their parents. Staff had the appropriate skills and knowledge to seek consent and were clear on how they sought verbal informed consent and written consent before providing care and treatment.
- There was a two-stage process in obtaining written consent. This ensured that informed consent was given throughout the consent process. Stage one of the

consent process was sought during the pre-operative consultation and stage two was carried out on the day of treatment. During both stages, risks and benefits were discussed and all parents and, where appropriate, patients were asked if they understood the plan of care.

- We observed two consent consultations being undertaken. In both instances there was a full explanation of what would happen during the operation and an explanation of why the surgery was needed, what bleeding could be expected, what pain could be expected and what would happen to the child throughout the process. There was also an explanation given as to what would happen and further consents obtained if the surgeon needed to suspend or change the operation.

Are services for children and young people caring?

Good 

We rated the caring domain as **good** because:

Compassionate care

- Staff cared for patients with compassion. Feedback from patients confirmed that staff treated them well and with kindness.
- Patients were treated with dignity, compassion and empathy. We observed staff introducing themselves and providing care in a respectful manner. Staff spoke with patients in private to maintain confidentiality.
- Parents were encouraged to be chaperones to their children. Notices were displayed in the clinic area and waiting area regarding chaperones.
- We spoke with three parents and one child. All of them said that staff were kind and caring and gave us positive feedback.
- The provider conducted patient feedback for every patient and family that used the service. Responders were asked to rate various aspects of care on a scale of one to ten with one being poor and ten being excellent.
- We examined 20 patient feedback forms and all gave a rating score of ten to the question "Were staff friendly, helpful and professional?"

Services for children and young people

- Children were not left alone at any time and received one-to-one care whilst on the ward.

Emotional support

- Staff provided emotional support to patients to minimise their distress.
- We observed that staff were reassuring to patients and their families. They explained everything clearly and, where age appropriate, they explained what was going to happen to the patient and took the time to answer any questions. The patient was kept engaged and relaxed whilst pre-operative checks and preparations were being carried out.
- Children were brought round in the recovery area with the parents present before being taken down to the ward.
- Patients were supported on discharge with information on how to manage their specific conditions. Patients received a post-discharge follow-up call to offer advice and check on pain levels.
- Comments on patient feedback forms reflected the emotional support given by the medical team. For example: “Everyone made our son feel relaxed, calm and secure, before and after his op, which he was obviously anxious about. We were very appreciative of this, as well as the efficiency and professionalism of the whole surgery.”
- “Everyone made the whole process from beginning to end as easy and worry-free as possible.”
- “The nurse really looked after my son and cheered him up and comforted him when he woke up.”

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 attended a pre-operative assessment, at which the surgeon got to understand the patient needs, took a full medical history and could answer any questions or concerns about the proposed procedure.
- Of the 20 patient feedback forms we examined, all gave a rating score of ten to the questions: “Were any

questions and queries dealt with promptly and professionally?”; “Was all the information you received clear and easy to understand?” and “Aftercare – information provided.”

- We observed that medical staff explained to worried parents how long the procedure was likely to take, how long it would take the child to recover before they could go home and that they would speak to the parents if the procedure was likely to take longer than expected.
- Where appropriate, dependant on the age of the child, the clinician explained the treatment to the child and asked them if they were happy and had any questions.
- We observed that staff took the time post-discharge, to say goodbye to the patient, make sure that they were OK and happy and made sure that parents were aware of aftercare information and had the relevant contact details if they had any questions or concerns.

Are services for children and young people responsive?

Good 

We rated the responsive domain as **good** because:

Service delivery to meet the needs of local people

- The provider planned and provided services in a way that met the needs of local people.
- Manchester Children’s Clinic was a purpose designed paediatric only medical facility offering outpatient consultations for urinary incontinence, paediatric urology and day-case paediatric surgical procedures.
- The clinic was a child-friendly environment with a play area in the waiting room and a ward specifically designed for children with an underwater theme.
- There was parking available outside the clinic and it was a located on a bus route with regular buses from and to Manchester City Centre.
- Treatment was only available to those patients with medical insurance or self-payers and most treatments offered were those where a patient would experience a long waiting list for elective surgery in the NHS.

Services for children and young people

- Outpatient clinics took place on a Saturday so children did not have to miss school to attend. Outpatient appointments could also be offered at one of two private hospitals in the Manchester area on a weekday evening if this was more convenient to the patient and their parents and closer to where they lived.
- Surgical procedures were carried out on a Sunday on one or two days per month and ensured that this minimised the amount of time a child needed to take off school, if any time at all.

Meeting people's individual needs

- The service took account of patients' individual needs.
- The entrance to the clinic was accessible to people with limited mobility. There was ramp access into the building and part of the reception desk was lower for wheelchair users. There was wheelchair access throughout the building via a lift.
- There was an accessible toilet for patients or carers living with a disability and baby changing facilities on the ground floor and en-suite bathroom facilities in the ward area.
- The waiting area was located on the ground floor of the building and contained a small table and chairs for children and a selection of toys.
- The Accessible Information Standard requires healthcare providers to make information available to patients who have information or communication needs relating to a disability, impairment or sensory loss in a way that they can read, receive or understand. We found that the provider did not offer patient information in large print or easy-read formats for patients or carers with sight impairment or learning disabilities or for young people to understand.
- Patients' individual needs were recorded on their patient record and all staff were aware of the patient's needs as they progressed through the treatment pathway.
- The service had access to telephone interpreters for those patients or carers where English was not their first language but written information was not available in different languages.
- Patients with complex individual needs that could not be met effectively by the service would be referred an NHS trust for treatment to maintain the patient's safety and meet their needs most effectively.

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.
- The consultant surgeon was responsible for discharging the patient when they were fit for discharge which would generally be within an hour of the completion of the surgical procedure.
- The service only treated a small number of outpatient and day-case patients per year. These were generally patients who required minor surgery or treatment and would ordinarily have to wait a long time on an NHS waiting list for non-urgent minor surgery or treatment.
- Patients were only accepted if they were self-paying or had suitable medical insurance to cover the costs of treatment.
- Patients who were accepted for treatment were offered a choice of outpatient appointments for a pre-operative assessment and could generally be offered a date for surgery within two weeks of acceptance for surgery.
- From July 2017 to June 2018 there were 29 day-case attendances at the service and 80 outpatient attendances. The outpatient attendances were made up of 13 first attendance and 67 follow-up attendances.
- There were only five different types of surgical procedures carried out from July 2017 to June 2018. The majority of procedures were circumcisions.
- Most patients who were treated at the facility came to a first attendance at which a pre-operative assessment or other assessment or treatment was undertaken and the payment package included at least two follow-up outpatient attendances.
- Discharge arrangements ensured that the patient and their family understood prescribed medications, dates of follow-up appointments and follow-up telephone call and emergency telephone number.

Services for children and young people

- Discharge summary letters were sent to the patient's GP and referring clinician within a week of the patient discharge.
- There were no elective surgery cancellations within the reporting period.

Learning from complaints and concerns

- The provider treated concerns and complaints seriously and learned lessons from the results. They shared these with all staff.
- The provider had a complaints policy and clear processes in place for dealing with and escalating complaints whether they were informal or formal.
- The service had received no formal complaints. There had been one concern raised informally with the service by a patient who had not received a follow-up telephone call within 48 hours. We saw that the clinic manager had apologised to the parents and patient for the lack of follow-up call and safeguards had been put in place to minimise the chances of the happening again. The concern had been discussed with the rest of the staff.
- We saw that parents were asked whilst in the building whether they had any concerns and feedback was sought for every patient experience. Any concerns were addressed immediately.
- After every surgical list there was a de-brief session between all the staff to see if anything could have been done better or suggest improvements.

Are services for children and young people well-led?

Requires improvement 

We rated the well-led domain as **requires improvement** because:

Leadership

- Managers had the right skills and abilities to run a service providing high quality, sustainable care. Leaders were experienced and had the capability to make sure that a quality service was delivered and risks to performance were addressed.

- The clinic was led by a consultant paediatric surgeon, who had set up the service and a clinic manager. They were supported by the regular medical team who worked in the service, including a consultant paediatric anaesthetist; a sister in charge; an operating department practitioner, a paediatric theatre assistant and a paediatric ward nurse.
- The consultant surgeon was a leader in his specialism field and was the education lead in their substantive post at an NHS paediatric hospital. The clinic manager was the assistant operational manager for theatre scheduling at the same hospital and the consultant anaesthetist was the clinical lead for anaesthesia at the same hospital. Other staff were leads in their respective departments also at the NHS paediatric hospital.
- The clinic manager was enrolled with the Institute of Leadership and Management.
- Staff told us that managers were very supportive and were always open to new ideas. They said that they felt well supported and there was good communication.
- The clinical lead ensured that a de-brief session was held for staff at the end of a surgical list to ensure that staff received information and feedback and had the opportunity to reflect on anything that could have been done better or improvements that could be made.
- Staff were confident that managers had the skills, knowledge and experience to carry out their duties and this was reflected in what we saw. We observed that managers encouraged supportive relationships among staff and had the capability to lead by example.
- Staff were clear about reporting lines and told us that leaders were honest, proactive and they felt comfortable in approaching them with any concerns.
- Leaders demonstrated shared values that encouraged pride and positivity in the organisation and focussed attention on the needs and experiences of patients.
- Managers held a monthly management meeting and this had recently been extended to the rest of the medical team so they could add their input without the need for more frequent separate team meetings.

Vision and strategy

Services for children and young people

- The service had a vision for what it wanted to achieve and workable plans to turn it into action, developed with involvement from staff and stakeholders.
- There were a set of values for the service that were displayed in the waiting area. These were: Pride; respect; empathy; compassion; consideration and dignity.
- There was no formal, written, vision and strategy for the service however, the clinical lead (consultant surgeon) was evidently focussed on providing the service to invest in the building whilst maintaining the same quality of service. They had identified other colleagues within their substantive place of work who were interested in utilising the facilities so that more surgical lists could be carried out there for patients who had health insurance or pay privately.
- It was proposed that two further urology surgeons and an orthopaedic surgeon would join the business. The orthopaedic surgeon would carry out surgical removal of ingrowing toenails in children.
- The provider used a systematic approach to continually improve the quality of its services and safeguarding high standards of care by creating an environment in which excellence in clinical care would flourish.
- The service had clear governance roles and responsibilities that were divided between the chief executive (the consultant surgeon) and the registered manager (the clinic manager).
- The chief executive undertook the roles of clinical lead; escalation and appeals officer for any complaints and safeguarding lead. The clinic manager undertook the roles of complaints manager; fire safety officer; health and safety officer; infection control lead and information governance lead.
- The provider used a quality management and corporate governance system to manage and record overall quality and compliance in a small business. This was an electronic risk-based compliance system.
- There were various modules in the system to aide in the effective governance of the business, for example; corporate governance; staff management; training and competency; health and safety; compliance monitoring and overall management.

Culture

- Managers promoted a positive culture that supported and valued staff, creating a sense of common purpose, based on shared values.
- We spoke to all the medical team who worked at the clinic. They described a very close-knit team who worked well together and were very proud to work at the clinic over and above their normal working week in an acute trust. They described the team as “one big happy family”.
- The service had a policy of paying all staff the same regardless of their seniority so all felt of equal importance to the running of the service.
- Staff said that they felt rewarded in their work and would be happy to take their own child there for treatment.
- Staff described a service and a team that was always open to new ideas and they did not let each other become complacent.
- The provider had a medical advisory committee made up of all the clinical staff and clinic manager. The committee met approximately every six months to discuss key governance areas, including incidents and practising privileges, infection prevention control, health and safety and key business decisions.
- The medical advisory committee meeting minutes were brief and did not reflect whether the meetings were effective.
- The provider managers, including the consultant anaesthetist met at least monthly to discuss key business agenda items, including the vision and strategy for the business.
- Policies were not as robust as they could be. For example, the safeguarding policy had evident omissions and the policies and procedures on the deteriorating patient did not contain specific pathways, for example, on asthma or hypoglycaemia.

Governance

Services for children and young people

- There was no named Level four safeguarding lead, either in the provider or the local authority, for staff to approach for more specialist advice when required

Managing risks, issues and performance

- The service identified risks and took actions to eliminate or reduce them but did not have a formal or effective system to do this and cope with the expected or unexpected.
- The service did not hold a formal risk register with risks identified and actions taken or planned to reduce the risks.
- Managers could describe the risks they had identified and explain what actions had been taken to minimise the risks but they had not been formally recorded on a risk register. We saw evidence that risks were being managed but the system for managing them could be improved for business continuity purposes and to identify trends.
- An example of a risk that had been identified and reduced was the risk that staff sickness or absence by a member of the medical team may mean that a surgical list may have to be cancelled at short notice. The risk had been reduced by the recruitment of three additional bank staff members who could cover at short notice in the event of regular team absences.
- Another example of an identified risk was medications that had been delivered on more than one occasion that were close to their expiry dates. The clinical lead had taken actions to ensure that the pharmaceutical supply company understood their medicine requirement needs and sent medication with longer expiry dates.
- Incident management and feedback systems were not robust to ensure information was communicated to each staff member and opportunities to learn from incidents.
- There was a limited audit programme in place. For example, audits were not carried out on pain relief, the WHO checklist, fasting times or hand hygiene.

Managing information

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

- Information was kept securely and maintained the confidentiality of patients. The service used an electronic patient records system with two layers of security access. Any patient identifiable information transported between sites was kept in a lockable folder and any patient or staff identifiable information on site was kept in a lockable fireproof cabinet.
- Patient records were scanned and linked quickly to the patient's record for each episode of care and paper records were then securely destroyed.

Engagement

- The service engaged well with patients and staff to plan and manage appropriate services.
- Staff reported that they had all been there from the opening of the clinic and had been part of putting the business together. They were involved in meetings about the running of the service and their input was encouraged.
- The service sought the views of patients on a number of subjects, such as the cleanliness of the facility, refreshments provided, information provided and how they had been treated by staff. All patients and their parents were asked to complete the patient feedback form before leaving the clinic.
- The service had received 100% positive feedback for all aspects of the service.

Learning, continuous improvement and innovation

- There was a commitment to improving services by learning from things went well and when they went wrong, promoting research and innovation.
- We saw that there was a clear commitment to expanding and improving the business whilst maintaining current levels of quality and care.
- The consultant surgeon was a leader in his field of speciality and was committed to using the best equipment and techniques to provide the best care to patients.
- We saw that the service was receptive to and took patient and staff feedback seriously to drive improvements.

Outstanding practice and areas for improvement

Areas for improvement

Action the provider SHOULD take to improve

- The provider should review the safeguarding policy so it reflects the “PREVENT” government strategy.
- The provider should ensure that the safeguarding policy covers information about female genital mutilation (FGM) and what to do if suspected or identified or if a clinician is asked to perform female genital mutilation.
- The safeguarding policy should include contact information in the relevant boxes in the event of staff needing to make a relevant referral or seek further advice from a level four or above trained person.
- The service should consider introducing relevant pathways to recognise the deteriorating patient and manage individual conditions causing deterioration in the patient, such as asthma or hypoglycaemia.
- The provider should introduce a clinical and non-clinical incident recording system to identify trends and record incidents formally to enable learning.
- The provider should make information more accessible to patients and carers who have information or communication needs relating to a disability impairment or a sensory loss in a way that they can read, receive or understand.
- The provider should introduce a formal risk register to record risks identified, actions taken and plans to reduce the risks.
- The provider should consider undertaking a wider range of clinical audits.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

This section is primarily information for the provider

Enforcement actions

Action we have told the provider to take

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