The Whiteley Clinic London

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?	Not sufficient evidence to rate
Are services caring?	Good
Are services responsive?	Good
Are services well-led?	Outstanding

Summary of findings

Letter from the Chief Inspector of Hospitals

The Whiteley Clinic London is operated by The Whiteley Clinic Ltd which is an organisation consisting of clinics in three locations across England. The Whiteley Clinic London was governed by and follows protocols of The Whiteley Clinic Ltd. The London clinic has no inpatient beds. Facilities include consultation rooms, treatment rooms, one operating theatre for endovenous or other surgery, and a second with radiological shielding approved for fluoroscopy, and scan room used for diagnostic screening.

We carried out a comprehensive inspection of The Whiteley Clinic London on 21st March 2017 as part of our national programme to inspect and rate all independent hospitals.

We inspected the following core service:

- outpatients and diagnostic imaging services (including surgery)

To get to the heart of patients' experiences of care and treatment, we ask the same five questions of all services: are they safe, effective, caring, responsive to people's needs, and well-led? Where we have a legal duty to do so we rate services' performance against each key question as outstanding, good, requires improvement or inadequate.

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

We rated this hospital as good overall.

Our key findings were as follows:

- Staff were aware of how to report incidents. Incidents and complaints were reviewed at the monthly clinical governance meeting. Processes were in place for investigating, reviewing and sharing learning from incidents.
- Standards of cleanliness and hygiene were high throughout the clinic. Equipment within the clinic was maintained and serviced appropriately, and medicines were stored securely.
- Staff were competent within their roles. Most staff within the clinic were up to date with their mandatory training. The clinic undertook timely inductions and appraisals, and staff had the appropriate skills to carry out their duties.
- All procedures and treatment at the clinic were based on research that had been ongoing since the opening of the Whiteley Clinic Ltd in 1999. NICE guidelines for the management of varicose veins (CG168) published in 2013 mirrored the policies and procedures already undertaken at the clinic.
- The clinic undertook regular patient audits. Research undertaken by the Whiteley Clinic Ltd demonstrated a high success rate in treating venous disease.
- All patient feedback that we received was positive. Patients said that they felt fully involved in their treatment. Staff regularly checked patients in relation to their comfort level.
- The service was flexible in responding to patient needs. Appointments were usually offered within three weeks. Alternative arrangements were made on the rare occasion that clinics were cancelled.
- The clinic and staff working there had a vision and drive to deliver evidence based and effective treatment for the management of varicose veins. The clinic demonstrated an ability to apply cutting edge research to clinical care and treatment, to deliver the best patient outcomes.
- The clinic used the Whiteley Protocol, a research based protocol used in the treatment of venous disease. All staff were trained in the Whiteley Protocol to ensure a consistent high standard of care.
- The senior management team were visible and approachable. There were high levels of engagement with staff through 'state of the nation' talks and annual academic days.

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.

Summary of findings

The hospital should:

Ensure all staff comply with the procedures and guidelines when disposing of sharps to reduce the risk of needlestick injuries.

Create a list of authorised staff and schedule a review for each patient group direction used at the clinic as recommended by NICE guidelines on patient group directions (MPG2)..

Ensure all response times to complaints are recorded so that the clinic can be assured that they are responding within the appropriate time frame.

Professor Sir Mike Richards
Chief Inspector of Hospitals

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Outpatients and diagnostic imaging	Good	The clinic demonstrated an ability to apply cutting edge research to clinical care and treatment to deliver the best patient outcomes. The leadership team were driven to continuously improve standards, and provide high quality care and the best results for their patients. The latest research demonstrated an 88% success rate in treating patients with varicose veins followed up over fifteen years. Staff were aware of how to report incidents. Processes were in place for investigating, reviewing and sharing learning from incidents. Standards of cleanliness and hygiene were high throughout the clinic. Infection control policies and procedures were in place to prevent the spread of infection. The clinic had processes to assess patient risk. Patients were able to contact a consultant outside of working hours if they had any medical concerns. All procedures and treatment were based on current research at the clinic. The NICE guidelines for the diagnosis and management of varicose veins (CG168) published in 2013 mirrored policies and procedures undertaken at the clinic. All patient feedback that we received was positive. Patients said that staff put them at ease and made them feel comfortable during their time at the clinic. The clinic usually offered an appointment within three weeks. Staff aimed to be flexible and, where available, offered an appointment at a different location if the patient wished to be seen earlier. The clinic used the Whiteley Protocol, a research based protocol used in the treatment of venous disease. All staff were trained in the Whiteley Protocol to ensure a consistent high standard of care. Staff told us, and we saw, that the leadership team were visible and approachable. Management had an open door policy and this enabled staff to raise concerns when necessary. The clinic used pelvic vein embolisation, a major advance in the treatment of venous disease.

Summary of findings

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Summary of this inspection

Background to The Whiteley Clinic London

The Whiteley Clinic London is operated by The Whiteley Clinic Ltd. The Whiteley Clinic Ltd. offers services from clinics in Guildford, London and Bristol, for patients with venous conditions. The head office is located in Guildford and the service in London opened in 2014. Being close to Bond Street tube station and the new crossrail terminal, the clinic is convenient to all patients coming in to London.

The London Clinic is approximately 3000 ft^2 and has consulting rooms, treatment rooms, one operating theatre for endovenous or other surgery and a second with radiological shielding (cadmium lined paint) approved for fluoroscopy. Use of a C-arm (a medical imaging device based on x-ray technology) enables the clinic to perform pelvic vein embolisation which has been one of the main advances in the treatment of venous disorders.

Regulated activities provided by the clinic are treatment of disease, disorder or injury, surgical procedures and diagnostic and screening procedures. These activities are provided for the treatment of vascular conditions on an outpatient basis.

Third party providers managed laser protection, occupational health, pathology, pharmacy and radiology protection.

This is the first inspection of this service by CQC at this location. We inspected the service on 21 March as an announced inspection.

The current registered manager at the clinic has been in post since June 2016.

Our inspection team

Our inspection team was led by:

Inspection Manager - Max Geraghty, CQC

The team included CQC inspectors, supported by specialist advisors including a surgery doctor and radiographer.

The inspection team was overseen by Nicola Wise Head of Hospital Inspection.

Why we carried out this inspection

We inspected this hospital as part of our national programme to inspect and rate all independent healthcare providers. We inspected outpatient and diagnostic services, which included surgery carried out as outpatients.

How we carried out this inspection

We reviewed a wide range of documents and data we requested from the provider. This included policies, minutes of meetings, staff records and results of surveys and audits. We placed comment boxes at the hospital prior to our inspection which enabled staff and patients to provide us with their views. We reviewed comment cards, which had been completed by patients. We carried out an announced inspection on the 21st March 2017.

Summary of this inspection

We interviewed the management team. We spoke with a range of staff, including medical staff, health care assistants, nurses, vascular technicians and administrative staff.

We also spoke with patients and relatives who were using the clinic.

We observed care in the outpatient and diagnostic imaging departments, in the minor operating theatres and reviewed patient records. We visited all the clinical areas at the clinic.

We would like to thank all staff, patients, carers and other stakeholders for sharing their views and experience of the quality of the care they received at The Whiteley Clinic London.

Information about The Whiteley Clinic London

Services offered at the hospital included outpatients and diagnostic imaging, surgery, radiology procedures and cosmetic surgery.

During our inspection we visited the minor operating theatre, radiology theatre, scan room, consultation and treatment room, waiting area and recovery area. We spoke with ten members of staff including managers, medical staff, nurses and reception staff. We spoke with seven patients and reviewed 18 'tell us about your care' comment cards that patients had completed prior to our visit. We looked at eight sets of patient records during the inspection.

Activity (October 2015 to September 2016)

In the reporting period October 2015 to September 2016, the hospital recorded 660 outpatient attendances all of which were funded through non-NHS means.

10 consultant doctors worked at the hospital under practising privileges. The hospital employed 4.3 FTE registered nursing staff and 0.6 FTE health care assistants.

Track record on safety

No never events

No serious injuries

No deaths

Seven clinical incidents in surgery and other services, all rated as 'no harm'.

No surgical site infections.

11 complaints received by the hospital

Services offered at the hospital

Treatment for:

Vascular conditions (including varicose veins, venous ulcers, thread veins, pelvic congestion syndrome, lymphoedema, deep vein thrombosis)

Hyperhidrosis

Cosmetic procedures

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

Staff were aware of how to report incidents. Processes were in place for investigating, reviewing and sharing learning from incidents.

Most staff within the clinic were up to date with their mandatory training.

Standards of cleanliness and hygiene were high throughout the clinic. Infection control policies and procedures were in place to prevent the spread of infection.

Equipment within the clinic was maintained and serviced appropriately. Records were kept for authorised use of the C arm and laser equipment. Medicines were stored securely within the clinic.

The clinic had processes to assess patient risk. Patients were able to contact a consultant outside of working hours if they had any medical concerns.

The service had enough staff with the appropriate skills and experience to provide care and treatment to patients at their level of need.

Are services effective?

Not sufficient evidence to rate

All procedures and treatment at the clinic were based on research that had been ongoing since the opening of the Whiteley Clinic Ltd in 1999. The NICE guidelines for the diagnosis and management of varicose veins (CG168) published in 2013 mirrored the policies and procedures already being undertaken at the clinic.

The clinic were carrying out a number of local audits. Staff strove for 100% compliance and when this was not achieved managers put an action plan in to place.

The clinic undertook regular patient audits that it compared with previous years and between Whiteley locations, to ensure that the standard of care did not drop.

The clinic undertook timely inductions and appraisals. Staff had the appropriate skills and knowledge to carry out their role.

Are services caring?

Good

All patient feedback that we received was positive. Patients said that staff put them at ease and made them feel comfortable during their time at the clinic.

Summary of this inspection

During procedures we observed staff distracting patients by having light-hearted conversation with them. This had been demonstrated as an effective method of keeping patients calm, and reducing their pain.

Patients were kept fully involved during their treatment at the clinic and given many opportunities to ask questions.

Are services responsive?

Good

The facilities and premises were appropriate for the services being delivered. Adequate seating and refreshments were available for patients waiting to be seen.

The clinic usually offered an appointment within three weeks. The clinic aimed to be flexible and, where available, offered an appointment at a different location if the patient wished to be seen earlier.

Clinics were rarely cancelled, and when this did occur an alternative Whiteley Clinic consultant attended the clinic to undertake all procedures the same day.

Managers tried to deal with any patient concerns before a formal complaint was made. All complaints, informal or not, were logged by the clinic.

Are services well-led?

Outstanding

The clinic and staff working there had a vision and drive to deliver evidence based and effective treatment for the management of varicose veins. The clinic demonstrated an ability to apply cutting edge research to clinical care and treatment to deliver the best patient outcomes.

The leadership team were driven to continuously improve standards, and provide high quality care and the best results for their patients. The latest research demonstrated an 88% success rate in treating patients with varicose veins followed up over fifteen years.

The clinic used the Whiteley Protocol, a research based protocol used in the treatment of venous disease. All staff were trained in the Whiteley Protocol to ensure a consistent high standard of care.

Staff told us, and we saw, that the leadership team were visible and approachable. Management had an open door policy and this enabled staff to raise concerns when necessary.

The clinic used pelvic vein embolisation, a major advance in the treatment of venous disease.

Summary of this inspection

There were high levels of engagement with staff. Senior staff shared information, developments and research with staff through 'state of the nation' talks and annual academic days.

The clinic had recently worked in collaboration with the University of Surrey to develop a range of medical devices used in the investigation and treatment of venous disease.

Good

Outpatients and diagnostic imaging

Safe	Good
Effective	Not sufficient evidence to rate
Caring	Good
Responsive	Good
Well-led	Outstanding

Are outpatients and diagnostic imaging services safe?

Good

Incidents

The service reported zero never events between October 2015 and September 2016. Never events are serious patient safety incidents that should not happen if healthcare providers follow national guidance on how to prevent them. 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.

In the reporting period October 2015 to September 2016, the service reported seven clinical incidents all of which resulted in 'no harm'. Six incidents occurred within surgery and one incident occurred within other services. Within the same reporting period, the service recorded one non-clinical incident that occurred within other services. There were no clinical or non-clinical incidents within the outpatients and diagnostic image service.

The clinic had an incident policy dated June 2016 that outlined the responsibility for all staff to report adverse events and near miss situations.

Staff we spoke with were familiar with the process of how to report an incident. Staff logged incidents using the incident report form on the clinic electronic system. The clinic manager was responsible for investigating all incidents and feeding back to individual staff members.

Incidents were stored on the shared drive and could only be accessed using a password by the practice manager. A hard copy was placed within an incident folder kept within the practice manager's office.

Managers reviewed incidents at the monthly clinical governance meetings. We reviewed minutes of the clinical governance meetings held in July and October 2016. Staff discussed incidents during the meetings and noted any resulting actions to reduce the risks. Actions taken and lessons learnt were sent out to staff in an email that was a 'mandatory read'. Staff were required to confirm that they had read and understood the information sent out. The clinical quality nurse tracked this process and sent out reminders to staff where necessary to ensure information had been read.

Information and feedback in relation to incidents was frequently shared across clinic locations as staff rotated around different clinics to ensure adequate staffing cover. Managers across all site locations were present at the clinical governance meetings, which meant that learning could take place throughout all the Whiteley clinics.

We looked at four incidents that staff had logged within the clinic. We saw that in each case details were included of what had happened and what actions the clinic had taken as a result. For example, one incident we looked at identified during a scan that a patient had a blood clot. Staff called the patient in to the clinic to be scanned a day later, and again a week later when the clot was seen to be completely resolved. The sonographer made the patient aware of what was happening and kept a report on the patient file. We saw evidence that staff discussed this during the clinical governance meeting.

Staff received training on the duty of candour during their induction. The duty of candour regulation requires providers of health services to be open and transparent when things go wrong. This includes some specific requirements, such as providing truthful information and an apology. We saw that the clinic apologised and explained what actions it was taking when responding to complaints.

The clinic had not reported any incidents of ionising radiation. Staff were aware of Ionising Radiation (Medical Exposure) Regulations protocols and followed the clinic's policy in relation to these.

Mandatory Training

Mandatory training at the clinic was comprehensive. Modules included health and safety, fire awareness, basic life support, moving and handling, safeguarding of vulnerable adults level two and child protection level two. Recommended courses included information governance, equality and diversity, and complaints handling and conflict management.

All administrative staff were up to date with their training. All nurses and health care assistants had completed their training apart from one member of staff who was booked on all relevant courses. One out of four sonographers had yet to complete the basic life support course and child protection, the remainder were fully compliant. Data for consultants showed that 12 out of 14 had completed basic life support and moving and handling, and 13 of the staff group had completed health and safety and child protection.

The Whiteley Clinic Ltd were introducing a new system for undertaking mandatory training whereby staff would attend all day courses contracted out to an external company, rather than solely undertaking e-learning. The day courses included practical elements including basic life support and manual handling.

The clinical quality nurse monitored mandatory training and recorded the training completed on a spreadsheet. Staff received reminder emails when they needed to complete their training.

Consultants and clinical practitioners normally completed training in their main place of work (which was usually an NHS hospital), or enrolled on courses privately. One consultant we spoke with confirmed that he received reminders from the clinical quality nurse when his mandatory training was due for renewal.

Safeguarding

The practice manager and executive chairman were the safeguarding leads at the clinic.

All new starters undertook safeguarding training during their induction period. The clinic had an up to date safeguarding policy that was a mandatory read for all staff.

Staff we spoke with had varying knowledge and understanding about safeguarding, although they were clear about the process involved should they have any concerns. Staff told us that they very rarely had to raise a safeguarding alert, but if this did occur, they would discuss it with their manager in the first instance.

The clinic did not treat people aged under 18. However, staff received training on child protection for the rare occasions that patients brought children in to the clinic. During these times clinic staff informed patients that they were responsible for their children and were required to supervise them.

There had been no safeguarding concerns raised at the clinic during the reporting period between October 2015 and September 2016.

Cleanliness, infection control and hygiene

We observed that standards of cleanliness and hygiene were high throughout the clinic. All treatment and consultation rooms were visibly clean. We saw that staff signed schedules for cleaning, that they were complete and up to date.

The clinic had an up to date infection control policy that they followed. This included information regarding staff responsibilities and provided guidance on hand hygiene, personal protection equipment, spillages and decontamination.

The service had an audit schedule which included an infection control audit that took place every six months. We saw the last audit that took place in October 2016 where the clinic achieved 99% compliance. Staff put an action plan in place for those areas which were non-compliant.

For example, a bucket was found to be stored on the floor of the dirty utility room, so an email was sent to the manager of the cleaners to remind them how to store the bucket appropriately.

Between October 2015 and September 2016 the clinic reported no surgical site infections.

Hand sanitisers were available throughout the clinic. Handwashing instructions were seen encouraging staff and visitors to clean their hands to prevent the spread of infection. We observed staff washing their hands at appropriate points of care.

Personal protective equipment including gloves and aprons were available and stored appropriately in consultation rooms for use during the treatment of patients.

Staff did not always safely dispose of needles during procedures. The clinic held guidelines on the safe use and disposal of sharps within their infection control policy. The guidelines stated that the person using the sharp was responsible for disposing of it at the point of use. During one procedure we observed in theatre, we saw that staff placed needles on to the equipment trolley rather than in to a needle board or disposing of them in a sharps bin. This had the potential of causing needle stick injuries.

The clinic had a contract with an external agency for the management of equipment that required decontamination.

An external agency was responsible for cleaning of non-clinical areas and waste management within the clinic The clinic managed waste materials appropriately. Staff kept waste within bins in a locked room. An external agency carried out collections three times a week, although additional collections could be requested if necessary.

Staff were aware of their responsibilities for ensuring cleanliness within the clinic and preventing the spread of infection. We were told that staff member treating the patient was also responsible for cleaning the area following the appointment. Following a procedure we saw that staff cleaned equipment and surfaces appropriately.

Furniture within the patient recovery area was easy to wipe down and we saw that staff cleaned it regularly.

The clinic used disposable curtains within the treatment rooms. Staff replaced curtains twice a year. The curtains we checked were within date and staff had changed them recently.

Environment and Equipment

The service contracted an external company to maintain the main areas of the clinic. This included maintenance for air conditioning, pipework, lighting and plumbing. Staff told us that the agency were very quick to respond to maintenance calls, normally within two hours, and were regularly undertaking work on other floors of the building so could be easily contacted.

The clinic had a service and maintenance schedule that detailed last service date and service renewal date. An external company maintained the alarm system, emergency lighting and fire extinguishers that were serviced every year. Documentation showed that the servicing was up to date.

The clinic mainly used single use equipment which was disposed of after its use. Following non-invasive procedures staff wiped down all skin touching equipment as part of the cleaning schedule.

Electrical tests on equipment were undertaken every two years, or when equipment was new. We saw the relevant documentation to confirm this.

A list of authorised operators for the C-arm (a medical imaging device based on x-ray technology) was available within the clinic. We saw the risk assessment report for the C-arm undertaken in October 2016 that indicated controls were in place to reduce risk and levels of radiation exposure.

We saw that the clinic had completed a radiation safety self-audit checklist in August 2016. Staff compiled a plan of actions for completion. These included implementation of a fault log book and ensuring the door of the sluice room closed completely.

Laser equipment used at the clinic was leased from an external company who undertook maintenance for it. We saw that service records were in place. A technical support team were available for clinic staff to contact should any difficulties arise. If there were any concerns in relation to how the laser was functioning, clinic staff labelled it 'out of order' and sent it for testing.

Good

Outpatients and diagnostic imaging

The lead nurse was the laser protection supervisor for all of the Whiteley clinics and trained all staff including consultants on how to use the lasers on an annual basis. Risk assessments were undertaken for use of the lasers. We saw a list of authorised operators, and that staff had signed to confirm that they had received their training and read the risk assessments.

The clinic had a laser protection advisor who was organised through an external company. We saw the laser protection advisor report that covered the period March to November 2016. Recommendations were made within the report but no problems were identified.

Laser record audits took place every six months. We saw the last audit which took place in July 2016 where the clinic achieved 99% compliance. The one action that arose from the audit concerned the laser operator not recording the area of the body being treated within the laser register. Managers reminded the relevant member of staff, and we saw evidence that the situation was discussed at the clinical governance meeting in August 2016.

Medicines management

Medicines were stored securely in lockable cupboards. Keys for the medicine cupboard were kept within the key cupboard. Any member of nursing staff could access them. The nursing staff signed the keys in and out to show when they were in use.

Staff recorded medicines in a drug log book that included details of batch number and expiry date, quantity, drug name and name of staff who signed for it. Nursing staff completed the medicine orders, which were signed by the consultant and sent to the pharmacy for delivery. Staff placed orders in advance when weekend clinics were held.

The nursing staff checked the expiry dates of medicines every month to ensure they were still safe to use. We checked eight different medicines being used at the clinic, all of which were within date. The clinic did not use any controlled drugs.

The clinic supplied and administered some medicines under patient group directions (PGDs). PGDs provide a legal framework that allows some registered health professionals to supply and/or administer specified medicines to a predefined group of patients without them having to see a prescriber.

The National Institute for Health and Care Excellence guidelines on patient group directions (MPG2) recommends that PGDs should be used by named and authorised health professionals and have a structured programme of review, updating and reauthorisation. We reviewed the three PGDs in use at the clinic and found there was not a list of authorised staff for each PGD and no review dates indicated. This was brought to the attention of senior staff within the clinic.

The lead nurse received and reported any medicine safety alerts, and shared the information with clinic staff via the intranet.

The clinic did not use paper prescriptions. Staff raised private prescriptions electronically for each individual patient, and a copy was sent to the lead nurse for information and to ensure an audit trail was in place.

Some medicines used at the clinic were kept inside a fridge that was kept locked. Nursing staff kept keys to access the fridge. We checked three medicines stored within the fridge which were all within their expiry date.

We checked documentation that showed the fridge temperature was checked by nursing staff daily Monday to Friday when the clinic was open. During the month of March there were three days when staff did not check the fridge temperature. Whilst staff were aware of the reasons for the omissions (due to nursing error and one occasion when the clinic was closed), the reasons had not been noted on the paperwork.

We reviewed the fridge policy that was up to date. The policy included details for staff should the fridge become too warm, how to access the local pharmacy to find out whether medicines could still be used, and identified an alternative fridge within the building that could be used to store medication.

Records

The clinic followed their records management policy dated June 2016. This included details on record keeping, access and disclosure, closure and transfer.

We saw that patient records were stored securely. The clinic kept files within a locked room that could only be accessed by nursing or reception staff.

Good

Outpatients and diagnostic imaging

Staff checked patient lists in advance to ensure patient records were in the correct location for any follow up outpatient appointments.

Data received by the clinic indicated that between July and September 2016, no patients had been seen without their patient notes. Staff confirmed that they could not remember a time when patients were seen without the relevant documentation being in place.

Patient notes were kept manually within files. Notes were loosely filed which meant there was the potential for confidential papers to drop out and be lost. The clinic were in the process of transferring patient notes on to an electronic system, which was hoped to be completed by the end of 2017 and would mean paper records would no longer be in use.

We looked at eight patient records and saw that in most cases notes were legible. The service kept comprehensive records with appropriate documentation including vascular assessments, World Health Organisation (WHO) checklists and consent forms that staff had correctly signed and dated.

There were occasions where staff needed to transfer patient records between clinics, for example if a patient was to be seen at the London clinic the following day. When this occurred, patient records were transferred within a briefcase with a combination lock in a private vehicle to ensure patient confidentiality. Patient notes could also be scanned and shared between clinics via a secure electronic account.

Clinical and medicine record audits were undertaken every six months. The last audit from October 2016 showed 93% compliance with the medical records policy. Actions that were drawn from the audit were often discussed at the clinical governance meetings with feedback and reminders circulated to staff.

Assessing and responding to patient risk

We saw thorough patient assessments taking place at the clinic. Before any treatment could take place the patient would attend a pre-operative consultation to ensure they could be treated safely and that there were no complications. During a consultation, we observed staff undertaking relevant patient assessment and taking details including, patient history, previous surgery, current medication and warfarin (anti-coagulant) administration.

We saw that staff completed WHO five steps to safer surgery checklists for all theatre cases. We observed a WHO surgery checklist being undertaken with a patient and a sonographer marking the appropriate veins of the body where the procedure would take place. However, on one occasion we saw that the sonographer did not check the identification of the patient.

Following their procedures patients waited in the recovery area for a short time before they were able to leave. Patients received call bells and the area was overlooked by the nursing station so that patients could attract a member of staff should they feel unwell.

Data received from the clinic indicated that 100% of their vascular patients were assessed for venous thromboembolism (VTE) during the initial consultation, with sonographers providing more in-depth information during the scan. Due to the nature of the clinic, patients were continuously assessed for VTE throughout the patient journey.

Between October 2015 and September 2016, the clinic reported 21 incidents of VTE or pulmonary embolism. Information from the clinic stated that the incidents of VTE were isolated incidents, secondary to foam sclerotherapy treatment, where no symptoms were found. These would not normally be detected at a hospital, however, the clinic identified them as part of their ongoing research in to patient outcomes where the treatment process was looked at in detail. Staff followed up all incidents by scanning the patient until resolution and anticoagulants administered when deemed necessary. Staff discussed all incidents at the clinical governance meetings and academic days.

Staff encouraged patients to walk straight after their procedure. This was considered good practice in reducing the likelihood of deep vein thrombosis.

Patients could contact the clinic out of hours if they had any concerns. The consultants were on rota to be contacted by patients when they required help. This normally involved providing advice to the patient over the telephone. If required a consultant could arrange an emergency appointment to see the patient the next day. If the consultant considered that immediate care was required the patient would be advised to go to their local NHS accident and emergency department, although we were told this was a rare occurrence.

The clinic had appointed a radiation protection supervisor who informed us that the radiation protection advisor was easily accessible by email or telephone should they need advice. There was also provision to contact them during periods of annual leave.

The service had clear protocols to check pregnancy status for females due to have procedures at the clinic. We saw evidence of a flow chart used by staff at the clinic to follow with female patients. Radiographers followed the guidance with patients to ascertain pregnancy status prior to any scans taking place.

If a staff member became pregnant this would be escalated to the radiation protection advisor and a risk assessment undertaken.

The clinic kept emergency resuscitation equipment within the patient recovery area, and close to the theatres. We checked medication within the anaphylactic kit that was up to date. An oxygen cylinder and defibrillator were also available for emergency situations and were checked regularly. Resuscitation guidance was seen in every room.

Staff received training in basic life support. If a patient deteriorated then first aid would be given, and if necessary a call to the emergency services made. The resuscitation and treatment of anaphylaxis policies dated June 2016 provided guidance for staff to follow in emergency situations.

Nursing staffing

The service co-ordinated nursing and administrative staff across the three clinic locations depending upon the service demands for that day. Staff were flexible in their roles and happy to move to a different location at short notice. Hotel accommodation and travel costs were provided to staff that were moved from their usual location to maintain comfort and safety.

The service did not use a staff acuity tool to plan staffing requirements. The practice manager and lead nurse looked at planned clinics and theatre lists on a weekly basis to plan the nursing workforce. As clinic lists were prone to change at the last minute nursing staff from the Guildford or Bristol clinics could be requested to work in London at short notice if required. The lead nurse and clinical quality nurse also supported within theatre when required.

We saw the staff rota, which managers planned a month in advance. This demonstrated safe staffing numbers and appropriate skill mix. Nursing staff were always present when patients attended the clinic, the ratio ranged between 1:1 and 1:4 depending on the treatment being offered.

There was one registered nurse (0.8 FTE) and one part time health care assistant working at the London clinic. Managers said that staff were flexible and would work extra hours on busier weeks and be given time in lieu during quieter periods. There were no nursing vacancies at the time of our inspection.

The clinic used two regular bank nurses when the service was busy. One member of bank staff was trained in pelvic vein embolisation and worked at the clinic one Saturday each month. All bank staff had their own log in details and were able to access new policies and procedures. Managers told us that bank staff were involved in clinic activity, and were invited to team meetings and clinic academic days.

As staff were required to be trained and work within the Whiteley Protocol which was specific to the clinic, the clinic did not use agency staff as they would not be familiar with the correct policies and procedures.

There was one vacant receptionist post and a second receptionist due to leave. One receptionist post had been recruited to and there was ongoing recruitment to the second post. The practice manager assisted with front of house duties to help cover the existing vacancy.

Managers recognised the recruitment of nursing staff and health care assistants as an area of challenge to the clinic. This was not only because of existing shortages, but ensuring staff with the dedication and commitment to the Whiteley Protocol were in post. The Whiteley Clinic Ltd had enrolled in the National Apprentice Scheme for training healthcare assistants and their first apprentice was working at one of the other clinic locations.

Medical staffing

Ten consultants worked at the clinic under practising privileges. Practising privileges were granted in consultation with the Medical Advisory Committee once they were satisfied that certain conditions had been met. Checks included references, disclosure and barring service checks and occupational health. The practising privileges were reviewed every two years.

The clinic had a handbook for consultants using practising privileges that set out the policy and procedures for

Good

Outpatients and diagnostic imaging

practitioners to follow. Consultants would be trained in the Whiteley Protocol often by the executive chairman, and would not be left to practise alone until it was considered that they were confident to work within the protocols of the clinic. As such specific knowledge and experience was required the clinic did not use locum doctors. If for any reason the consultant was unavailable for clinic then it would be cancelled, although we were informed this happened very rarely.

The clinic was open between 8 am and 6 pm. If a patient needed medical advice outside of these hours, staff provided them with a telephone number on which they could contact a consultant.

As treatments requiring radiation only took place in London the radiation protection supervisor travelled to this location from other clinic locations as required.

Major incident awareness and training

Staff were aware of evacuation procedures during a fire, and these were explained to us on our arrival. Fire awareness was included within the annual mandatory training for which all staff apart from one (who had been booked on the course) had completed. Fire extinguishers were seen at appropriate locations within the clinic and their annual service was up to date at the time of our inspection.

Are outpatients and diagnostic imaging services effective?

Not sufficient evidence to rate

Evidence-based care and treatment

Care and treatment at the clinic was delivered with a commitment to providing the best possible outcomes for patients with varicose veins. All procedures and treatment were based on research that had been ongoing since the opening of the Whiteley Clinic Ltd in 1999.

Venous disease was treated using the Whiteley Protocol that was developed from the research undertaken by the Whiteley Clinic Ltd, and was ever evolving as new data and information came to the fore. The protocol included the identification of the problem, treatment and prevention, and cosmetic treatment where required. All doctors at the clinic were trained in the Whiteley Protocol so that patients could expect the same standards of care regardless of who undertook their procedure.

The National Institute of Health and Social Care Excellence (NICE) guidelines for the diagnosis and management of varicose veins (CG168) were published in 2013. These mirrored the policies and procedures already being undertaken at the clinic, and those which staff had been practicing at the Whiteley Clinic Ltd since 1999.

The clinic shared research findings within the medical community both nationally and internationally. A week before our inspection an international conference had been held by the College of Phlebology attended by delegates from over 30 countries. During the conference, broadcasts of live procedures undertaken at the London clinic were shared with those in attendance.

The clinic had won a number of national and international prizes as a result of its ongoing research that demonstrated the effective use of the clinic's procedures.

All procedures undertaken at the clinic were research based. New ideas were encouraged, but would only be implemented when there was research to demonstrate they were effective.

A grant previously awarded by Innovate UK had enabled the clinic to develop a Knowledge Transfer Partnership with the University of Surrey to develop medical devices for use in the management and treatment of venous diseases.

Person centred care was paramount within the clinic. When a patient attended they would first have a consultation, and then be seen by a vascular scientist who would complete a scan. From this an individual treatment plan would be devised which would provide detail regarding correction and prevention in relation to that patient's condition.

The clinic were carrying out a number of local audits. These included: clinical and medical records; consent form; infection control; laser and theatre register. The clinic strove for 100% compliance and when this was not achieved managers put an action plan in to place. For example, in the laser registry audit in July 2016 compliance was 99%.

We saw documents to indicate that staff used diagnostic reference levels appropriately within the clinic.

Good

Outpatients and diagnostic imaging

Nutrition and hydration

As the clinic only used local anaesthetic during procedures patients were able to eat or drink up to the time of going in to theatre.

Refreshments including tea, coffee, water and individually wrapped biscuits were available within the reception area for patients to help themselves to free of charge. As patients attending the clinic were normally leaving within three hours, more substantial food was not available. If patients were hungry after a procedure, they were encouraged to go to the nearby shop to buy something to eat. This encouraged them to walk and reduce the risk of deep vein thrombosis.

Staff told us that nutritional advice was offered to patients with ulcers.

Pain relief

Procedures were carried out using local anaesthetic and therefore the patient's pain level could be assessed throughout and analgesia adjusted accordingly. Staff also used patient distraction techniques to help reduce the patient's discomfort during treatment. This involved staff talking to the patient during their procedure, which had been demonstrated through research as an effective way of reducing pain.

Patients were asked to self-assess their own pain by describing it on a scale from 'no pain' to 'very sore'. This was repeated during patient follow up visits so that they were able to see their own improvement or deterioration. Staff offered patients advice or appropriate medication to relieve their pain symptoms.

We saw staff advising patients to tell them if they found the procedure too painful so that they could stop and reassess the pain level and readjust the analgesia if necessary.

We observed staff checking back with patients regarding their comfort levels, particularly when they had been standing for a period of time during their scan.

Staff gave patients pain relieving medication upon discharge when required.

Patient outcomes

Patient audits were undertaken on patients from one year after attending the clinic up to fifteen years. The latest research from the Whiteley Clinic Ltd demonstrated an 88% success rate on treating varicose veins in patients followed up after fifteen years.

The clinic scanned and assessed patients at each appointment so that any improvements or deterioration in the patient could be seen.

The service sent out patient satisfaction surveys electronically to patients once they were discharged. The survey asked about treatment, consultant, experience, outcomes, whether they were happy and whether they would recommend the clinic.

The clinic recognised that longer term follow up on patients was required due to the potential of recurrence of varicose veins. The Whiteley Clinic Ltd had demonstrated through research that if veins were stripped through open surgery then the same veins recur in 23% of patients within one year and 83% of patients within five to eight years. Therefore, the patient satisfaction surveys became redundant unless repeated in the longer term.

To ensure the correct advice was being given to patients during the consenting period, regular patient audits were carried out by the Whiteley Clinic Ltd which included outcomes from the London clinic. A patient group fitting criteria of treatment type, age range, disease type and specific year were invited for a free scan and assessment. Research was undertaken from the outcomes, and results presented internally and when interesting shared at national or international meetings.

Research demonstrated an 85.7% success rate of treating venous reflux using pelvic vein embolisation over a six to eight year follow up period. We also saw healing rates of 85% of patients with venous leg ulcers following surgical intervention over a twelve year period.

The patient audit results were compared with previous years and between locations to ensure that the standard in care did not drop.

Few other clinics treating venous disease provided information on patient feedback so it was difficult to make comparisons. However, the Whiteley Clinic Ltd were involved with producing a venous registry with the College of Phlebology that would help produce comparison data in the future.

Good

Outpatients and diagnostic imaging

The clinic did not currently contribute data to the Private Health Information Network (PHIN) as they did not have inpatients. However, the clinic were having ongoing discussions with PHIN in relation to what information they may be able to contribute. Due to the specialised work undertaken at the clinic, they did not participate in national audits.

Competent staff

The clinical quality nurse undertook inductions with new staff that would involve a tour around the clinic, information provided on health and safety issues and infection control. Bank staff were involved in the same induction process.

Clinical staff were expected to complete competencies to demonstrate their ability to undertake tasks within the clinic. We saw detailed competence frameworks for procedures undertaken at the clinic. Initially new clinical staff shadowed other members of staff, gradually working their way through the competencies. Staff were never left on their own until they felt confident and their competencies had been signed off. There was no specific time-frame for the induction period as it was recognised that some staff required more training than others. A new member of staff we spoke with confirmed they had received a full induction that had been helpful with their introduction to the clinic and their role.

There was a three month probation period. If staff were not performing at the desired level then managers would discuss this with them, and where necessary more training would be offered and the probation period extended.

Managers completed appraisals with staff on an annual basis to support development. Between January and December 2016 all nursing and health care assistants at the clinic had received an appraisal, and this was confirmed by staff we spoke with. During the appraisal staff were able to set objectives and consider areas of development. Managers reviewed objectives at six months to track progress. One member of staff told us they had wanted to become knowledgeable in phlebotomy and had highlighted this during their appraisal. They explained that they had attended a training course and were developing their skills in taking blood whilst being supervised by another member of staff.

The service had detailed new starter training and a 'core of knowledge' that was mandatory training for all staff working with lasers.

There were opportunities for additional training where required and deemed appropriate. Managers told us that staff had their training needs assessed and were able to access external courses. For example, one member of staff had been supported to undertake a maths degree with funding agreed.

Staff rotated around the three clinic locations which gave them opportunity to learn new skills and prevented staff from becoming disengaged with their role.

The lead for infection prevention and control attended training to keep up to date with knowledge in this area.

Bank staff were trained to the same standards as permanent staff with the understanding that they would be able to work within the Whiteley Protocol.

Self-development and growth was encouraged within the clinic. The intranet held a wide amount of information that all staff could access including lectures, procedures that had been recorded and uploaded, policies and learning resources.

Managers held annual academic days to which all members of staff were invited. This was a day where information, new developments and research were shared. Staff had an opportunity to present academic papers.

Interventional radiologists and radiographers used the C-arm whilst undertaking procedures. We saw a list of authorised staff who had undertaken the relevant training to use the equipment.

Multidisciplinary working

The clinic team comprised of consultants, radiographers, sonographers (vascular technicians), nursing and health care assistants. All professionals worked together throughout all stages of treatment to provide effective care. During an initial appointment at the clinic a patient would first be seen by a consultant, and would then have a scan undertaken by a sonographer.

We saw that letters were sent to GPs (when consent was given by the patient) to inform them of diagnosis and any

ongoing treatment. Staff told us they had regular contact with district nurses to advise them regarding specific care requirements once the patient was discharged including dressing changes.

All interventional procedures were undertaken with a consultant and a vascular technician present. No one worked in isolation within the clinic.

Seven day services

The clinic was open Monday to Friday between 8 am and 6 pm, although it would remain open longer if required due to patient need. Consultations and scans were offered on Monday evenings. The clinic opened one Saturday each month when there was additional demand for pelvic vein embolisation.

An emergency telephone line was available to patients out of hours. Consultants covered this on a rota basis. If necessary an emergency appointment would be made for the following day. When a patient required urgent care at the weekend a consultant would review them at the clinic or, where this was not possible, refer them to their nearest accident and emergency.

Access to information

Information was sent to GPs stating intention to treat after consent was provided by the patient. Staff informed us that letters were normally dictated and typed on the date the patient was seen in the clinic.

Consultants wrote within patient records that were stored securely at the clinic. Patient notes were not taken off site unless being transferred to another Whiteley clinic, at which times they were moved within a locked briefcase in a private vehicle.

If information from a patient's record was urgently required from a different clinic location, staff could scan it via a secure account on the same day.

Consent

We saw the use of a single consent form that documented consent for several procedures that could take place over time. This enabled documentation of consent to be found in one place and avoided the use of multiple forms.

Patients' questions and expectations in relation to their procedures were managed during their initial consultations. After their initial consultation patients would make an informed decision as to whether they wanted to go ahead with the procedure, and would telephone the clinic to make an appointment if they wished to proceed. Detailed information including risks and benefits were given to patients on the day of procedure when consent was taken.

The clinical quality nurse completed audits on consent forms every six months. The audit checked for patient identification, agreed treatment, full explanation of any complications that could occur, signing and dating of the form by the patient and clinician. We saw the last audit from October 2016 that showed 97% compliance.

Staff were aware of ensuring patients had mental capacity before consenting to treatment. We were told that patients lacking capacity were rarely seen at the clinic, however if patients displayed any signs of confusion then the procedure would be cancelled or postponed. Mental capacity was part of the mandatory safeguarding training. The clinic had a mental capacity act and deprivation of liberty policy that stated that should a patient appear to lack capacity at any time, staff should report this to the practice manager/lead clinician who would take appropriate action.

Are outpatients and diagnostic imaging services caring?

Good

Compassionate care

Staff were passionate about providing patients with a positive experience during their attendance at the clinic along with a high standard of care.

During our inspection we spoke with seven patients. All feedback we received about the clinic was positive, there were no negative comments.

Patients we spoke with said that staff treated them with dignity and respect. They felt relaxed when entering the clinic as they were greeted pleasantly by staff.

One patient told us that they heard the clinic had an "excellent reputation", and they did not think that anything could have been done to improve their experience. Another

said that they felt "very relaxed and confident" about having their procedures at the clinic. This was because staff put them at ease and made them feel comfortable during their time at the clinic.

During procedures we observed staff distracting patients by having light-hearted conversation with them. Staff told us they had tried different techniques to comfort patients in theatre. They had found that interacting with patients through talking or physical interaction such as reflexology had been the most effective way of keeping patients calm and reducing their pain. Staff explained that research had demonstrated patient interaction to be effective practice.

We received 18 patient comment cards all of which contained positive feedback. Comments included "Staff are pleasant and efficient.", "the staff were very caring and I was treated with the utmost dignity and respect," and "the environment is clean, safe and hygienic." One patient stated that they had recommended the clinic to friends.

Data from the most recent patient satisfaction survey showed that out of 45 respondents, 95% rated their overall treatment at the clinic as excellent, very good or good, and 95% were very likely or likely to recommend the clinic to a friend or relative.

Understanding and involvement of patients and those close to them

We observed good rapport between medical staff and patients. Staff said that as many patients attended the clinic on several occasions they were able to get to know them. This helped when assessing conditions as they felt patients would be more open to discussing their symptoms and any concerns.

During an initial consultation we saw staff clearly explaining what would happen during the patient's examination and how the local anaesthetic would be administered. During procedures we observed staff keeping patients fully informed of what was happening.

Patients were given opportunities to ask questions at all stages of their care. During a consultation we observed a patient being asked if she had any questions. As she was unable to think of any to ask at the time, she was given a pen and some paper to write down any questions she may have before going in for her scan.

Staff took time to explain fully how to use the compression bandages, stockings and underwear. We observed staff sensitively providing advice on how to maintain hygiene whilst using the compression underwear.

Patients were made aware of treatment costs before the commencement of any treatment. Staff communicated fees for initial consultation to the patient at the time they booked the appointment. Fees for treatments were sent to patients following their consultation. One patient told us that treatment costs were clear and staff wrote them down, rather than giving them verbally, which provided more privacy to the patient. The clinic recommended an external 0% finance company which allowed patients to stagger payment for treatment where necessary.

Patients we spoke with knew how to raise any concerns and said they would feel comfortable in doing so.

We observed a patient being given advice in relation to caring for their ulcer and clear instructions on how to change dressings at home.

Confidentiality was discussed with new members of staff during their induction. Patient information was kept secure and information was not shared with others unless permission had been granted by the patient. However, on one occasion we observed that the computer at the nurse's station was left unlocked without a member of staff being in attendance. This had potential for a breach in confidentiality and data protection to occur.

Emotional support

We observed staff giving patients comprehensive information before their procedures so they could make informed decisions whether to go ahead with the treatment.

Clinic staff offered the presence of a chaperone to patients during examinations. The clinic had a chaperone policy for staff to follow, and chaperone information was available within the patient waiting area.

Where patients were in pain or feeling anxious they were given stress balls to squeeze. Staff told us that they provided stress balls to patients when it was felt necessary, but otherwise kept them out of sight. This had been implemented following feedback from a patient that seeing the stress balls had raised her feeling of anxiety about the procedure and the anticipation that she would experience pain.

Good

Outpatients and diagnostic imaging

Patients felt reassured that as well as their conditions being treated, the clinic were committed to finding out and treating any underlying causes for their symptoms.

Patients told us the after care at the clinic was good. Patients were provided with a helpline for any urgent medical concerns. Emergency appointments could be booked the following day where necessary.

Are outpatients and diagnostic imaging services responsive?

Good

Service planning and delivery to meet the needs of local people

The facilities and premises were appropriate for the services being delivered.

The waiting area had adequate facilities for patients attending the clinic. Sufficient chairs were available for people waiting to be seen. The environment was calm and quiet. A variety of magazines were available for patients whilst they waited. A television was on for patient entertainment, but kept to a minimum volume so as not to disturb other patients and visitors.

A patient information folder was available for patients to peruse which contained newsletters, information about the clinic including its statement of purpose, patient pathway and details on pioneering venous surgery, research, information on chaperones, patient guide to making a complaint and the patient satisfaction survey.

The clinic was within easy walking distance of public transport.

Two changing rooms were available for patients to get undressed. Belongings could be placed in to secure cabinets. Staff provided patients with a bag that contained disposable underwear and a dressing gown to change in to, clean dressings and a contact card. Patients were given the bag along with any relevant documentation so they could bring it to follow up appointments with them.

Meeting people's individual needs

The clinic had access and toilet facilities for wheelchair users. An induction loop was available for patients with hearing aids.

Patients with dementia or who had a learning disability would be identified during the initial contact with the clinic. Staff asked the patient what support they needed when they visited the clinic and encouraged them to bring a carer with them. Staff told us that patients with a cognitive impairment were rarely seen at the clinic and when there were concerns around capacity to consent then treatment would not go ahead.

For patients whose first language was not English the clinic were able to provide a medical interpreter from a local translation company. We were told that the majority of patients attending the clinic were able to speak English. Staff we spoke with said that sometimes when there were language difficulties relatives would be used to translate information, which is not recommended as good practice.

Information leaflets, including a price list and explanation of some of the procedures carried out at the clinic, were available. The clinic would provide literature in an alternative format such as large print if required. Information within the clinic was not provided in any other languages than English, but the clinic would provide an interpreter to read literature to the patient if this was needed.

Patients were provided with disposable underwear to change in to during their procedure. This had recently been upgraded in quality and different sizes introduced following a staff suggestion at another Whiteley clinic. Due to its popularity, managers had introduced the idea throughout all the clinics.

Access and flow

Patients could refer themselves to the clinic via the website or by telephone, or alternatively be referred by their GP.

A self-diagnosis page was available on the website so that patients could assess, diagnose and begin to understand their condition before contacting the clinic to make further enquiries.

Appointments were usually offered within three weeks of the referral. The clinic aimed to be flexible by offering choice of appointment, location and consultant. It was sometimes possible for a patient to be seen quicker if they were willing to go to another clinic location. One patient we spoke with had booked an appointment with the London clinic, as this had been quicker than waiting for an

appointment at the clinic that was closer to where they lived. The patient was happy to have been offered this choice and unconcerned by the extra travel time to the clinic.

Clinic appointments took place between 8.30 am and 6 pm Monday to Friday. Consultations and diagnostic scans were also offered on Monday evenings. Pelvic vein embolisation procedures were occasionally performed on a Saturday when the demand existed.

Following an initial consultation followed by a diagnostic scan, an individual care plan would be provided for the patient. This meant that care was person centred and treatment was individually tailored to that patient. A consultant would explain the results of the scan and recommended treatment. Patients were provided with information regarding the procedure which they could take away to consider. If patients wanted to go ahead with the recommended treatment they could telephone to make a further appointment. Times between initial appointment and treatment varied as it was dependent upon the patient's timescale for making the decision.

Where a multiple number of procedures were required they could be broken down in to manageable sessions. Under certain circumstances, and following a risk assessment, two appointments could be offered, one at the beginning and one at the end of the day.

Patients that we spoke with told us they were seen on time whilst at the clinic.

Between November 2016 and April 2017 one consultant had to cancel their clinic due to sickness. Another Whiteley Clinic consultant was able to attend the clinic on that day that all nine patients attending were happy to see. The three procedures and six follow up/consultations therefore went ahead as scheduled.

Learning from complaints and concerns

The clinic received 11 complaints within the reporting period October 2015 and September 2016. No complaints were referred to the Independent Healthcare Sector Complaints Adjudication Service (ISCAS).

The clinic recorded complaints electronically. Staff kept a complaints log for all the Whiteley clinics that could be accessed by any of the three practice managers. This enabled sharing of information and actions taken across all three locations. Correspondence to patients regarding complaints was kept on the patient record.

The practice manager had the responsibility to deal with complaints. If a verbal complaint was made, the manager would attend to this and try and resolve it to the patient's satisfaction before a formal complaint was made. This would be entered on to the complaints log and within the patient's notes. All complaints, whether formal or not were logged and reviewed at management level.

Complaints were also received through the patient satisfaction survey. The practice manager would investigate and log the concern. If a medical complaint was received this would be escalated to the consultant for a response.

The clinic's complaints policy set out a response time of twenty days for complaints received at the clinic. Managers told us that staff normally tried to work within this timeframe, and where more investigation was required, would keep the patient informed.

We reviewed four complaints at the clinic. We saw that date of the complaint, nature of the concern, action taken to resolve the complaint and any changes made to policies/ procedures were logged. However, we were not always able to ascertain what date staff had responded to the complaint. This was not clear by looking at the complaints grid or the patient records. We could not be assured therefore that the clinic was always responding within the twenty day timeframe.

Senior managers discussed complaints every month at the clinical governance meetings. During the meeting it was sometimes agreed that changes should be made to protocols or procedures as a result of a complaint made. For example, the clinic had received a complaint stating that they had not been advised about the amount of pain they should expect during and after a procedure. Following discussions at the clinical governance meeting the follow up period for patients was changed from six to four weeks and a patient information leaflet was developed to be given to patients at the consultation stage providing advice in relation to pain.

Details of how to complain were found within the patient guide kept in the waiting area near reception. These could also be found on the website.

Good

Outpatients and diagnostic imaging

Are outpatients and diagnostic imaging services well-led?

Outstanding ☆

Leadership and culture of service

The leadership team were driven to continuously improve standards, and provide high quality care and the best results for their patients. This was done through proactive research where good outcomes were embedded in to clinical practice.

Nursing and health care assistants reported to the lead nurse at the clinic, and sonographers reported to the chief sonographer. The lead nurse, clinical quality nurse and chief sonographer reported to the practice manager. The senior leadership team reported to the executive chairman and the directors of the board.

The Medical Advisory Committee (MAC) meetings included the executive chairman and a senior consultant. External members attendance was requested if something 'unusual' occurred. The MAC was currently incorporated into the clinical governance meetings.

There was a collaborative approach to support staff with the objective of delivering high quality care. Managers held monthly meetings to discuss the operational running of the clinics. As the practice manager from each Whiteley clinic was present good practice from each site could be shared.

The relatively flat management structure encouraged openness and transparency within the clinic. Staff told us, and we saw, that the leadership team were visible and approachable. Managers had an open door policy and this enabled staff to raise concerns when necessary. The executive chairman, and founder of the Whiteley Clinic Ltd, was also a consultant vascular surgeon. He attended the clinic on a regular basis, and undertook procedures with consultants, nurses and other frontline staff present.

Several staff worked at multiple sites across the Whiteley clinics, although there was a specific practice manager for the London clinic who was always present except when attending meetings or training.

Managers told us they felt it was useful and important to travel between the clinics to speak to the nursing staff and communicate face to face rather than over the telephone. This offered staff better opportunity to discuss any pertinent issues.

Medical and nursing staff told us they were inspired by the leadership at the clinic, and their commitment to deliver a high standard of care. The focus on patient wellbeing and quality care was what encouraged many staff to continue working at the clinic.

Staff meetings at the London clinic were held monthly. However, senior staff told us they had been unable to hold a team meeting for the previous two months. This was due to the loss of reception staff that had resulted in the practice manager taking on more administrative duties. Team meeting minutes were circulated to staff following the meeting.

The practice manager was taking on extra duties to help cover the vacant receptionist post. She explained that managers at the other two locations helped her fulfil work during this busy period.

Vision and Strategy

The clinic put their clinical service, supported with research, development and teaching at the heart of everything, they did.

The vision of the clinic was to provide a high quality care for patients with varicose veins and venous disease. It aimed to achieve this by researching and offering the latest techniques that were proven to work within venous disease, whilst providing the services in a safe and comforting environment by educated and caring staff. Staff that we spoke with understood and shared this vision.

The clinic aimed to be at the forefront of all developments in the management of venous disorders and to teach and share their knowledge with other doctors, nurses and all professionals involved in treating venous disease.

There was an emphasis on finding any underlying causes of the condition, as well as treating the patients for their symptoms, with the aim of reducing recurrence in the future. The clinic was a leader within this field, and demonstrating through patient audit that a condition once thought incurable could now be treated effectively to reduce recurrence in the long term.

Good

Outpatients and diagnostic imaging

There was a proactive approach to seeking out and delivering effective models of treatment. The service delivered patient care in line with research and evidence of what worked. The senior management welcomed new ideas and ways forward, but required these to be based on research and evidence of successful outcomes for patients before they became embedded in to practice.

One consultant told us that the clinic was focused on obtaining the best patient outcomes. The aim was to move forward with patient treatment, and not about making profit.

Governance, risk management and quality measurement

The governance framework ensured an effective organisation structure which supported the safe delivery of service. It responded to matters of risk in a consistent and timely manner minimising the likelihood of risk across all business areas.

There was a robust system of governance. Clinical governance meetings were held monthly, attended by the executive chairman, practice managers, clinical quality nurse, lead nurse, finance manager, IT manager and senior consultant. We viewed minutes of the clinical governance meetings from October and November 2016 where we saw that staff discussed incidents, patient complaints, protocol updates and positive feedback.

The leadership team addressed risks proactively. Managers told us that concerns or risks would be discussed as soon as they were raised, and did not wait for the clinical governance meeting to highlight them. When deemed necessary an additional clinical governance meeting would be held to discuss any pertinent incidents or complaints.

Any lessons learnt, actions or changes to procedures were discussed during the clinical governance meetings. Minutes of the meeting were sent round to staff as a 'mandatory read' ensuring that staff were kept up to date with the latest developments within the clinic. Staff who had not read the information were sent a reminder.

Risk assessment was a continuous process at the clinic. The service carried out risk assessments when situations of concern or incidents arose. An investigation would follow with actions put in to place to reduce the risk of the incident happening again. Formal risk assessments were also carried out for example for the control of substances hazardous to health (COSHH). We saw that these were documented and kept within the clinic risk assessment file.

We saw the health and safety risk register which identified risks at the clinic, potential consequences, risk likelihood, impact and rating and what actions were being taken to mitigate the risk. For example, a contract was in place with an external company for checks to be carried out on the water to reduce the likelihood of a legionnaire outbreak.

Public engagement and staff engagement

The clinic engaged with the public and staff in a number of ways. The leadership team welcomed both positive and negative feedback from patients, viewing it as a way of driving forward improvement within the service. Staff encouraged patients to leave comments and feedback at any time during their care verbally, by telephone or in writing. Patients could speak to any members of staff who would bring any significant issues to the attention of the practice manager. The clinic also sent out electronic patient satisfaction surveys to patients following their attendance at the clinic. Clinical governance meetings included discussions on positive and negative feedback from patients and consideration given to improvements that could be made.

Patients could leave feedback within a comments book placed within the waiting room. We saw one comment left in January 2017 that noted good interaction between the executive chairman and frontline staff at the clinic. Prior to that no comments had been entered since July 2015. A comments/suggestion box was also available to patients. Managers informed us this was emptied on a regular basis and discussed at the clinical governance meetings.

There were high levels of engagement with staff. The executive chairman shared information, developments and research with staff through 'state of the nation' talks using its video conferencing facilities. These talks provided a platform for staff to raise any ideas or concerns with senior management.

The clinic held an annual academic day for all staff to attend. This gave an opportunity for staff to come together and hear external speakers, as well as learn about the latest developments within the clinic.

Good

Outpatients and diagnostic imaging

Staff told us they had received support to develop their careers further. We saw staff had attended a variety of external training courses, supported by their managers.

Exit interviews were undertaken with staff that left to find out the reasons why people were not staying. Any pertinent issues or recurring themes were discussed by senior management with the aim of retaining staff in the future.

Staff supported students wishing to do work experience at the clinic. This allowed staff members to impart the knowledge that they had gained whilst working at the clinic and encourage future generations of doctors and nursing staff wishing to pursue a scientific career, or who had an interest in venous disease. For students who wished to gain more knowledge and experience the clinic held summer research fellowships.

The clinic held open days encouraging members of the local community to find out more about the clinic. A complimentary ten minute consultation and scan was included.

The founder of the Whiteley Clinic Ltd had also established the Leg Ulcer Charity that provided information and support for those suffering with leg ulcers.

Innovation, sustainability and improvement

The clinic and staff working there had a vision and drive to deliver evidence based and effective treatment for the management of varicose veins. The clinic demonstrated an ability to apply cutting edge research to clinical care and treatment to deliver the best patient outcomes.

The clinic used the Whiteley Protocol, a research based protocol used in the treatment of venous disease. The Whiteley Clinic Ltd had its own research, development and teaching team that was unique within the venous medical profession. All members of staff throughout the Whiteley Clinic locations were trained in the protocol which meant treatment was consistently delivered to a high standard, and that patients' questions could be answered appropriately at all stages throughout the patient pathway.

The clinic offered a walk in, walk out service using local anaesthetic which meant that patients could return to their normal working lives the following day.

One of the major advances in the treatment of venous diseases was the research in to and use of pelvic vein embolisation. This procedure was uniquely performed at the London clinic by two specialised interventional radiologists. Staff from the research centre at the head office regularly visited the London clinic to collate data and co-ordinate research in relation to this procedure.

The clinic had recently been awarded a grant from Innovate UK. Knowledge Transfer Partnerships (KTP) is a UK-wide program that has been helping businesses for the past 40 years to improve their competitiveness and productivity through the better use of knowledge, technology and skills within the UK knowledge base. This was administered through the clinic's head office and staff at the London clinic were involved where appropriate.

The KTP led to the clinic working in collaboration with the University of Surrey to develop a new range of medical devices used in the investigation and treatment of venous diseases.

By continually assessing and researching their own procedures and practice the clinic were able to develop an effective method of managing varicose veins. Findings were shared nationally and internationally across the medical community.

The Whiteley Clinic Ltd regularly performed patient audits by inviting a group of patients from all locations including the London clinic, to return for a free scan and assessment. The results of their findings were published. We saw one published article, which had followed patients up five to eight years after their procedure. The latest research undertaken by the Whiteley Clinic Ltd had demonstrated an 88% success rate in patients followed up over fifteen years. Through this the clinic were able to demonstrate low rates of recurrence of varicose veins, a condition once considered incurable.

Outstanding practice and areas for improvement

Outstanding practice

There was an emphasis on finding any underlying causes of varicose veins, as well as treating the patients for their symptoms, with the aim of reducing recurrence in the future. The clinic was a leader within this field, and demonstrating through patient audit that a condition once thought incurable could now be treated effectively to reduce recurrence in the long term.

The service delivered patient care in line with research and evidence of what worked. The senior management welcomed new ideas and ways forward, but required these to be based on research and evidence of successful outcomes for patients.

The clinic used the Whiteley Protocol, a research based protocol used in the treatment of venous disease. The Whiteley Clinic Ltd had its own research, development and teaching team that was unique in the treatment of venous disorders. All members of staff throughout the Whiteley clinic locations were trained in the protocol which meant that patients' questions and concerns could be answered appropriately at all stages throughout the patient pathway.

A grant previously awarded by Innovate UK had enabled the clinic to develop a Knowledge Transfer Partnership with the University of Surrey to develop medical devices for use in the management and treatment of venous diseases.

Areas for improvement

Action the provider SHOULD take to improve

Ensure all staff comply with the procedures and guidelines when disposing of sharps to reduce the risk of needlestick injuries.

Create a list of authorised staff and schedule a review for each patient group direction used at the clinic as recommended by NICE guidelines on patient group directions (MPG2).

Ensure all response times to complaints are recorded so that the clinic can be assured that they are responding within the appropriate time frame.