The Private Clinic of Harley Street Limited

The Private Clinic Limited - Leeds

Inspection report

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

Ratings

Overall rating for this location	Inadequate
Are services safe?	Inadequate
Are services effective?	Requires Improvement
Are services caring?	Insufficient evidence to rate
Are services responsive to people's needs?	Good
Are services well-led?	Inadequate

Summary of findings

Overall summary

This location has not been inspected before. We rated it as inadequate because:

- The service did not provide consistently safe care. Staff did not consistently assess the risks to patients and act upon risk assessments. Staff did not follow all procedures to control and manage the risk of infection or to record consent appropriately. Staff did not keep consistently good care records or use effective systems to manage medicines appropriately. The service did not learn lessons from incidents.
- Staff did not carry out effective audits of the environment or clinical practice.
- The service did not take account of all patients' individual needs.
- The service was not consistently well-led. Leaders did not use effective systems to run services. Staff were not always clear about their roles and accountabilities. Managers did not operate governance systems to identify, manage and mitigate risks to the health, safety and welfare of patients.

However:

- The service had enough staff to care for patients. Staff had training in key skills, and understood how to protect patients from abuse,
- Staff provided good care and treatment, gave patients enough to eat and drink, and pain relief when they needed it.
- Managers monitored the effectiveness of the service and made sure staff were competent. Staff advised patients on how to lead healthier lives, supported them to make decisions about their care, and had access to good information. Key services were available five days a week.
- The service planned care to meet the needs of local people and made it easy for people to give feedback. People did not have to wait too long for treatment.
- Managers used reliable information systems. Staff understood the service's vision and values, and how to apply them in their work. Staff felt respected, supported and valued. They were focused on the needs of the business and of patients receiving care
- The service engaged well with patients to plan and manage services and all staff were committed to improving services continually.

Following our inspection, we served the provider a letter of intent which told the provider CQC were considering using urgent enforcement powers because our inspection had identified concerns which put people who use services at the risk of harm. The provider was offered the opportunity to put forward documentary evidence to provide assurance that the risks identified had already been removed or were immediately being removed. The provider responded with assurance that some but not all of the concerns had been immediately addressed and so we served the provider a Warning Notice under Section 29 of the Health and Social Care Act 2008. The warning notice told the provider they were in breach of Regulation 17 and gave the provider a timescale to make improvements to achieve compliance. The principles we use when rating providers require CQC to reflect enforcement action in our ratings. The warning notice identified concerns in the safe and well-led domain. This means that the warning notice we served has limited the rating for safe and well-led to inadequate.

We will undertake further activity to check on the action the provider has taken.

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Surgery	Inadequate	

Summary of findings

Contents

Summary of this inspection

Background to The Private Clinic Limited - Leeds

The Private Clinic Limited – Leeds is operated by The Private Clinic of Harley Street Limited and is registered to provide care and treatment for people requiring cosmetic surgery procedures on a day case basis.

The provider is registered to provide the following regulated activities:

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

The clinic has a manager registered with CQC.

The clinic provides cosmetic surgery for privately funded patients over the age of 18. Procedures are carried out under local anaesthetic and conscious sedation to private patients from Leeds and the surrounding areas. Patients also travel further distances to use the service. The service also provides cosmetic surgery consultations for procedures under general anaesthetic to be carried out at another of the provider's registered locations.

Facilities within the hospital include a procedure room with a one-bedded recovery room, a hair transplant procedure room, two treatment rooms, two consulting rooms and a nurse consulting room. The main cosmetic services provided are liposuction, removal of varicose veins including sclerotherapy, and hair transplantation.

We carried out an unannounced inspection on 9 March 2022 using our comprehensive inspection methodology. This was the first time the service has been inspected.

How we carried out this inspection

During the inspection visit, the inspection team:

- visited consultation rooms, procedure rooms, and treatment rooms, and looked at the safety and quality of the environment. On the day of the inspection there were no consultations or procedures being carried out, so we were unable to speak to patients or observe how staff were caring for them.
- spoke with the registered manager who was the clinic lead nurse, spoke with three other members of staff including an administrator, the clinic manager and a consultant.
- reviewed 12 patient care and treatment records and looked at a range of policies, procedures and other documents relating to the running of the service.

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

Areas for improvement

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

Summary of this inspection

Action the service MUST take to improve:

- The service must ensure there are effective systems to make sure criteria is consistently followed regarding pre-operative risk assessment and the suitability for service users to proceed with surgical intervention. Regulation 12 (1) (2) (a) (b)
- The service must ensure there are effective safety checks in place for consumables throughout the clinic. Regulation 12 (1) (2) (a) (b)
- The service must ensure the design, maintenance and use of facilities, premises and equipment are suitable for its purpose. Regulation 12 (1) (2) (d)
- The service must ensure that risk registers are kept up to date and that they identify all risks to staff and patients. Regulation 12 (1) (2) (a) (b)
- The service must ensure that sufficient resuscitation equipment is available to staff in all patient care areas within the service. Regulation 12 (1) (2) (e)
- The service must ensure that emergency items such as the anaphylaxis kit are readily available to staff and service users receiving treatment in all areas in the event of anaphylaxis event. Regulation 12 (1) (2) (e)
- The service must ensure there is an effective system to separate clean and dirty utility areas and equipment. Regulation 15 (1) (a) (c) (d) (f)
- The service must ensure there is an effective system to ensure the safe use of the freezer. Regulation 15 (1) (a) (c) (d) (e) (2)
- The service must ensure there is an effective system to adequately monitor procedure room environments including temperature checks. Regulation 15 (1) (e)
- The service must ensure there is an effective system to check and monitor the condition of furniture in the hair transplant room. Regulation 15 (1) (a) (2)
- The service must ensure there is an effective system to check all clinical equipment and furniture is cleaned properly. Regulation 15 (1) (a) (2)
- The service must ensure an effective nurse call system is used. Regulation 15 (1) (c) (d)
- The service must ensure there is an effective system to check the safe use of sharps boxes. Regulation 17 (1) (2) (a) (b)
- The service must ensure there is an effective system to log, manage and learn from incidents. Regulation 17 (1) (2) (a) (b)
- The service must ensure safe and effective medicines management. Regulation 12 (1) (2) (g)
- The service must ensure that all medicines are stored appropriately. Regulation 12 (1) (2) (g)
- The service must ensure that controlled drugs are managed and audited appropriately, and the controlled drugs register is completed correctly. Regulation 12 (1) (2) (g)
- The service must ensure there is an effective system to ensure clinicians undertake adequate and appropriate patient risk assessments prior to and during all procedures. Regulation 12 (1) (2) (a) (b)

Our findings

Overview of ratings

Our ratings for this location are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Surgery	Inadequate	Requires Improvement	Insufficient evidence to rate	Good	Inadequate	Inadequate
Overall	Inadequate	Requires Improvement	Insufficient evidence to rate	Good	Inadequate	Inadequate

Inadequate

Surgery

Safe	Inadequate
Effective	Requires Improvement
Caring	Insufficient evidence to rate
Responsive	Good
Well-led	Inadequate

Are Surgery safe?

Inadequate

We had not inspected this service before. We rated it as inadequate.

Mandatory training

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

Staff received and kept up to date with their mandatory training. Managers monitored mandatory training and alerted staff when they needed to update their training. The clinic manager used the provider's electronic system to view staff mandatory training information. Managers could easily see which staff members had completed training and which training modules were due for renewal. Reminders were sent to staff and managers when training was due, and shifts were planned to ensure all staff could be released to complete their training. All staff had completed all mandatory training modules. However, the two clinic leads; the clinic manager and lead nurse had scheduled safeguarding training for the day of our inspection, so this was rescheduled.

The mandatory training was comprehensive and met the needs of patients and staff. Staff training was a combination of e-learning modules and face to face training courses. Training modules included basic life support, moving and handling, infection prevention and control, resuscitation, fire safety and sepsis.

Clinical staff completed training on recognising and responding to patients with mental health needs and learning disabilities. A member of staff told us they had completed training in how to recognise potentially vulnerable patients such as those experiencing body dysmorphia. They were able to describe how they could discuss this sensitively with a patient.

Safeguarding

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

Staff received training on how to recognise and report abuse. All staff had completed safeguarding to level two but the safeguarding leads at the location had not completed safeguarding training to level three. This was not in line with Royal College of Nursing Safeguarding Children and Young People: Roles and Competencies for Healthcare Staff (2019)

intercollegiate guidance. However, the provider had recently identified clinical staff should complete Safeguarding level three training and both safeguarding leads for the clinic (the registered manager and the clinic manager) had booked onto the online course which was scheduled for the day of inspection. Following the inspection staff told us both safeguarding leads had completed the training in March and April 2022.

Staff told us they had access to a clinician at corporate level who was trained to safeguarding level four. Staff told us they took their safeguarding responsibilities seriously and were vigilant in observing for potential issues, even though a safeguarding concern rarely presented.

Information about the local safeguarding board and local authority team contact numbers were available to staff in the clinic.

There was a clear safeguarding policy which was available on a shared computer drive.

Staff knew how to identify adults and children at risk of, or suffering, significant harm. Staff had training about female genital mutilation and PREVENT which includes information on how to identify and act when sexual exploitation or trafficking is suspected. We also saw information about potential abuse displayed in patient toilets.

Staff knew how to make a safeguarding referral and who to inform if they had concerns. Staff understood their safeguarding responsibilities and could describe the process for referring a concern and give examples of when they might need to follow this. Staff told us they had not needed to report any safeguarding concerns.

Staff explained no children were allowed to visit the premises due to COVID-19 restrictions and patients were informed of this when arranging appointments that included any visits to the clinic. This arrangement was continuing during our inspection.

Cleanliness, infection control and hygiene

The service did not always control infection risk well. Although the premises were visibly clean, staff did not always keep equipment clean.

Patient areas were visibly clean and had suitable furnishings, although these were not always clean or well-maintained. Sterile services equipment, such as surgical instruments, was decontaminated by an external provider which the provider had a service level agreement with.

Clinical areas were clean and had suitable furnishings which were clean and well-maintained; however, we saw disposable curtains in the recovery area labelled with the date they were last changed which was August 2021. This was not in line with best practice guidance or the provider's policy. Cleaning records were up-to-date and demonstrated that all areas were cleaned regularly. The provider used an external agency to clean the location every day and had a service level agreement in place. Upholstered couches and patient seating were impermeable and could be wiped clean. The clinic lead nurse told us the procedure room was deep cleaned six-monthly.

Staff followed infection control principles including the use of personal protective equipment (PPE) before, during and after cosmetic surgery procedures such as varicose vein ablation and sclerotherapy in the procedure room. Hair transplant procedure was a clean procedure which did not require use of aseptic technique. We observed that the

provider had adequate levels of personal protective equipment (PPE) in stock in all clinical areas. Patient consultations or procedures were not taking place on the day of our inspection, so we were unable to observe staff adhering to infection prevention controls including handwashing, the use of personal protective equipment or adhering to the bare below the elbow principles.

Public areas had posters and were clearly marked to promote Covid-19 awareness, hand hygiene and social distancing. All hand sinks had the five steps of hand washing displayed in line with best practice guidance, hand wash, towels and hand sanitising gel were readily available.

The Provider had an up to date infection control policy in place and had taken additional precautions to prevent the spread of COVID -19. Patients and visitors were screened on arrival using temperature recordings together with an appropriate questionnaire regarding contacts and symptoms.

The clinic was visibly clean and tidy in most areas. Some equipment was labelled to show when it was clean, and staff told us they cleaned all equipment after patient contact. However, we found a workbench in the hair transplant procedure room was badly cracked at one end and there was some sticky residue from labels or tape. This could pose an infection risk when tissue for transplant was prepared on this bench. However, staff told us after the inspection the workbench had been replaced. A wheeled clinical stool in this room was visibly dirty around the base and marked with an unknown substance.

A freezer in the hair transplant utility room was heavily encrusted with ice and appeared not to have been defrosted and cleaned for some considerable time. where hair follicles removed during the procedure were placed in sterile containers until ready for separation and implantation.

There was no evidence of freezer cleaning checks. However, following the Inspection, staff told us the freezer was immediately defrosted and a process put in place to ensure it would be defrosted on a planned basis.

The storeroom where surgical instruments were kept was clean although several boxes for equipment not used in this procedure room were stacked high on the utility bench.

There were sufficient hand washing facilities and hand sanitisers throughout the clinic.

The flooring in clinical areas could be easily cleaned. The clinic carried out legionella checks each month. The clinic carried out infection prevention and control audits. Fabric chairs had been highlighted as an infection risk and had been changed to chairs that could be easily cleaned.

Staff worked effectively to prevent, identify, and treat surgical site infections. Patients undergoing hair transplant surgery received post-operative antibiotic therapy to prevent infection/folliculitis post-surgery. The hospital monitored issues with wound healing after surgery as well as surgical site infections. There had been one surgical site infection reported and two incidents of delayed healing following surgical procedures between March 2021 and February 2022, although following the inspection staff told us these had all taken place at a third party site and not on clinic premises.

The decontamination of surgical equipment was carried out offsite by a third-party contractor. We reviewed a number of sterile packs which evidenced they were sterile and in date.

Inadequate

Surgery

Environment and equipment

The design, maintenance and use of facilities, premises and equipment did not always keep people safe. Staff were not always trained to use them. Staff did not always manage clinical waste well.

The design, maintenance and use of facilities, premises and equipment was not suitable for its purpose. The clinic was a converted town house with clinical rooms over four floors. There was no lift access for disabled patients or in the event of an emergency situation for patients requiring transfer out due to complications of surgical intervention. The width of the staircase was not suitable to transfer patients in an emergency life-threatening situation for example transfer by stretcher or trolley out of the facility for ongoing treatment. The stair bannister rail was unsafe, the rail running to the second floor where hair transplant procedures were undertaken in a clinical room was loose in two areas posing a risk to patients and staff.

The provider team had not identified the unsafe staircase bannister as a risk to patients. The health and safety risk assessment completed in January 2022 did not include an assessment of the staircase. However, following the inspection staff told us works had been carried out on the bannister rail and this had been secured which was confirmed with a structural engineer's report.

Managers told us the unstable bannister was noted on the local risk register. The risk register provided by the service did not show that the unstable bannister was a known risk. Staff told us they had experienced two non-emergency situations which involved patients fainting. Staff told us these events had been well managed although neither event had identified potential concerns about the need to safely transfer patients from treatment rooms.

The service delivered care across four floors. There was one evacuation chair available which was stored in the basement. This was not readily available in an emergency. Staff had completed the training required to use the evacuation chair.

Managers told us the service had implemented weight limits for patients to ensure staff would be able to use the evacuation chair in an emergency. This was not documented and could not be evidenced during the inspection.

The provider did not check the temperature of the hair transplant clinic room therefore we could not be assured the room was kept at an appropriate temperature. We did not see records of temperature checks for the procedure room in the basement during the inspection, but staff informed us following the inspection that temperature checks were carried out daily.

The service did not always have suitable facilities to meet the needs of patients. We did not see any patient call bells although staff told us patients would not be left alone. However, staff also told us patients undergoing hair transplant procedures would be offered a break during a long procedure and could use the consultation room or treatment room on the top floor of the clinic. A member of staff would always be available nearby so patients could call for help when staff took a break at the same time.

There was a system installed for staff to call for assistance and to be used as necessary. The lead nurse told us if staff could not use this system they would telephone staff for help or go to the landing and shout for assistance.

Annual portable appliance testing had been completed for all equipment in June 2021. Staff told us there was a service level agreement with an external provider to give assurance surrounding fire extinguisher checks and a certified inspection of the premises.

Inadequate

Surgery

Staff did not store or dispose of clinical waste safely in line with guidance. During our inspection the clinical waste room door was left unlocked; the bin was not locked which contained clinical waste. Audits completed by clinic staff showed 100% compliance for clinical waste storage safety. However, during inspection there were several audited areas not compliant. The door to the clinical waste room was propped open. This storeroom was in the basement of the building and meant that clinical waste from other levels of the building had to be carried down the main staircase which patients and staff used. Staff told us clinical waste was collected weekly by an external company. The collections took place early in the morning to avoid times when patients might be on the premises.

Sharps bins were assembled and labelled correctly. However, two sharps bins in the procedure room and patient recovery room were left in a dangerous state with exposed items pointing upwards within the opening. The sharps bin lids were not in the semi closed position in line with guidance. We escalated this with the lead nurse at the time of inspection. These had not been identified by staff and, although there was an audit process in place for the lead nurse to check sharps boxes regularly, this had not been identified in the last two audits.

The door of the cleaning cupboard which contained cleaning chemicals was left unlocked.

The storage cupboard where chemicals requiring control of substances hazardous to health (COSHH) were stored was left unlocked and ajar. The door to the COSHH cabinet itself was left unlocked with the key left in situ. There were items stored directly on the floor which included a box of sodium chloride. Following the inspection, the provider informed us that on the day of the inspection the Clinical lead had been undertaking a stock room check. However, none of these rooms were secured during the inspection.

A number of out of date venflons (Intravenous catheters) were found in the storage room. This identified inadequate stock rotation and packaging would not be guaranteed sterile after the use by date. We highlighted these concerns to the provider at the time of our inspection.

There were also out of date oropharyngeal nasal swabs stored in a cabinet in the basement corridor leading to the procedure room.

The service did not always have enough suitable equipment to help them to safely care for patients. All staff were trained in basic life support and if a patient became unwell there was a process in place to instigate basic life support and dial 999 for emergency services. The service kept emergency drugs for anaphylaxis and a defibrillator. Emergency life support equipment was checked daily, and this was recorded. However, there was only one resuscitation trolley, located in the basement next to the procedure room. There was no emergency resuscitation equipment in the second-floor treatment room apart from a grab bag. Following our inspection staff informed us that, in order to mitigate the risk of a patient suffering a cardiac arrest, they had ordered two more defibrillators to be stored for use on the first and second floors of the building.

An anaphylaxis kit was kept in a consulting room on the first floor and staff told us following the inspection that another anaphylaxis kit was kept with the resuscitation trolley in the basement. This meant neither kit was readily available in the hair transplant procedure room on the second floor, where it could be required in an emergency.

Staff told inspectors, and the provider's records showed, they carried out daily safety checks of specialist equipment. All compliance audits carried out by clinic staff measured 100% for all checks carried out and the most recent audit records showed the resuscitation trolley was correctly stocked.However, during our inspection, we found areas audited were not compliant. Dates and signatures were missing from the checklist for the resuscitation trolley, there were out of date consumables such as the EpiPen and an opened size 5 face mask. Items missing from the trolley included: NG tube, size 7

endotracheal tube, size 5 oropharyngeal mask, and pre-filled atropine. Adrenaline was listed as 6mg ampoules on the check list; however, there were 20mg in 10mls ampoules on the trolley. Unsafe management of the trolley contents, including medicines, posed a risk to patients because, in the case of an emergency, not all items required for resuscitation were available.

There was evidence that equipment was not cleaned effectively. A clinical stool was soiled with an unknown substance.

A side room adjoining the hair transplant clinical room contained a double sink with several storage cupboards. Staff told us this room was a clean area. However, there were packing boxes for equipment no longer in use as well as sterile equipment for both hair transplant procedures and for cool sculpting fat freezing procedures stored in this room. This posed a risk of infection to patients as the room was not a dedicated clean utility area.

A small tabletop freezer within the room was used to store cool packs to cool and store extracted hair follicles mid-procedure during hair transplantation. The freezer temperatures were not monitored daily in line with best practice guidance.

A laser machine was stored in a clinical room on the third floor which had the key left in the machine. The Laser Safety Information for Staff (Local Rules) document provided during the inspection stated, “when not in use, laser control keys will be removed and kept in the locked key box”. This had not been done prior to our inspection and no laser procedures were booked for that day. The Laser Protection Advisor’s report stated access should be controlled during treatments and a single therapist used the laser. The clinic room was in use that day by an external provider and it was not clear if the Advisor was aware staff from another provider used the room regularly. There was a service level agreement in place for this use.

Items were stored in clinical rooms inappropriately, for example a replacement part for the laser machine was stored in an open box on the top of the machine.

Fire extinguishers were obstructed by stored items on the middle floor landing of the building; two floor standing oscillating fans restricted access in the event of an emergency. This was not mentioned in the fire safety report. This posed a risk to patients and staff in the event of a fire.

Fire risk assessment carried out by UK Fire Safety Solutions LTD on 01 December 2021 stated the evacuation procedure from the basement treatment rooms should be practiced as part of the bi-annual fire/evacuation training. Verbal evidence provided during the inspection identified the last evacuation drill was carried out in 2020 and none of the staff present had taken part in the drill. An evacuation drill and training to use the equipment was planned for 22 March 2022.

The fire risk assessment did not mention evacuation from the treatment room on the second floor.

Several consumables stored within the procedure room setting had expired. We escalated this with the clinical lead nurse at the time of inspection.

Patient privacy curtains in the recovery room had not been changed since August 2021. We discussed this with the clinical lead nurse who was unsure if the provider had a policy surrounding this.

Assessing and responding to patient risk

Staff did not always complete and update risk assessments for each patient to remove or minimise risks. Staff did not always follow a recognised process to identify and quickly act upon patients at risk of deterioration.

Inadequate

Surgery

The service had stopped providing conscious sedation in the month before our inspection. Staff had previously reported they had insufficient staff so support care in the procedure room. However, the decision had been taken two months prior to the inspection by the executive team to suspend these services in late January 2022. The main Private Clinic Limited hospital in London provided liposuction procedures.

However, there was information on the whiteboard in the procedure room from the last procedure carried out and patient records we reviewed from a range of patients who had undergone cosmetic surgery and hair transplants included pages for pre-operative assessments, operation notes and post-operative records. From these we found staff did not always complete risk assessments for each patient on admission or arrival, using a recognised tool, and staff did not always review risk assessments, including after any incident.

From patient records provided during the inspection we were not assured that the patient selection process and assessment was robust, although staff knew about specific risk issues including venous thromboembolism (VTE). There was an eligibility criteria document to accept patients at the clinic. The Surgical Patient Acceptance Criteria listed pre-existing conditions that would not be appropriate for procedures carried out at the clinic. On reviewing patient records it was apparent criteria identified by pre-operative risk assessment was not consistently followed concerning the suitability for patients for surgical intervention. We reviewed 12 patient records which included four hair transplant patient records and noted the provider's criteria was not consistently followed regarding anaesthetic review surrounding pre-operative risk assessment or the suitability for patients to proceed with surgical intervention.

One patient record showed staff had provided care which put the patient at risk because the surgeon had made the decision to treat despite the set criteria. Staff has not fully assessed the risks to the patient resulting from their medical history and current medicines. Staff had failed to assess and document the patient's American Society of Anaesthesiology (ASA) Grade status. The provider's own Surgical Patient Selection Criteria supplied to the inspection team showed patients with conditions graded as ASA Grade 3 for example a cerebrovascular accident (CVA); a stroke would not be suitable for treatment at the clinic. Following the inspection, the provider told us the ASA grade in the patient selection criteria only referred to patients undergoing a general anaesthetic. However, the provider did not have a method to assess risks for service users with conditions that meant they may have had heightened risks for anaesthetics or procedures.

The service had access to specialist mental health support if staff were concerned about a patient's mental health. The service had recently involved local services when they believed a patient may have been at risk of self-harm or suicide.

The provider did not always use a nationally recognised tool to identify deteriorating patients in the procedure room. Records of patients undergoing conscious sedation showed staff did not always undertake patient observations throughout procedures in line with National Institute of Clinical Excellence (NICE) guidance.

Staff did not always document specific risk issues and patient comfort during hair transplant procedures. The hair transplant surgeon explained cases lasted an average of five to six hours, but they did take breaks. Staff told us they regularly checked on the patient's comfort and condition throughout the day. They ensured the patient had plenty of comfort breaks to take regular drinks, use the toilet if needed and to have a meal break. However, this information was not recorded in patient records.

Staff arranged, psychosocial assessments and risk assessments for patients thought to be vulnerable or at risk of coercion, abuse, self-harm, or conditions such as body dysmorphia. Staff told us that the provider had instigated a psychological assessment process in December 2021. Consultants could refer patients at point of consultation for a psychological assessment for surgery if deemed necessary. Patients were advised that this was a requirement prior to

receiving treatment and it would incur an additional cost. A doctor explained the process to us at the time of inspection and staff told us they had not used the service for any patients requiring hair transplants or surgical procedures up to the time of this inspection but patients would be required to have the assessment if clinicians were concerned regarding their mental health.

The service made sure patients knew who to contact to discuss complications or concerns.

A doctor told us patients were given a clear discharge plan following hair transplant surgery regarding the care & treatment of the scalp. This included scalp care, pain management and the importance of taking the prescribed post-operative medicines and maintenance. Staff booked follow up appointments for day two then at three, six and twelve-months following any surgery. However, there were blank pages with nothing recorded for follow up visits or calls in three records we reviewed. Patients were given contact numbers for the clinic for the surgeon and registered manager for post-operative advice. Staff told us the provider had an on-call system to ensure 24-hour cover was available.

Nurse staffing

The service did not always have enough nursing and support staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment.

Staff had reported two incidents in the previous 12 months where there had been insufficient staff to complete a procedure list. Local managers had made the decision to cancel these procedures. Managers told us they had recently reviewed staffing levels and skill mix.

The service had low sickness rates. There was a small staff group and managers said staff sickness was not a problem.

Medical staffing

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

The service had enough medical staff to keep patients safe. Doctors were directly employed by the clinic or worked under practising privileges. The human resources (HR) team at head office managed all responsibilities regarding practising privileges and the employment of doctors.

The service always had a consultant on call during evenings and weekends. Contact details for a nurse on call were given to patients pre- and post-operatively. If the nurse required support in dealing with a patient who requested help post-operatively, there was an on-call rota for medical staff during evenings and at weekends.

Records

Staff kept records of patients' care and treatment although there were significant gaps in documentation. However, records were stored securely and easily available to all staff providing care.

Staff could access patient records easily and were stored securely. Records were stored in locked cabinets in the main office.

We reviewed 12 sets of patient records in total including patients who had undergone conscious sedation which highlighted inconsistencies and omissions.

Inadequate

Surgery

Pre-operative screening was completed by the nurse, but no records included the screening record signed by the patient. In four patient records, the patients' height and weight were not recorded. There was no record of observation recorded in recovery following a procedure. In one record of a hair transplant procedure there was no record of the time a specific medicine was given, who it was given by, or checked by. The World Health Organisation (WHO) five steps to safer surgery check list was not consistently completed by staff at the time of sign out. Post-operative call sheets were not consistently completed, and some record sheets were blank.

The hair transplant procedure room register showed omissions of information including dates of surgery, finished/out times and staff names.

Medicines

The service used systems and processes to safely prescribe, administer and record medicines. However, medicines were not stored securely and safely and were not always clearly labelled or segregated as required for safe disposal in line with the guidance.

The management of controlled drugs including record keeping was not effective. The service had a contract with a local pharmacy for disposal of controlled drugs. However, the controlled drugs cabinet within the procedure room setting had one medicine which had expired, and a bottle of sedative medicine with no cap and it had been punctured and used. These had not been clearly labelled or segregated as required for safe disposal. This was highlighted to clinical nurse lead at the time of inspection and it was not clear how this issue would be managed by staff on site.

Staff did not always complete medicines records accurately and or keep them up to date. Review of the provider's controlled drugs (CD) book highlighted several omissions for example: missing consultant names and signatures, amount given, no second check documented or signed for by a registered person for stock checks or administration of CD's. There was an incident where a doctor had not signed for medicines given during a procedure and this had not been completed until they returned to the clinic several weeks later. These findings were not in line with medicines management regulations. Following the inspection, the provider informed us the decision had been made that controlled drugs were no longer required at this location and all had been removed. The provider told us they had informed the home office that controlled drugs were no longer held on the premises.

Staff did not always follow systems and processes to prescribe and administer medicines safely. The surgeon was knowledgeable about potential toxicity from using too much local anaesthetic and signs and symptoms to look out for. They said staff recorded the patient's height and weight on the operation note so the surgeon did not exceed the recommended dose for each patient. The drug calculation and maximum recommended dose was recorded in the patient's record. However, an incident had occurred where a patient had been administered an excess of local anaesthetic. Staff had administered additional local anaesthetic to treat the patient's pain during the procedure. An investigation following the incident found the patient's cannula had become dislodged and insufficient sedative medicines were received. This incident was reported appropriately, a comprehensive action plan was compiled, an internal investigation was completed, and the findings were shared with the patient, across the organisation, and with CQC. Staff followed the Duty of Candour process to ensure an apology was given to the patient.

Staff did not always store and manage all medicines safely. Intra-muscular injectable medicines for the use of a number of skin conditions were stored in an unlocked cupboard along with two ampoules of sodium chloride (10ml) in the clinical consulting room on the first floor. This is not in line with the safe storage of medicines.

Staff received information from safety alerts and incidents through regular bulletins.

Inadequate

Surgery

Incidents

The service managed patient safety incidents well. Staff recognised and reported incidents and near misses. Managers investigated incidents but not all lessons learned resulted in changes to practice. When things went wrong, staff apologised and gave patients honest information and suitable support. Managers ensured that actions from patient safety alerts were implemented and monitored.

Staff knew what incidents to report and how to report them. Staff raised concerns and reported incidents and near misses in line with the service's policy. The hair transplant doctor discussed practice with inspectors. A needlestick injury had been reported in December 2021 when a hair transplant assistant had sustained an injury when putting items into a sharps bin and was pierced by another sharp. Managers had documented lessons learnt from this incident with evidence showing how the learning from the incident had been shared with the team through a bulletin. However, we observed sharps bins during the inspection which had items sticking up into openings and lids were fully open; this showed lessons had not been learnt and any compliance checks had been ineffective. The two most recent sharps audits showed 100% compliance for sharps bin checks with no items protruding and all lids closed. This was not in line with what was found on inspection.

The service had reported no never events.

Staff reported serious incidents clearly and in line with the service's policy. A serious injury had occurred where a patient had not received sufficient sedation as their cannula had become dislodged. This was reported to CQC within the correct timeframe.

Staff understood the duty of candour and had followed it although only a verbal explanation and apology had been given immediately following the incident. Staff told us they were open and transparent, and they gave patients and families a full explanation when things went wrong. However, staff told us after the inspection the patient was fully involved and was sent a Duty of Candour letter both before and after the investigation. The outcome of the investigation was also shared with the patient.

Staff received feedback from investigation of incidents, both internal and external to the service. They met to discuss the feedback and look at improvements to patient care. Managers investigated incidents thoroughly and there was evidence that some changes had been made as a result of feedback and an action plan showed staff had completed training.

Managers debriefed and supported staff after any serious incident.

Are Surgery effective?

Requires Improvement

This service had not been inspected before. We rated it as requires improvement.

Evidence-based care and treatment

The service provided care and treatment based on national guidance and evidence-based practice. Managers checked to make sure staff followed guidance. However, not all audits picked up errors or areas of non-compliance.

Inadequate

Surgery

Staff followed up-to-date policies to plan and deliver high quality care according to best practice and national guidance. Changes to policies were cascaded to staff at clinic level. All guidelines were up to date and referenced to the latest national guidance. Managers carried out monthly audits to check staff followed guidance. Although audits measured compliance at 100%, evidence found on inspection showed compliance was not consistent. Patient care was planned but not always carried out in line with the most recent guidelines set out by the National Institute for Health and Care Excellence (NICE) or the Guidelines for the Provision of Anaesthetic Services; the Royal College of Anaesthetists. This included full anaesthetic and procedure risk assessments regarding patient pre-existing conditions and continued observations during procedures. Staff did not ensure all care offered and provided was based on up to date evidence. No procedures were being carried out at the time of our inspection. They did not operate every day and some lists were cancelled due to short staffing. Clinic staff explained the team had also recently decided to stop offering conscious sedation for all procedures due to a shortage of procedure room support staff. Staff said patients would only be offered local anaesthetic in future.

Staff said the clinic provided follow-up phone calls or appointments for patients where relevant, to monitor their progress following surgery and to provide ongoing care where required. However, three records had blank pages and did not show any calls had been made.

Nutrition and hydration

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

Staff made sure patients had enough to eat and drink including those with specialist nutrition and hydration needs. Patients waiting to have surgery were not left nil by mouth for long periods.

All patients undergoing hair transplant procedures were offered snacks and decaffeinated hot and cold drinks They ensured patients had plenty of comfort breaks to take regular drinks and or eat snacks.

Pain relief

Staff assessed and monitored patients regularly to see if they were in pain but did not always give pain relief in a timely way. They supported those unable to communicate using suitable assessment tools but did not always give additional pain relief to ease pain.

Staff assessed patients' pain using a recognised tool and gave pain relief in line with individual needs and best practice. Patients received pain relief soon after requesting it and staff prescribed, administered and recorded pain relief accurately. Review of a serious injury reported to CQC in April 2021 showed a patient undergoing a liposuction procedure had not received the correct anaesthetic because their cannula had not been attached properly and was dislodged during the procedure. Staff did not prescribe pain relief following the procedure but advised the patient to obtain their own. The patient experienced significant pain and was admitted to their local NHS hospital the day following the procedure. They had an overnight stay to manage their pain. Clinic records showed a full investigation was completed and staff were required to attend training and improve pain management techniques. Staff told us after the inspection that as a result of this incident practice was changed to include prescription for pain following procedures.

However, records for four patient hair transplant records evidenced these patients had received local anaesthetic which had been risk assessed pre-operatively to prevent local anaesthetic toxicity. Staff told us patients' pain levels were reviewed throughout the procedure and patients were encouraged to escalate increasing levels of pain. All patients undergoing hair transplant procedures were discharged with pain relief and advice on how to manage pain post operatively.

Inadequate

Surgery

Patient outcomes

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

The service participated in clinical audits. The provider collected Patient Reported Outcome Measures (PROMS) data and reported outcomes for varicose vein procedures between January and December 2021. Patients undergoing varicose vein procedures were given a questionnaire to complete before their treatment and then repeated six months later.

Outcomes for patients were positive, consistent and met expectations, such as national standards. Managers and staff used the results to improve patients' outcomes. The objectives were to measure the positive effect the procedure had on patient wellbeing as well as identifying any problems or issues that may have occurred. The service collected information from 30 patients over six surgeons' caseloads. Patient perceptions post-surgery all showed improvements for all five questions asked and the results showed high levels of satisfaction with surgical outcomes.

Managers and staff carried out a comprehensive programme of repeated audits. Managers conducted a number of monthly audits to monitor performance and quality and adherence to

policies and procedures. There was a schedule of observational audits which was directed at corporate level by The Private Clinic of Harley street Ltd and carried out at the clinic by clinic staff. Managers and staff told us they used the results to improve patient outcomes and audit results were routinely discussed at team meetings and more widely at corporate leadership meetings. Results provided for January to December 2021 showed:

- Surgical instruments – 100% compliant
- Medical records – 94% compliant
- Medicines Management – 100%
- IPC Sharps Safety – 100%

However, during inspection examples of non-compliance were found across a range of audit areas including medicines management, IPC, and sharps safety.

Staff told us senior managers from the corporate leadership team benchmarked surgeons' performance against their own performance statistics from previous years and analysed trends. They shared a Quality Improvement Report each month which highlighted areas of non-compliance with national audits and required actions to improve practice, as well as data regarding patient experience, adverse events, incidents and complaints. Every Quarter the Doctors Dashboard was shared with clinic managers and clinical leads. This focused on performance of individual surgeons and formed part of the annual appraisal for surgeons. The clinic manager told us any issues in performance would be addressed by the provider's chief medical officer. There were no examples of issues reported at The Private Clinic - Leeds.

This formed part of the annual appraisal for surgeons. The clinic manager told us any issues in performance would be addressed by the chief medical officer of The Private Clinic of Harley street Ltd. There were no examples of issues reported at The Private Clinic - Leeds.

The service reported no unplanned transfers to other services and no unplanned returns to procedure room in the12 months prior to our inspection.

Inadequate

Surgery

Competent staff

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

Staff were experienced, qualified and had the right skills and knowledge to meet the needs of patients.

Managers gave all new staff a full induction tailored to their role before they started work. The staff induction programme included the information and skills required for support staff roles. The senior leadership team monitored the performance and practising privileges of consultants working at the clinic.

Managers supported staff to develop through yearly, constructive appraisals of their work.

Clinic staff had received an appraisal or one to one meeting with their line manager within the preceding 12 months. Staff explained consultants received an annual appraisal with the chief medical officer as part of their annual medical revalidation. The chief medical officer had oversight of evidence required for practising privileges and surgeon's competencies. However, no records were kept on site, but staff could request this information from the HR department.

All staff had attended clinical updates that were relevant to their role and staff told us they were encouraged to access professional development courses and to learn new skills. They were offered a wide range of clinical courses and updates as well as non-clinical development courses such as leadership skills. All staff conducting invasive procedures such as cannulation received training updates and mentorship to ensure safe practice.

Managers made sure staff attended team meetings or had access to full notes when they could not attend. Managers identified any training needs their staff had and gave them the time and opportunity to develop their skills and knowledge. Managers made sure staff received any specialist training for their role. Staff told us they had attended a course on recognising potential mental health issues including body dysmorphia. Staff said they felt empowered to talk with patients about any concerns and to take the relevant action to ensure patients did not pursue a procedure that was not in their best interest.

Multidisciplinary working

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

Staff told us that prior to each surgical list they held effective multidisciplinary meetings to discuss patients and improve their care. However, as no procedures were taking place during our inspection, this could not be observed. Following the inspection staff told us a surgical MDT met bi-monthly to discuss, share and review cases. This was chaired by a Senior Plastic Consultant Surgeon and Doctors nationwide participated. This provided the opportunity to review and discuss complex cases and share learning.

Seven-day services

Patients were provided with contact details for the service seven days a week for advice and support after their surgery.

The clinic provided consultations and procedures up to five days a week on weekdays. At weekends staff worked a rota to answer any patient questions and nurses said they could always get a response from a doctor at any time if there was an urgent clinical query.

Inadequate

Surgery

Health promotion

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

The service had relevant information promoting healthy lifestyles. There were leaflets with guidance and support on display. Staff assessed each patient's health and staff told us advice was provided if the doctor felt a procedure would not be beneficial or if the individual could adopt a healthier lifestyle.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

Staff supported patients to make informed decisions about their care and treatment. They followed national guidance but did not always ensure that patients gave consent in a two-stage process with a cooling off period of at least 14 days between stages. They understood how to support patients.

Staff understood how and when to assess whether a patient had the capacity to make decisions about their care. Staff told us they were clear that if a patient did not have capacity to make decisions about their health, then they would not be eligible for treatment at the clinic. Staff received consent training as part of their mandatory training and updates.

Staff did not always clearly record consent in the patients' records. The clinic adhered to a two-week cooling off period between the initial consultation and the surgery so that patients had time to make an informed choice and were aware of the risks and implications of the surgery.

Staff clearly recorded the procedures patients were consenting for in the patients' records. However, seven sets of records were reviewed and in two records, the incorrect dates had been recorded and in one record only part of the consent form had been completed.

Are Surgery caring?

Insufficient evidence to rate

There were no procedures booked or patients in the clinic during our inspection, so it was not possible to inspect Caring.

However, there were examples of positive feedback from patients about the service.The service monitored feedback patients gave on public domains such as Google reviews and Trust Pilot. Feedback was very positive.

Are Surgery responsive?

Good

We had not inspected this service before. We rated responsive as good.

Meeting people's individual needs

The service was inclusive and took account of patients' individual needs and preferences. Although staff made reasonable adjustments to help patients access services not all facilities at the clinic were accessible to patients unable to climb stairs. There was a system for referring patients for psychological assessment before starting treatment, if necessary.

Inadequate

Surgery

Staff understood and applied the policy on meeting the information and communication needs of patients with a disability or sensory loss. However, facilities including consultation rooms, and procedure rooms were not accessible for patients with limited mobility and people who used a wheelchair. Staff told us if a patient was unable to use stairs, they would be signposted to a different location within the Private Clinic Limited group for their procedure, but a consultation could be arranged in the reception area. Staff said this was possible during COVID-19 restrictions because only one patient could access the clinic at a time, although staff were not sure how this could be accommodated if restrictions were to be lifted and other patients used the waiting room at the same time.

Patients had a consultation and examination at their first visit. A subsequent pre-operative assessment appointment was provided to patients prior to their admission, conducted face to face or by telephone as appropriate. Patients were referred to the surgeon of their choice where possible and seen by the same consultant throughout their treatment ensuring continuity.

Managers made sure staff, and patients could get help from interpreters or signers when needed. Pre-assessment staff identified individual needs such as hearing, sight or language difficulties or disabilities. Interpretation services were available by prior arrangement, for patients where English was not their first language. Posters were displayed in clinical areas such as the consultation room highlighting that the provider offered translation services via telephone.

Patients were given a choice of food and drink to meet their cultural and religious preferences. Staff told us they resourced food locally and could offer a range of differing choices to meet patients' individual needs. Snacks were available for patients when taking a break during a hair transplant procedure.

Access and flow

People could access the service when they needed it and received the right care. However, patients unable to use stairs could not access the procedure rooms.

There was no lift provided. This prevented access for individuals unable to mobilise up or down stairs for procedures. There was no toilet facility on the top floor for patients. Those undergoing lengthy procedures in the hair transplant procedure room would have to go down the stairs to the next floor to use the toilet facilities.

Managers monitored waiting times and made sure patients could access services when needed and received treatment within agreed timeframes and targets. The service was able to provide appointments, procedures and follow-ups at a time to suit the patient. The clinic used an electronic booking system where appointments and procedures could be booked in advance.

Managers made sure patients could access services when needed and received treatment within agreed time frames. The administration team also ensured people did not wait too long in waiting areas to see a doctor.

Managers worked to keep the number of cancelled appointments, treatments, or operations to a minimum. Staff told us some surgical procedures had to be postponed or cancelled due to staff shortages. The service had very recently made the decision to stop using conscious sedation. If a patient requested a procedure with conscious sedation, they would be offered their procedure at the provider's London location.

Staff explained procedures using local anaesthetic only required fewer staff and the clinic could regularly provide these staff. Clinical cancellations were rare, and if this happened, surgery would be re-scheduled for an appropriate date.

Inadequate

Surgery

Learning from complaints and concerns

It was easy for people to give feedback and raise concerns about care received. The service treated concerns and complaints seriously, investigated them and shared lessons learned with all staff. The service provided patients with information about their complaint. The service had a system for referring unresolved complaints for independent review.

Patients, relatives and carers knew how to complain or raise concerns. The service clearly displayed information about how to raise a concern in patient areas. Staff understood the policy on complaints and knew how to handle them.

Staff said they dealt with patient verbal complaints and concerns immediately they were raised and made apologies appropriately. Staff explained these rarely escalated to formal complaints. Staff knew how to acknowledge complaints and patients received feedback from managers after the investigation into their complaint. Complaints were recorded on the electronic clinic system, investigated, and discussed at team meetings.

Managers shared feedback from complaints with the senior team and other staff and told us learning was used to improve the service. Due to the low number of complaints received, staff had identified no themes or trends from complaints about the service.

The complaints process included the option for patients to request a review by the Independent Sector Complaint Adjudication Service (ISCAS) should they not be satisfied with a response received about their complaint.

Are Surgery well-led?

Inadequate

We had not inspected this service before. We rated Well-led as inadequate.

Leadership

Clinic leads and managers did not always have the skills and abilities to run the service. Senior leaders did not always understand or manage the priorities and issues the service faced. However, clinic managers were visible and approachable in the service for patients and staff. Leaders supported staff to develop their skills and take on more senior roles.

Leaders did not demonstrate insight into issues the service faced and were not always aware of the risks, issues and challenges in the service. Managers were not always clear about their roles and their accountability for quality. Our inspection identified significant risks which put people at the risk of harm. The provider did not operate effective systems and processes to ensure the service was well-led.

Leadership at the Leeds clinic was provided by the lead nurse and clinic manager. This team was supported by the corporate leadership team which consisted of a chief medical officer, a head of nursing, head of quality and risk, operational lead and several other lead roles. The clinic leadership team told us that leaders from the corporate team were easily accessible and visited the clinic regularly. The head of quality and risk was based on site at the Leeds clinic and staff told us they provided regular information and support.

Inadequate

Surgery

Managers and staff at the clinic presented with the skills and knowledge to understand the challenges to the quality and sustainability of the services they were providing. They were able to articulate the main risks on their risk registers and the actions and processes to manage them. However, risks the inspection team identified such as those regarding use and suitability of the clinic building, had not been recognised or added to the risk register appropriately.

Staff told us they felt very well supported by their managers and felt they would be listened to if they raised any issues or concerns. There were promotion and development opportunities for staff throughout the service and these were encouraged and fully funded.

Vision and Strategy

The service had a vision for what it wanted to achieve and a strategy to turn it into action.

At corporate level there was a clear vision and strategy which was evident throughout organisational policies and clearly articulated at the clinic.

Culture

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

Staff told us they felt positive and proud to work for the service, and they worked well as part of a team. Staff told us they felt supported, valued and respected in their roles. There was an open and honest approach to sharing learning at clinic level and through the corporate team so that staff could learn from issues that occurred at other clinics.

There were very few staff present at the time of our inspection and it was not possible to observe staff working effectively together. Although they had clear responsibilities, staff provided limited information and lacked confidence when explaining some processes and procedures.

Staff had access to regular meetings with their manager, team meetings, development and team days away.

Staff spoke very highly of the managers and staff at the clinic and had very high praise for the efficient and safe running of the service, including the recruitment, induction and support processes.

Governance

Leaders did not operate effective governance processes, throughout the service. Staff were not always clear about their roles and accountabilities.

Governance processes were not effective at the Leeds clinic. Leaders relied on ineffective governance systems which did not identify or mitigate risks. For example, audits carried out by clinic managers showed consistent 100% compliance rates, but our inspection found several instances of non-compliance within clinical areas which should have been picked up in audits. Audits were completed by staff who were involved in the practices and processes being audited. The inspection found there were doors left unlocked to the clinical waste room, a storage room, a cleaner's cupboard, and the COSHH cupboard. Equipment was stored in front of fire extinguishers, a laser machine with its key in place within a clinical room being used by another provider for patient treatment on the day of the inspection, a bannister that was unstable in two areas outside clinical rooms that patients and staff regularly used, and emergency equipment stored three floors away from a procedure room. There was dirty furniture within a procedure room, a fridge and freezer with no

evidence of cleaning, defrosting, or temperature checks being carried out. Medicines were not stored appropriately, and controlled drugs were not stored, checked, or documented correctly. Sharps boxes had items sticking up within the openings and there was evidence that a member of staff had suffered a needlestick injury from such an object only months before our inspection. Staff were not able to identify the individuals responsible for carrying out the checks.

However, there was a clear governance structure with communication between the clinic leadership and the corporate leadership team. The clinic managers attended monthly meetings with the corporate senior leadership team which fed into quarterly medical advisory committee (MAC) meetings and quarterly quality, risk and governance committee meetings at corporate level.

Minutes of quality, risk and governance committee meetings were comprehensive and covered issues such as staffing, incidents, complaints, and performance. Meeting minutes and bulletins were available to all staff.

The service had a process in place to review practicing privileges for consultants on an annual basis. This was carried out by the chief medical officer for The Private Clinic of Harley street Ltd. There was also a process to check that surgeons carrying out cosmetic surgery had an appropriate level of valid professional indemnity insurance. However, there was an example where a surgeon had not followed the organisation's clinical eligibility criteria and had carried out a procedure on a patient who had a pre-existing condition that should have prevented them from being eligible. The clinical decision-making process was not documented in the patient's notes.

Management of risk, issues and performance

Leaders and teams used systems to manage performance effectively. They did not always identify and escalate risks and issues and identify actions to reduce their impact. Staff contributed to decision-making to help avoid financial pressures compromising the quality of care.

Staff told us the clinic risk register showed only open risks and explained all risks had to be closed by the corporate head of nursing once they had assessed them as safe. The clinic manager also provided a copy of the risk register for 2020 to 2021. There were actions and staff responsibilities documented for each risk and staff used a traffic light system to rate risk severity and impact. However, the risks found on inspection regarding storage and disposal of controlled drugs, suitability of the building including the staircase and condition of the bannister, had not been identified by staff who worked in the clinic every day.

Staff had regular opportunities to meet, discuss and learn from the performance of the service.

The corporate quality, risk and governance committee held sub-group meetings for; infection prevention and control, medicines management, equality and diversity, quality, health and safety, education, training and workforce, and freedom to speak up, and provided monthly reports on clinic performance. The clinic manager and lead clinicians attended meetings according to their role, and cascaded relevant information to clinic staff.

Information Management

Staff could not always find the data they needed, in easily accessible formats, to understand performance, make decisions and improvements. The information systems were secure but not integrated. Data or notifications were consistently submitted to external organisations as required.

The service used data to benchmark against the provider's other locations, however our inspection showed the service's compliance data could not be relied upon to assess performance.

Inadequate

Surgery

Data was updated on a continuous basis and discussed at relevant monthly meetings and data was used to measure any required improvements. The inspection found not all audits carried out showed a true picture of staff practice. Examples showed monthly audits were ticked and marked as 100% compliant but observations during the inspection showed that, on that day, practice was not compliant.

Records and data systems were used in line with data security standards and passwords were used by staff to access all data systems. Staff explained patient photographs were safely and securely stored but staff had not been able to find records easily. Managers explained the clinic staff were in the process of re-cataloguing this information to make it more easily available. These improvements had been started but not yet completed at the time of our inspection.

Data and notifications including patient reported experience measures (PREMS) were provided to recognised external bodies as required. Staff discussed performance measures and outcomes at corporate meetings where leaders from individual clinics attended and results were used to make improvements. Information was shared with clinic staff.

Engagement

Leaders and staff actively and openly engaged with patients and staff. They collaborated with partner organisations including other independent health providers to help improve services for patients.

Managers told us staff were encouraged to share ideas for improvement and to access relevant meetings, specialist groups and conferences if they wished.

The service provided a monthly communications bulletin which included topics such as patient safety, quality and learning from incidents and complaints. Staff bulletins included local clinic information that staff had discussed and contributed to. These included examples of learning from incidents and complaints.

The service encouraged patient feedback using a questionnaire and results were shared with the senior leadership team. The service also submitted data to the friends and family test.

Staff told us managers followed up on any complaints and would meet with patients if appropriate to discuss their concerns and, if required, the service would provide fully or partially funded treatments.

Learning, continuous improvement and innovation

All staff were committed to continually learning and improving services. They had a good understanding of quality improvement methods and the skills to use them. Leaders encouraged innovation and participation in research.

Leaders participated in regular learning from internal and external reviews and shared learning with staff to make improvements.

There was a development programme available to staff and all were encouraged to attend leadership development as well as enhancing their clinical skills and developing new ones.

The clinic staff were proud of comments and reviews from patients using social media.