

Acuitus Medical – London





Quality Report

106 Crawford Street, London, W1H 2HY
Tel: 02079934849
Website: www.centreforsurgery.com

Date of inspection visit: 20/02/2020
Date of publication: 14/04/2020

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

Ratings

Overall rating for this location	Good	
Are services safe?	Good	
Are services effective?	Good	
Are services caring?	Good	
Are services responsive?	Good	
Are services well-led?	Good	

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

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

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

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

Summary of findings

Letter from the Chief Inspector of Hospitals

Acuitus Medical – London is operated by Acuitus Medical Ltd. The service provides elective cosmetic surgery for self-funding patients aged 18 years and over. Facilities include one operating theatre, a combined admissions room and recovery room and two consultation rooms. There is also a waiting room, toilet and changing facilities.

We inspected this service using our comprehensive inspection methodology. We carried out the inspection on 20 February 2020. We gave staff 48 working hours' notice we were coming to inspect to ensure the availability of the registered manager and patients.

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

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

Services we rate

This is the first time we rated this service. We rated it as **Good** overall because:

- The service had enough staff to care for patients and keep them safe. Staff had training in key skills, understood how to protect patients from abuse, and managed safety well. The service controlled infection risk well. Staff assessed risks to patients, acted on them and kept good care records. They managed medicines well. The service managed safety incidents well and learned lessons from them. Staff collected safety information and used it to improve the service.
- Staff provided good care and treatment, gave patients enough to eat and drink, and gave them pain relief when they needed it. Managers monitored the effectiveness of the service and made sure staff were competent. Staff worked well together for the benefit of patients, advised them on their treatment, supported them to make decisions about their care, and had access to good information. Key services were available five days a week.
- Staff treated patients with compassion and kindness, respected their privacy and dignity, took account of their individual needs, and helped them understand their conditions. They provided emotional support to patients.
- The service planned care to meet the needs of the patient population, took account of patients' individual needs, and made it easy for people to give feedback. People could access the service when they needed it and did not have to wait too long for treatment.
- Leaders ran services well using reliable information systems and supported staff to develop their skills. Staff understood the service's vision and values, and how to apply them in their work. Staff felt respected, supported and valued. Staff focused on the needs of patients receiving care. Staff were clear about their roles and accountabilities. All staff were committed to improving services continually.

However:

- We found two policies on safeguarding and infection prevention control containing an outdated or incorrect reference. One of these was corrected following our inspection feedback.
- The service did not currently subscribe to the Independent Sector Complaints Adjudication Service (ISCAS), which is a voluntary subscriber scheme for the independent review of complaints. Although this is not mandatory, it is best practice for providers in the independent sector.
- The strategy of the service was not clear. No formal strategy document was provided.
- Response rates to patient surveys tended to be low.

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

Summary of findings

Dr Nigel Acheson

Deputy Chief Inspector of Hospitals (London and South)

Summary of findings

Our judgements about each of the main services

Service

Surgery

Rating

Good



Summary of each main service

Cosmetic surgery is the sole core service provided at this location. We rated this service as good because it was safe, effective, caring responsive and well-led.

Summary of findings

Contents

Summary of this inspection

	Page
Background to Acuitus Medical – London	7
Our inspection team	7
Information about Acuitus Medical – London	7
The five questions we ask about services and what we found	9

Detailed findings from this inspection

Overview of ratings	13
Outstanding practice	30
Areas for improvement	30

Good



Acuitus Medical - London

Services we looked at:

Surgery

Summary of this inspection

Background to Acutus Medical – London

Acutus Medical – London is operated by Acutus Medical Ltd. The service opened in February 2019 for non-surgical procedures and started carrying out regulated activities in April 2019. It is a private cosmetic surgery clinic in London. The clinic accepts self-referrals from patients living in London and nationally. The service does not provide services to NHS-funded patients or patients under the age of 18. It provides a range of cosmetic

procedures including rhinoplasty (nose reconstruction), rhytidectomy (facelift), breast augmentation (implants), liposuction (fat removal) and abdominoplasty (tummy tuck). All patients are seen on a day case basis.

The service has had a registered manager in post since opening at this location in 2019.

The clinic also offers non-surgical cosmetic procedures. We did not inspect these services because they were not within our scope of regulation.

Our inspection team

The team that inspected the service comprised a CQC lead inspector, a CQC assistant inspector, and a specialist advisor with expertise in theatre nursing. The inspection team was overseen by Nicola Wise, Head of Hospital Inspection.

Information about Acutus Medical – London

The service has no overnight beds. It is registered to provide the following regulated activities:

- Treatment of disease, disorder or injury
- Surgical procedures

During the inspection, we visited the whole clinic, including the reception, waiting area, consultation rooms, operating theatre, recovery/admission room and storage areas. We spoke with six staff including the operations manager, medical director, registered manager, registered nurses and the clinic administrator. We spoke with two patients and reviewed five sets of patient records.

There were no special reviews or investigations of the service ongoing by CQC at any time during the 12 months before this inspection. This was the service's first inspection since registration with CQC in April 2019.

Activity (April 2019 to November 2019)

- Between registration in April 2019 and November 2019, the clinic recorded 117 day case procedures and 457

outpatient attendances. The most common procedures performed at the clinic in this time were: liposuction (28), skin lesions (15), ear lobe repair (11), labiaplasty (10), lip reduction (eight), tattoo removal (six), areola/nipple reduction (six) and other procedures (33).

- Four surgeons worked at the service under practising privileges. The service employed two whole-time equivalent (WTE) nursing staff and two WTE support staff. The accountable officer for controlled drugs (CDs) was the registered manager.

Track record on safety

- Zero never events.
- The service reported one clinical incident, resulting in 'low' harm, as well as three 'near misses'.
- Zero serious injuries.
- Zero incidences of hospital acquired Meticillin-resistant *Staphylococcus aureus* (MRSA).
- Zero incidences of hospital acquired Meticillin-sensitive *staphylococcus aureus* (MSSA).

Summary of this inspection

- Zero incidences of hospital acquired Clostridium difficile (C.diff).
- Zero incidences of hospital acquired Escherichia coli (E. coli).
- The service reported one complaint in the reporting period.

Services provided at the service under service level agreement:

- Laser maintenance and compliance
- Alarm maintenance
- Fire-related testing
- Maintenance and testing of medical equipment
- Clinical waste management
- Maintenance and replacement of oxygen cylinders
- Instrument decontamination
- Psychological assessments
- Interpretation services

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?

This is the first time we rated safe for this service. We rated it as

Good because:

- The service provided mandatory training in key skills to all staff and made sure everyone completed it.
- Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it.
- The service controlled infection risk well. Staff used equipment and control measures to protect patients, themselves and others from infection. They kept equipment and the premises visibly clean.
- The design, maintenance and use of facilities, premises and equipment kept people safe. Staff were trained to use them. Staff managed clinical waste well.
- Staff completed and updated risk assessments for each patient and removed or minimised risks. Staff identified and quickly acted upon patients at risk of deterioration.
- The service had enough staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment.
- Staff kept detailed records of patients' care and treatment. Records were clear, up to date, stored securely and easily available to all staff providing care.
- The service used systems and processes to safely prescribe, administer, record and store medicines.
- The service managed patient safety incidents well. Staff recognised and reported incidents and near misses. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support.
- The service collected safety information and shared it with staff.

However:

- At the time of inspection, the service did not provide staff with any training in children's safeguarding but did provide this to staff following our feedback.
- Staff did not log the serial number of private prescriptions, although the service introduced a prescription log following our inspection.

Good



Summary of this inspection

Are services effective?

This is the first time we rated effective for this service. We rated it as **Good** because:

- The service provided care and treatment based on national guidance and evidence-based practice. Managers checked to make sure staff followed guidance.
- Staff gave patients enough to eat and drink. Staff followed national guidelines to make sure patients fasted before surgery.
- Staff assessed and monitored patients regularly to see if they were in pain and gave pain relief in a timely way.
- Staff monitored the effectiveness of care and treatment. They used the findings to make improvements and achieved good outcomes for patients.
- The service made sure staff were competent for their roles. The registered manager appraised staff's work performance and held supervision meetings with them to provide support and development.
- Doctors and nurses worked together as a team to benefit patients. They supported each other to provide good care.
- Key services were available five days a week to support timely patient care.
- Staff gave patients advice regarding their procedure.
- Staff supported patients to make informed decisions about their care and treatment. They followed national guidance to gain patients' consent.

However:

- We found two policies on safeguarding and infection prevention control containing an outdated or incorrect reference. One of these was corrected following our inspection feedback.

Good



Are services caring?

This is the first time we rated caring for this service. We rated it as **Good** because:

- Staff treated patients with compassion and kindness, respected their privacy and dignity, and took account of their individual needs.
- Staff provided emotional support to patients, families and carers to minimise their distress. They understood patients' personal needs.
- Staff supported and involved patients to make decisions about their care and treatment.

However:

Good



Summary of this inspection

- On the day of inspection, we noted the main consultation room did not have a lockable door, but the service added a lock following our feedback.

Are services responsive?

This is the first time we rated responsive for this service. We rated it as **Good** because:

- The service planned and provided care in a way that met the needs of their patient population.
- The service was inclusive and took account of patients' individual needs and preferences. Staff made some reasonable adjustments to help some patients access services.
- People could access the service when they needed it and received the right care promptly.
- 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.

However:

- The service did not currently subscribe to the Independent Sector Complaints Adjudication Service (ISCAS), which is a voluntary subscriber scheme for the independent review of complaints. Although this is not mandatory, it is best practice for providers in the independent sector.

Good



Are services well-led?

This is the first time we rated well-led for this service. We rated it as **Good** because:

- Leaders had the integrity, skills and abilities to run the service. They understood and managed the priorities and issues the service faced. They were visible and approachable in the service for patients and staff.
- The service had a vision for what it wanted to achieve.
- Staff felt respected, supported and valued. Staff focused on the needs of patients receiving care. The service had an open culture where patients, their families and staff could raise concerns without fear.
- Leaders operated effective governance processes, throughout the service. Staff at all levels were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service.

Good



Summary of this inspection

- Leaders and teams used systems to manage performance effectively. They identified and escalated relevant risks and issues and identified actions to reduce their impact. They had plans to cope with unexpected events.
- The service collected reliable data and analysed it. Staff could find the data they needed, in easily accessible formats, to understand performance, make decisions and improvements. The information systems were integrated and secure.
- Leaders had some engagement with patients and staff to plan and manage services.
- Staff were committed to continually learning and improving services, although no formal quality improvement training had been provided.

However:

- The strategy of the service was not clear. No formal strategy document was provided.
- On the day of inspection, we found a piece of patient feedback on a noticeboard in a public area which contained the email address of a patient. We raised this with the nominated individual, who removed the email immediately.
- Response rates to patient surveys tended to be low.






Detailed findings from this inspection

Overview of ratings

Our ratings for this location are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Surgery	Good	Good	Good	Good	Good	Good
Overall	Good	Good	Good	Good	Good	Good

Surgery

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

Are surgery services safe?

Good 

This is the first time we rated safe for this service. We rated it as **good**.

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. The mandatory training provided to all staff was comprehensive and met the needs of patients and staff. Training was provided to staff in the following subjects: fire safety, infection control and standard precautions, lone working and personal safety, handling of violence and aggression, information governance, complaint training and conflict resolution, health and safety at work, control of substances hazardous to health (COSHH), Reporting of Injuries, Diseases and Dangerous Occurrences Regulations (RIDDOR), resuscitation and safeguarding adults level 2. The registered manager monitored mandatory training through a training tracker and alerted staff when they needed to update their training. The registered manager audited training compliance regularly. We saw that most staff were 100% compliant with all required training, apart from a nurse who was yet to complete the safeguarding adults level 2 course. On the day of inspection, we saw that staff were booked to complete any sessions they had not already completed. The registered manager gave staff time to complete this training within working hours.

There was an up-to-date policy on sepsis management and all nursing staff received training on sepsis as part of their core training programme. Staff were able to tell us about the signs of sepsis and how they would manage this.

Medical staff who worked at the service also worked for NHS trusts (or for a locum agency in one case) and completed their mandatory training there. The service monitored their compliance with mandatory training annually.

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. However, at the time of inspection, the service did not provide staff with any training in children's safeguarding but did provide this to staff following our feedback.

Staff received training specific for their role on how to recognise and report abuse. At the time of our inspection, all staff had completed safeguarding adults level 2 training. Staff could give examples of how to protect patients from harassment and discrimination, including those with protected characteristics under the Equality Act 2010. All members of staff we spoke with understood their responsibilities for safeguarding patients and reporting any potential safeguarding concerns.

There were clear processes, and staff were able to describe the necessary steps they would take to address concerns; they could describe how to access the safeguarding policy and who to speak with for advice. Staff told us they had never had to raise a safeguarding concern requiring

Surgery

escalation but were aware of how they would do so. In the 12 months before our inspection, the clinic did not report any safeguarding concerns to the local authority and CQC did not receive any safeguarding notifications.

The service's safeguarding policy was in date and included information on female genital mutilation (FGM). The service gave nursing staff separate training on how to recognise and report FGM. When we reviewed the safeguarding policy, we found one outdated reference to guidance from 2005. Following our inspection, the service removed the reference from the policy.

At the time of our inspection, no staff received training on the safeguarding of children, as the service did not work with any patients under the age of 18 years. This was not in line with the intercollegiate guidance 'Safeguarding Children and Young People: Roles and Competencies for Healthcare Staff' (2019), which states all healthcare staff, even those working primarily with adults, should be aware any adult may pose a risk to children due to their health or behaviour. Following our inspection, all staff completed online level 2 safeguarding for children training.

The service had an up-to-date chaperone policy. Staff had completed chaperone training and were able to describe how to carry out this role. The service displayed notices advising patients a chaperone was available on request.

The service promoted safety in recruitment procedures and ongoing employment checks. Staff had Disclosure and Barring Service (DBS) checks carried out at the level appropriate to their role. We saw staff had up-to-date DBS certificates.

Cleanliness, infection control and hygiene

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

All areas were visibly clean, and most areas had suitable furnishings which were clean and well-maintained. However, in the consultation rooms, there were screens made from woven paper, which were porous and not easily cleaned in order to maintain good infection prevention control (IPC) standards. Following our inspection, the service replaced the changing screens with wipe-clean screens.

The service provided up-to-date cleaning records demonstrating all areas were cleaned regularly. Cleaning staff followed IPC procedures, following a daily cleaning rota. Staff cleaned equipment after patient contact.

The service conducted audits to assess compliance with IPC requirements and provide assurances around cleanliness. In the last two months, the audit showed 100% compliance. In the December 2019 audit, the service identified some actions, such as ensuring all shoes replaced on shelves in the changing room were clean. The registered manager also reminded one member of staff to remove a stoned ring.

Staff followed infection control principles including the use of personal protective equipment (PPE). PPE (gloves and aprons) were available throughout the service and we observed staff using them in line with best practice to keep patients safe. We saw staff washing and decontaminating their hands before and after patient contact, as well as both pre and post-operatively, in line with the World Health Organisation (WHO) and Association for Perioperative Pathway (AfPP) guidance. Monthly hand hygiene audits formed part of the wider IPC audit, with compliance rates for the previous two months standing at 100%. We saw there was access in all areas to hand washing facilities and hand sanitiser. However, in the second consultation room, we noted there was no hand towel dispenser or soap dispenser mounted to the wall. Following our inspection, the service purchased both a hand towel and soap dispenser for this room.

The service used clinical wear (commonly referred to as "scrubs") for intra-operative procedures. Designated theatre shoes were available for staff to wear in the procedure room. This was in line with best practice (AfPP Theatre Attire, 2011).

The service used single patient use surgical instruments for the most part. The service outsourced decontamination of equipment to another service. This eliminated the risk of cross patient contamination from re-used medical equipment. We saw there had been one incident reported in the last 12 months relating to a set of surgical instruments being visibly soiled. Staff picked up this issue before any use of the instruments and reported this to the outside provider for further investigation.

The service screened any patients for MRSA (antibiotic resistant bacteria) in line with national guidance

Surgery

(Department of Health Implementation of modified admission MRSA screening guidance for NHS (2014). The pre-operative risk assessment form included patient history for MRSA. There had been no incidents of MRSA from when the service opened for regulated procedures in April 2019. However, we noted the IPC policy dated October 2019 contained a reference to a mental health trust in relation to MRSA screening.

The service provided patients with written information about pre-operative skin preparation before their surgery. Staff checked with patients they had used the pre-operative skin preparation on the day of surgery. There were notices for patients and relatives displayed with information about reducing the risk of surgical site infections (SSIs). Information provided indicated there had been no SSIs since the service opened.

Environment and equipment

The design, maintenance and use of facilities, premises and equipment kept people safe. Staff were trained to use them. Staff managed clinical waste well.

The design of the environment followed Department of Health, health building notes (HBN). The service had suitable facilities to meet the needs of patients. Nursing staff carried out weekly environmental audits to ensure the environment was safe and fit for purpose.

The service had enough suitable equipment to help them to safely care for patients. Staff carried out daily safety checks of specialist equipment. All equipment checked had been recently serviced and labelled to indicate the next review date. An external company serviced all equipment annually. All equipment in the operating room was neatly stored and well-maintained. We saw portable electrical equipment displayed a sticker with its most recent testing date. All the items checked were within date for testing.

Emergency equipment was readily available. Staff checked resuscitation equipment against a checklist to ensure essential equipment was available and in working order. The resuscitation trolley was tamper evident, with a record kept of tag numbers to ensure staff did not use items without replacing them.

The service stored potentially hazardous chemicals in a locked cabinet in line with the control of substances hazardous to health (COSHH) guidelines.

Toilet and shower facilities were available for patients, with a call bell system available for patients in case of an emergency occurring, or a patient requiring assistance in the bathroom. However, we noted the call bell cord was not within easy reach for patients from a seated position. Following our inspection, the service added a hook to the call bell cord, so it was easily reachable inside the bathroom.

Staff disposed of clinical waste safely. We saw clinical and domestic waste bins were available and clearly marked for appropriate disposal. Staff followed waste segregation procedures such as 'management and disposal of healthcare waste' (Health Technical Memoranda 07-01). Sharps bins were correctly assembled, labelled and disposed of in line with safer sharps regulations.

There were processes for providing feedback on product failure to the Medicines and Healthcare Products Regulatory Agency (MHRA). The service recorded the details of products used on each patient, such as the lot number (an identification number assigned to a particular quantity or lot of material from a single manufacturer). This information was recorded in the patient record.

The service stored disposable equipment and clinic room supplies, such as dressings and syringes, in an ordered and tidy manner. All items we checked were within their expiry date. However, we found one box of lifting threads in a consultation room that had expired. The registered manager informed us staff used these for demonstration purposes only and marked the box as such when we raised the issue.

Fire safety equipment was fit for purpose and in date. This included fire extinguishers, fire blankets, an alarm system, heat and smoke detectors, and emergency lighting. All staff had received fire training. The service checked fire extinguishers monthly and a fire alarm test took place weekly.

There was a business continuity plan for the site, which detailed what actions staff should take in the event of an emergency. There was a back up generator in case of power failure, which was tested monthly.

Assessing and responding to patient risk

Surgery

Staff completed and updated risk assessments for each patient and removed or minimised risks. Staff identified and quickly acted upon patients at risk of deterioration.

There was an admission policy with exclusion criteria. The service excluded some patients from treatment, while others required further investigation, a medical support letter from a GP and approval by the medical director. Patients with a body mass index (BMI) of 30 or over required review by the medical director before the service accepted the patient for surgery. The service referred those deemed unsuitable for surgery at the clinic elsewhere.

The admission policy also stated any patients with mental health conditions managed in primary care by their GP required a medical summary to enable surgeons to decide on whether surgery was suitable. An independent psychologist assessment was required in cases where doubt remained. The service had a service level agreement with an organisation providing psychological services they could refer these patients to. The service did not accept any patient with schizoaffective disorder for admission.

There were systems and procedures to assess patients' fitness for surgery. Patients saw the consultant pre-operatively at the initial consultation appointment. The lead consultant assessed and examined each patient and explained their treatment options, the risks and the expected outcome of treatment. The service required all patients to complete a medical history and health questionnaire before consultations or procedures. The surgeon considered each patient's medical history, general health, mental health concerns and history of previous cosmetic surgery before any surgery took place.

On the day of surgery, the service asked women of childbearing potential if there was any possibility they could be pregnant. Staff carried out pregnancy tests with the patient's consent, where indicated. This was in line with national guidance (NICE guideline [NG45]: Routine preoperative tests for elective surgery, April 2016).

The service carried out cosmetic procedures performed under local anaesthesia or intravenous sedation. During surgical procedures involving intravenous sedation, there were four staff present in the operating theatre. These included the surgeon, anaesthetist and two registered nurses, or a nurse and the medical director. The service had monitoring equipment which included capnography

equipment which assesses ventilation for patients undergoing sedation. This was in accordance with The Association for Perioperative Practice (AfPP) - Leading Perioperative Excellence (December 2018).

For procedures involving intravenous sedation, the pre-anaesthetic checks involved a member of the surgical team going through patient consent and explaining the procedure to the patient again. The nil by mouth status and allergy status were also rechecked at this stage.

A safer surgical checklist based on the World Health Organisation (WHO) guidance was in use at the service. The surgical safety checklist for patients is intended for use throughout the perioperative journey, to prevent or avoid serious patient harm. By following the checklist, health care professionals can minimise the most common and avoidable risks endangering the lives and well-being of surgical patients. On the day of inspection, we saw staff engage in the WHO checklist process, with all members of staff present at the team brief taking place before the procedure. The service audited WHO checklist completion as part of the monthly records audit. In 15 sets of notes audited by the registered manager between November 2019 and January 2020, there was 100% compliance with the WHO checklist.

Patients had observations recorded before, during and after surgery. We reviewed five sets of patient records and saw all observations were complete. Staff used a nationally recognised tool to identify patients at risk of deterioration and escalated them appropriately. Staff monitored patients' clinical observations such as pulse, oxygen levels, blood pressure and temperature. The service used a scoring system based upon these observations known as a national early warning score (NEWS 2) to identify patients whose condition was at risk of deteriorating. Nursing staff received training on the NEWS 2, which staff completed for each patient operated on using intravenous sedation. The service assessed all patients for risk of venous thrombo-embolism (VTE). We saw evidence of this in the patient records.

Only one patient could undergo a procedure at a time due to the size and layout of the service. This meant no patient was left unattended in the recovery area. The anaesthetist remained in the service until the service discharged the patient. Clinical staff adhered to the discharge checklists which were based on the British Association of Day Surgery's guidelines. We saw these checklists formed part

Surgery

of the patient record. If a patient's discharge was delayed beyond usual clinic hours, the clinic would remain open until the necessary time with the relevant staff continuing to provide ongoing care and treatment. This had not happened in practice, as any cases involving deep intravenous sedation were scheduled in the morning to allow for maximum daytime recovery.

In an emergency, the service used the standard 999 system to transfer the patient to an NHS hospital. We saw evidence all staff had received life support training appropriate to their role. Since opening, there had been no unplanned transfers to other hospitals. If a patient needed to return to theatre, the surgeon who had performed the operation remained on-call. From opening in 2019 to February 2020, there were no unplanned returns to theatre.

The admissions policy stated patients should be escorted home by a responsible adult following a procedure undertaken under intravenous sedation. All patients had to have access to a telephone in case they needed to contact someone for follow up advice or treatment. Patients were able to contact staff at the clinic for support at any time. The service gave patients a telephone number to call following their procedure, which went through to a member of clinic staff 24 hours a day, seven days a week. Staff called patients each day for 10-14 days following each procedure to check on their wellbeing and recovery.

Staff were encouraged to monitor signs of infection and sepsis as part of the wound care process post-surgery. Staff we spoke to were able to tell us about the signs of sepsis and received training on this.

The service had a major haemorrhage pack. Staff checked this weekly. We saw all items were in date and available.

Nursing and support staffing

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

The service had enough nursing and support staff to keep patients safe. The service employed two whole-time equivalent (WTE) nursing staff and two WTE support staff. Staffing levels complied with the Association for Perioperative Practice (AfPP) guidelines. All staff we spoke with felt staffing levels were adequate to provide safe and effective care for patients. For all cases involving

intravenous sedation, two nurses (or one nurse and the medical director) supported the surgeon and anaesthetist. For all cases involving local anaesthetic, the surgeon and a nurse were present. Nurses were trained to monitor patients for signs and symptoms of toxicity when liposuction was performed under local anaesthesia.

The service had not used any agency staff since opening in April 2019. The service reported no sickness or unfilled shifts in this period. In the case of staff sickness, managers contacted other staff to see if they could work. Surgery would be cancelled and rearranged if required. The service had not cancelled any procedures due to inadequate staffing since the clinic opened.

The service reported 50% turnover since the time of opening. The service did not conduct formal exit interviews but told us this was due to the fact it was a new site, and this fitted with the picture nationally with issue of recruiting long-term nursing staff.

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 worked with consultants under a practising privileges framework. At the time of inspection, four consultants were employed under a practising privileges agreement. All elective operations were planned in advance to ensure the availability of the required surgeon, as they had different areas of speciality.

The service ensured the surgeon was always contactable 24 hours a day, with the patient provided with their contact details to use in the 48 hours following a procedure if needed. All surgeons lived within London and would be available to attend the clinic within a 30-minute time frame if required. This was also true for any locum anaesthetists used by the service. In the event of the surgeon being unobtainable, the medical director (who was a plastic surgeon himself) assured us he would attend to care for a patient.

Records

Surgery

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

Patient notes were comprehensive, and all staff could access them easily. We reviewed five sets of medical notes and found these complied with General Medical Council (GMC) and Nursing and Midwifery Council (NMC) standards for documentation. We saw evidence of a discussion with the patient about post-operative pain, sickness and medication in these records. All entries had names and dates on every page. Monthly documentation audits checked the storage, completeness and accuracy of patient records. The registered manager followed up any issues with staff to ensure notes were comprehensive and clear. In February 2020, the audit showed 100% compliance with documentation standards.

The clinic stored records securely. Most of the patient records were paper based, to ensure all information was in one place. The service kept paper records in a locked cabinet and transferred these to the provider's other location in a concealed bag with an authorised person (nominated individual/registered manager) usually by car for long-term secure storage.

Doctors recorded any follow-up notes electronically. The service reported no patients were seen for follow-up appointments without relevant medical records being available. Paper medical records would remain at the location until all follow-up appointments were complete to ensure ready access to the operative records.

The service gave all staff individual log-ins and passwords to access electronic records and computers. Staff locked terminals when not in use.

Records were organised in a way that allowed identification of patients who had been treated with a particular device or medicine in the event of product safety concerns or regulatory enquiries. There was a standard process to upload information the next working day to the national breast implant online registry. Surgeons also had access to the registry to crosscheck their cases had been uploaded to the registry. This was in line with national guidance (Royal College of Surgeons Professional Standards for Cosmetic Surgery, April 2016).

Medicines

The service used systems and processes to safely prescribe, administer, record and store medicines. However, staff did not log the serial number of private prescriptions, although the service introduced a prescription log following our inspection.

Staff stored and managed all medicines in line with the provider's policy. Senior staff told us they conducted audits of any medicines in stock to ensure any unused items were disposed of and stock levels did not become too high. We saw the monthly medicines management audits for the three months prior to inspection, which noted 100% compliance with storage requirements.

In the January 2020 prescribing and administration audit, the service found some issues recording of medication intra-operatively, which the registered manager shared directly with these individuals. On the day of inspection, we found all medicines administration records checked were complete, accurate and contained records of allergies if necessary.

Staff kept medicines and intravenous (IV) fluids in locked cupboards with restricted access to ensure security. All medicines we checked were within date. When clinical staff were on site, they were responsible for the safe custody of the medicine keys. The service stored keys in a key safe, which was only accessible to registered members of staff.

The service stored controlled drugs (CDs) in a locked cupboard, which a registered nurse held the keys for. Two qualified nurses checked drug stock daily and a spot check of the register confirmed levels were correct. We saw weekly CD audits for the last three months confirming the service monitored storage and documentation relating to CDs regularly.

Staff monitored medicine fridge temperatures daily to maintain the function and safety of refrigerated medicines. Staff acted when these were outside of normal range.

The clinic had adult antimicrobial guideline for the use of antibiotics, which identified prophylactic antibiotics used for specific procedures. This was in line with national guidance from the National Institute for Health and Care Excellence (NICE).

Doctors used headed paper to write prescriptions. The service printed these off in batches of 25, with serial numbers detailed on each piece of paper. The service kept these in a locked cabinet. The prescriptions could be filled

Surgery

at any pharmacy. However, we noted staff did not log the serial number of each prescription, which could potentially lead to their misuse. Following our inspection, the service created a prescription log, with nursing staff receiving training on the use of this.

Incidents

The service managed patient safety incidents well. Staff recognised and reported incidents and near misses. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support.

All staff knew what incidents to report and how to report them. Staff raised concerns and reported incidents and near misses in line with the provider's policy. Staff recorded incidents on paper-based forms.

From starting to carry out regulated procedures in April 2019 to February 2020, the service reported one incident, relating to a stock of antibiotics running out, resulting in 'low' harm. Three 'near misses' were also reported, although one of these was not graded for potential harm.

There were processes for investigating incidents. Staff informed us that managers shared any learning and feedback individually and in monthly meetings. Staff met to discuss the feedback and look at improvements to patient care. Staff gave examples of changes in practice from incidents, such as nurses being aware to inform the surgeon if a stock of any medicine was running low and of alternatives available.

The service reported no serious incidents (SIs) since opening in 2019. The registered manager would debrief and support staff after any serious incident.

The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain notifiable safety incidents and provide reasonable support to that person. Staff understood the duty of candour. They were open and transparent and gave patients and families a full explanation when things went wrong. There had been no incidents meeting this threshold since the service opened.

Safety Thermometer (or equivalent)

The service collected safety information and shared it with staff.

The NHS safety thermometer is an improvement tool to measure patient harms and harm-free care. It provides a monthly snapshot audit of the prevalence of avoidable harms in relation to new pressure ulcers, patient falls, venous thromboembolism (VTE) and catheter-associated urinary tract infections. The service was not required to use the safety thermometer as it was a private healthcare provider. However, the service collected some of this information relevant to day case surgery. There had been no cases of VTE (a deep vein blood clot) or pulmonary embolism (PE) (a blood clot in the lungs) since the service opened in 2019. Patients who attended the service underwent outpatient or minor day case procedures. This meant there was a very low risk of patients acquiring a pressure ulcer, VTE or PE while having treatment.

Are surgery services effective?

Good 

This is the first time we rated effective for this service. We rated it as **good**.

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.

Staff followed up-to-date policies to plan and deliver high quality care according to best practice and national guidance. Staff followed treatment guidelines based on National Institute for Health and Care Excellence (NICE) guidance, such as NG89: 'Venous thromboembolism in over 16s: reducing the risk of hospital-acquired deep vein thrombosis or pulmonary embolism'. Staff were able to access policies and procedures on the shared drive. Policies we reviewed were within their review date and contained appropriate references to national guidance. However, we found two policies on safeguarding and infection prevention control containing an outdated or incorrect reference. One of these was corrected following our inspection feedback.

Surgery

The provider carried out clinical audits to monitor consistency of practice. These included medical records, medicines management, infection prevention and control, and staff training and competencies. We saw evidence staff discussed results in the monthly clinical governance committee, with any agreed actions shared in staff meetings and by email.

The surgeon discussed the expected outcome with each patient before treatment. The service also reviewed outcomes post-operatively. The surgeon discussed any relevant psychiatric history, with an onward referral for psychological assessment if required. This was in line with professional standards (RCS Professional Standards for Cosmetic Surgery April 2016).

Nutrition and hydration

Staff gave patients enough to eat and drink. Staff followed national guidelines to make sure patients fasted before surgery.

Staff made sure patients had enough to eat and drink. The clinic provided water, tea and coffee to all patients. Following surgery, staff offered patients a selection of cold snacks before discharge.

The service sent patients information on surgery prior to any procedure, which included information on fasting times. Information advised patients not to eat solid food for six hours, and not to have clear fluids for two hours, before their operation. Records indicated staff checked to ensure patients had adhered to fasting times before surgery involving intravenous sedation went ahead. The service did not conduct a fasting audit to ensure all patients followed the Association of Anaesthetists of Great Britain and Ireland (AAGBI) best practice guidance on fasting prior to surgery. Due to the size of the service, with only one patient admitted at a time, it was unlikely patients fasting before surgery would be without food for excessively long periods. This was because theatre lists were short and carefully planned.

The service managed nausea and vomiting effectively. The service prescribed an anti-sickness medication to patients undergoing intravenous sedation before surgery. Staff routinely monitored patients for nausea and vomiting during and following their procedure.

Pain relief

Staff assessed and monitored patients regularly to see if they were in pain and gave pain relief in a timely way.

Staff assessed patients' pain using a recognised tool and gave pain relief in line with individual needs and best practice. Staff assessed pain regularly both during and following surgery, until the patient was discharged from the service. We saw evidence in records that pain scoring used the numeric rating scale (NRS) and staff gave patients pain relief where indicated.

All patients were prescribed pain relief medication to take at home following their surgery, unless contraindicated. Staff gave patients a telephone call the day after each procedure to check their wellbeing and whether they were in any pain. This daily call continued for 10-14 days, dependent on each patient's needs.

The service did not audit pain management.

Patient outcomes

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

Patient reported outcomes measures (PROMs) assess the quality of care delivered from the patient's perspective. The service collected patient related outcome measures (PROMS) data in line with Royal College of Surgeons (RCS) standards. We saw the PROMS data for 14 patients who had undergone liposuction at the service, and 100% were satisfied with the outcome and said they would undergo the surgery again knowing the outcome. Senior staff were exploring ways to improve the collection of PROMS data, as many patients did not engage with the surveys. No other PROMS data was provided by the service when we asked.

From opening for regulated procedures in April 2019 to February 2020, there were no unplanned readmissions within 28 days of discharge, no unplanned returns to theatre and no surgical site infections. We saw evidence from the minutes of meetings indicating staff discussed any complex cases or complications relating to surgery.

The registered manager and staff carried out a programme of repeated audits to check improvement over time.

Surgery

Managers checked the effectiveness of care and treatment through local audit, with improvements implemented where required. The clinic was supplying national data to the Private Healthcare Information Network (PHIN).

Competent staff

The service made sure staff were competent for their roles. The registered manager 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. The registered manager gave all new staff a full induction tailored to their role before they started work.

In August 2019, the provider introduced a comprehensive bespoke core competency framework and training programme for registered nurses working in the perioperative environment at the service. The core competency framework and training programme were based on the European Operating Room Nurses Association (EORNA) common core curriculum for perioperative nursing (2019), the Perioperative Care Collaborative National Core Curriculum (2017) standards and the Standards and Recommendations for Safe Perioperative Practice (fourth edition) by the Association for Perioperative Practice (AFPP). The core competencies consisted of 47 modules covering topics relating to professional, ethical and legal practice, perioperative care and practice, interpersonal relationships and communication, managerial and leadership skills, and education and professional development.

Nursing staff completed a mixture of observation, e-learning, one to one training, group training and external sessions, taking place over six weeks. Nurses then completed self-assessments on what they had learned, with further practical assessment and sign-off by the medical director. The whole programme ran over a period of three months, with nurses repeating the programme every two years to ensure their skills kept up to date. We saw evidence nursing staff had either completed the course or were in the process of completing this, depending on when they had started working for the service. Nursing staff we spoke to were complimentary about the programme.

The registered manager supported staff to develop through yearly, constructive appraisals of their work. We saw evidence all staff had received an appraisal this year. The

registered manager identified any training needs for their staff had and gave them the time and opportunity to develop their skills and knowledge. All staff we spoke with were happy with their access to continuous professional development.

The service gave administrative and clerical staff additional training to support the delivery of safe and effective care. For example, they had received training about some of the procedures undertaken at the service so they could answer some of the patient's initial questions.

There was an up-to-date policy for the granting and reviewing of practising privileges. The service granted consultants' practising privileges after scrutiny by the medical director. The granting of practising privileges is an established process whereby a medical practitioner is granted permission to work with an independent hospital. The documents required before practising privileges were granted included evidence of private medical insurance cover, immunisation status, appraisal records, Disclosure and Barring Service (DBS) check, and two references. DBS checks identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable. We reviewed consultant files which demonstrated all relevant documentation was up to date and reviewed annually. The medical director told us concerns about a consultant's practice would be identified through the appraisal process undertaken by the main employer. If such concerns were shared or noted during annual checks, the service would investigate and take action as appropriate.

New consultants would work alongside the medical director when first operating to ensure they were comfortable with the surgical environment and process at the clinic. We observed this on the day of inspection.

The consultant surgeons were skilled, competent and experienced to perform the treatments and procedures they provided. The four consultants employed under a practising privileges agreement were on the General Medical Council (GMC) Specialist Register. The Specialist Register is a list of doctors who are eligible for appointment as substantive, fixed term or honorary consultants in the health service in the UK. Three consultants were listed as specialists in plastic surgery, with the fourth specialising in obstetrics and gynaecology.

Surgery

The provider informed us surgeons only worked within their scope of practice and operated completely within their area of known practice and ability. The provider's procedure for determining scope of practising privileges involved an initial interview with the medical director, who was a plastic surgeon. In this meeting, the medical director discussed the applying surgeon's CV, skills, experience and expertise, with a view to determining scope of practice. We saw evidence of discussion of scope of practice in three practising privileges out of four records. The fourth consultant had just started at the service and had a background in obstetrics and gynaecology. The provider reassured us they would be only undertaking female aesthetic gynaecological procedures such as labiaplasty at the clinic. The surgeons attended conferences and further training appropriate to their role.

All anaesthetists were employed on a locum basis, with the agency conducting checks to ensure they were appropriately trained and supervised.

Multidisciplinary working

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

Treatment provided was consultant-led. All team members were aware of who had overall responsibility for each patient's care.

Staff held regular meetings to discuss patients and improvements to their care where there had been complications. We saw minutes from these meetings.

Staff told us they enjoyed working with their colleagues and were complimentary about the support they received from one another. We observed good working relationships between all staff. Staff delivered care in a coordinated way. There was evidence of staff working together to meet patients' needs.

The service shared relevant information with the patient's GP. The service gave patients a discharge summary and information, which included details of the surgery performed, post-operative advice, contact numbers and follow-up appointments. The service asked patients for their consent to share information with their GP. If patients consented, the surgeon wrote to their GP following a consultation. They informed them of the planned procedure and asked whether there were any

contraindications. The service sent a discharge summary to the patient's GP post-operatively if the patient consented. This included details of the surgery performed and any implants used, where appropriate. The service gave patients who did not consent a copy of their discharge summary.

The service would involve mental health services when required. They had a service level agreement with an organisation providing psychological services they could refer these patients to if they felt necessary. They would also write to the patient's GP if they had any concerns about a patient's mental health.

Seven-day services

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

The service was open for consultation appointments and surgery from 9am to 6pm, Monday to Friday, and 10am to 6pm on Saturdays (usually just for consultations). The service only undertook planned surgery with operating lists organised in advance.

The service gave patients their consultant's mobile telephone number and they had direct access to the consultant for 48 hours post-operatively. The service contacted patients every day for 10-14 days following surgery to ensure they did not have any concerns.

Health promotion

Staff gave patients advice regarding their procedure.

Staff recorded the smoking status and alcohol intake of patients at the initial consultation. The service advised patients to stop smoking for two weeks before and after surgery. This was to reduce the risk of any complications and help promote healing.

Before treatment, the service provided patients with materials they could read outlining their procedure. The service advised them to use a pre-operative skin wash to reduce the risk of post-operative infection and to bring a post-operative garment, if advised, to support the wound healing process.

On discharge, the service provided patients with further information on how to look after themselves post-procedure.

Surgery

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

Staff supported patients to make informed decisions about their care and treatment. They followed national guidance to gain patients' consent.

Staff understood the relevant consent and decision-making requirements of legislation and guidance, including the Mental Capacity Act 2005. All staff received training relating to the Mental Capacity Act 2005. The service did not treat any patients who lacked capacity. Senior staff told us if there were any concerns about a patient's capacity to consent, they would not proceed with cosmetic surgery without seeking further information from the patient's GP.

Staff made sure patients consented to treatment based on all the information available. Staff clearly recorded consent in patients' records. We saw evidence patients came in for an initial consultation appointment, where they met with the surgeon who would perform their procedure. At this appointment, the surgeon discussed all the risks and benefits of the procedure, as well as all relevant patient history.

The Royal College of Surgeons' professional standards for cosmetic surgery states consent must be obtained in a two-stage process, with a cooling-off period of at least two weeks between the stages to allow the patient to reflect on their decision. All records we reviewed had a clear gap of at least two weeks from consultation to the surgery procedure, apart from one, where the patient had signed a waiver. The patient reconfirmed their intention to go ahead with a procedure by completing the consent form on the day of the procedure.

We reviewed five patient records and found complete consent forms, signed and dated by the patient and the operating surgeon. The consent forms included details of the planned surgery, intended benefits, potential risks and complications in line with Royal College of Surgeons' guidance.

Are surgery services caring?

Good 

This is the first time we rated caring for this service. We rated it as **good**.

Compassionate care

Staff treated patients with compassion and kindness, respected their privacy and dignity, and took account of their individual needs.

Staff were discreet and responsive when caring for patients. Staff took time to interact with patients in a respectful and considerate way. Patients said staff treated them well and with kindness. We spoke with two patients, and both spoke positively about how staff had treated them.

Patients often shared their feedback online. This was overwhelmingly positive. The service had a rating of 4.9 out of five, based on 69 reviews, at the time of our inspection.

The service collected and shared patient feedback, including compliments, with all staff during team meetings. The service encouraged patients to give feedback through a patient satisfaction questionnaire. We saw collated feedback for December 2019 and January 2020, based on 13 feedback forms from patients from both of the provider's locations. Senior staff informed us they could not separate feedback by site. In terms of overall care, 92% of patients surveyed rated this as 'excellent', and the remaining 8% rated it as 'good'. Further, 92% of patients said they would recommend the service to others, and all patients rated the maintenance of their comfort and privacy as 'excellent' or 'good'.

Staff followed policy to keep patient care and treatment confidential, and were able to describe how they would hold sensitive conversations with patients. Staff understood and respected people's privacy and dignity needs, including during physical or intimate care and examinations. There was a chaperone policy, and staff had undertaken formal training in how to act as a chaperone. However, on the day of inspection we noted the main consultation room did not have a lockable door, and the 'do not disturb' sign was not in use whilst patient consultations were taking place. This presented the risk of someone walking in to the appointment while an examination was taking place. Following our inspection, the service added a lock to the door of the main consulting room.

Emotional support

Staff provided emotional support to patients, families and carers to minimise their distress. They understood patient's personal needs.

Surgery

Staff could describe how they would give patients and those close to them help, emotional support and advice when they needed it. The clinic told us they could offer patients as many consultations as necessary to ensure patients were happy with the procedure. The service offered any additional consultations free of charge.

Staff recognised many patients were anxious about having surgery and they made sure patients always had enough time to ask questions during their consultations. Staff understood the impact a person's care and treatment could have on their wellbeing. At the initial consultation, the surgeon asked patients about their medical history, social circumstances and mental health status. The service had links with a psychological service who they could refer patients to, if they had any concerns about their emotional wellbeing.

On the day of inspection, we saw staff were empathetic to a patient who was anxious about their surgery. They took the time to reassure them. Staff were able to tell us how they would support patients at distressing times.

Staff gave patients appropriate and timely support and information. The service gave all patients the surgeon's personal mobile number, who they could contact if they had any concerns or questions for 48 hours following a procedure. The service conducted daily wellbeing calls for 10-14 days following each procedure.

Understanding and involvement of patients and those close to them

Staff supported and involved patients to make decisions about their care and treatment.

Staff made sure patients understood their care and treatment. Staff talked with patients in a way they could understand. Staff supported patients to make informed decisions about their care. Patients told us they felt involved in their care and had received the information they needed to understand their treatment.

Patients gave positive feedback about the service. Staff could give examples of how they used patient feedback to improve the quality of care they provided. We saw collated feedback for December 2019 and January 2020, based on 13 feedback forms collected from patients at both of the provider's locations. All patients rated the information given about fees and services as 'excellent', and all rated the information given by the surgeon and about the

recommended procedure as 'good' or 'excellent'. Similarly, all patients rated their involvement in the decision making as 'good' or 'excellent' and all patients regarded the information given as easy to understand.

People considering or deciding to undergo cosmetic surgery were provided with the right information and considerations to help them make the best decision about their choice of procedure and surgeon. Patients received comprehensive information about the surgery they were considering. This included how the procedure was performed, costs, and the risks and complications associated with the procedure.

There were appropriate and sensitive discussions about the cost of treatment. The service advised patients of the cost of their planned treatment at the booking stage. The service also sent this information by email, so patients were fully aware of their planned treatment costs.

The service only performed surgery under local anaesthetic and deep sedation. The service informed patients who underwent deep sedation they needed to have an escort home. This meant patients were empowered to be independent and manage their own health very quickly after surgery.

Are surgery services responsive?

Good 

This is the first time we rated responsive for this service. We rated it as **good**.

Service delivery to meet the needs of local people

The service planned and provided care in a way that met the needs of their patient population.

The registered manager planned and organised services, so they met the needs of the patient population. As the clinic provided private elective cosmetic surgery, the service planned appointments at times to suit the patients. The clinic was open six days a week for consultations and post-operative wound care appointments. The service planned theatre lists in advance.

The clinic was in central London, with good public transport links, making it accessible to patients from a wide geographical area.

Surgery

Facilities and premises were appropriate for the services being delivered. There was a small waiting area, with enough seating for patients, and those accompanying them. People had access to water, magazines, information leaflets and toilets.

Meeting people's individual needs

The service was inclusive and took account of patients' individual needs and preferences. Staff made some reasonable adjustments to help some patients access services.

The service did not routinely treat patients with complex needs. Staff made sure patients living with mental health conditions received the necessary care to meet all their needs. Staff referred patients to a psychological service if they were concerned about their mental health and wellbeing.

Managers made sure staff and patients could get help from interpreters when needed. There were arrangements for patients who required translation services. The service could request interpreters to attend appointments or staff could access telephone support.

The service did not have information leaflets available in other languages or formats on the day of inspection, although told us this could be arranged. At the time of our inspection, no patient had requested this.

There were no facilities available for patients who were hard of hearing.

The service required all patients to be independently mobile. The treatment room was down a set of stairs. If patients were not suitable for this day case setting, one of the surgeons had practising privileges at another medical facility. Staff made arrangements for the patient to have the procedure there.

Access and flow

People could access the service when they needed it and received the right care promptly.

Between starting to carry out regulated activities in April 2019 and November 2019, the clinic recorded 117 day case procedures and 457 outpatient attendances. The most common procedures performed at the clinic in this time were: liposuction (28), skin lesions (15), ear lobe repair (11), labiaplasty (10), lip reduction (eight), tattoo removal (six),

areola/nipple reduction (six) and other procedures (33). The service cancelled two procedures for non-clinical reasons. When patients had their appointments cancelled at the last minute, the manager ensured these were rearranged as soon as possible.

Patients could contact the clinic by email or telephone. Patients considering surgical procedures would have a face-to-face consultation with the relevant surgeon. Following this appointment, subsequent consultations could be offered, or the surgery could be booked. Patients undergoing cosmetic surgery waited a minimum of two weeks between consultation and procedure. This 'cooling off' period was in line with national recommendations (Royal College of Surgeons Professional Standards for Cosmetic Surgery, April 2016).

The service did not audit patient waiting times for surgery or consultations. This was because all procedures were elective, and patients were able to choose their preferred dates. Staff could only treat one patient at a time due to the size and layout of the service. This meant the service carefully planned surgery, with no long procedures booked in take place after 2pm. We saw collated feedback for December 2019 and January 2020, based on 13 feedback forms from patients from both of the provider's locations. All patients rated waiting times as 'good' or 'excellent'.

If patients had an issue following surgery, the service provided them with a telephone number to contact a clinician to discuss this. In an emergency, the patient was directed to an acute hospital accident and emergency department. For non-emergency issues, the operating surgeon would review the patient. The service arranged any revisions to surgical outcomes as a further planned episode of 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. However, the service did not currently subscribe to the Independent Sector Complaints Adjudication Service (ISCAS).

Surgery

Staff understood the policy on complaints and knew how to handle them. Staff told us they dealt with informal complaints in the first instance. In the case of a formal complaint, the provider

had a policy for handling complaints and concerns. The policy stated the service would acknowledge any complaints within three working days, with a full response within 20 working days of receipt. Where this timeframe was not possible, the service would send a letter to the complainant to inform them of the revised schedule.

Patients knew how to complain or raise concerns. Managers investigated complaints and identified themes. Between opening in February 2019 and November 2019, the clinic recorded one complaint. This complaint related to a range of factors in relation to the procedure. The service acted to resolve the complaint to the patient's satisfaction. We saw evidence that managers investigated the complaint and ensured learning was shared across the service.

There were processes for patients to appeal if they were unhappy with the outcome of their complaint. If patients remained dissatisfied with the outcome of their complaint, the service advised them to escalate this to the Citizens Advice Bureau. The service did not currently subscribe to the Independent Sector Complaints Adjudication Service (ISCAS), which is a voluntary subscriber scheme for the independent review of complaints. Although this is not mandatory, it is best practice for providers in the independent health sector.

Are surgery services well-led?

Good 

This is the first time we rated well-led for this service. We rated it as **good**.

Leadership

Leaders had the skills and abilities to run the service. They understood and managed the priorities and issues the service faced. They were visible and approachable in the service for patients and staff.

The leadership team was made up of the registered manager, the medical director and the operations director

(also the nominated individual). The service recruited the registered manager before this location opened. They came from a clinical background, giving them a good understanding of the clinical needs of the service.

The leadership team had good knowledge of the service, with a clear understanding of the risks and challenges the service faced. Leaders had introduced a new governance structure with clear lines of responsibility and reporting, as well as a regular audit programme and risk assessment process.

All staff informed us they found the leadership team to be approachable and supportive. As a small team, all staff worked together regularly and were able to seek advice and speak freely with one another. We saw evidence of formal staff meetings where staff could raise any issues or suggest ideas to improve the service. Leaders told us they were proud of their staff who worked hard to deliver high quality care for patients.

Vision and strategy

The service had a vision for what it wanted to achieve but no clear strategy to turn it into action.

The service's vision was to 'create a multidisciplinary clinic offering both cosmetic surgery and non-surgical treatment options all under one roof', with patient safety at the heart of everything. The mission of the service was to deliver an outstanding patient experience, with a commitment to innovation and training. This was based on the values of transparency, individuality and passion.

Most staff were familiar with the vision and values and how they related to their role in the organisation. The service displayed the values on the walls of the clinic and the website.

However, the strategy of the service was not clear. No formal strategy document was provided when we requested this. Senior staff told us the focus had been to get the site running and compliant with regulations. They wanted to continue to train staff and retain them effectively.

Culture

Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. The service had an open culture where patients, their families and staff could raise concerns without fear.

Surgery

We observed good team working amongst staff on the day of inspection. Staff we spoke with told us they felt supported, respected and valued within the team. Staff told us they were happy working at the clinic and felt they contributed to creating a positive work environment. Staff attended team meetings. Managers encouraged staff to provide feedback, and meeting minutes showed this feedback was discussed and considered.

Staff felt supported in their work and said there were opportunities to develop their skills and competencies, which managers encouraged. Staff told us they felt confident to raise any concerns. There was an up-to-date policy on raising concerns, which outlined how to escalate any issues. Senior staff told us any errors were discussed openly and managed in a fair way, with an emphasis on learning, to better design systems that promoted safe behaviours.

Governance

Leaders operated effective governance processes, throughout the service. Staff at all levels were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service.

Since August 2019, the clinic had introduced a new clinical governance structure designed to have oversight on all clinical areas of the business, including regulatory compliance, risk management, patient safety, patient experience, workforce, information governance, clinical effectiveness and quality assurance. Each domain had been allocated a lead who was responsible for having oversight of that area. The medical director, operations director and the registered manager attended the monthly clinical governance committee. The registered manager prepared a monthly report covering all the domains detailed above for discussion at the monthly committee meeting.

Staff had a good understanding of incidents, risk and local performance. We saw staff meeting minutes, which demonstrated discussion of incidents and learning. The service shared these with all staff.

There were systems to grant and review practising privileges, with the medical director taking the lead on this. The granting of practising privileges is an established process whereby a medical practitioner is granted

permission to work with an independent hospital. We saw staff files included up-to-date details of professional registration, appraisal, DBS checks and training undertaken. The service checked these annually, with a formal review of practising privileges taking place every three years, as per the provider's policy. Staff working under practising privileges had an appropriate level of professional indemnity insurance in place. There was a quarterly surgeon's meeting that covered all clinical aspects of medical staff's practice.

Managing risks, issues and performance

Leaders and teams used systems to manage performance effectively. They identified and escalated relevant risks and issues and identified actions to reduce their impact. They had plans to cope with unexpected events.

The service had introduced a new risk management policy in August 2019, which required staff to complete a risk assessment for each potential risk, detailing all existing and additional controls identified. These risks were then reviewed and added to the risk register if deemed appropriate. We saw evidence of these assessments, as well as the provider's risk register, which referenced ongoing risks to the service, ranging from ensuring patients were consenting fully to environmental concerns. Staff graded these with level of risk and reviewed them regularly, with mitigating actions to minimise each risk recorded against each item. The service stored the risk register centrally on a shared drive. Senior staff were able to tell us about current risks on the register.

We saw fire evacuation plans throughout the service and staff were aware of them. There was a business continuity plan for the site, which detailed what actions staff should take in the event of an emergency. There was a back-up generator in case of power failure, which was tested monthly.

There were clear structures and processes to ensure the quality of the services and operational processes delivered, and systems to identify where actions should be taken. The registered manager collated service performance on key metrics, such as patient feedback and audit performance, and shared these with staff. A range of local audits took place, with the resulting information shared amongst staff to promote improvement. We saw the service acted upon internal audit results.

Surgery

Managing information

The service collected reliable data and analysed it. Staff could find the data they needed, in easily accessible formats, to understand performance, make decisions and improvements. The information systems were integrated and secure.

Patient reported outcomes measures (PROMs) assess the quality of care delivered from the patient's perspective. The service collected PROMS data on selected procedures in line with Royal College of Surgeons (RCS) standards. The service collated and submitted demographic and procedural data from online scheduling software to the Private Healthcare Information Network (PHIN).

Staff had access to the organisation's computer systems. They could access policies and resource material. All staff we spoke with demonstrated they could locate and access relevant and key records easily and this enabled them to carry out their day-to-day roles. All staff had access to their work email, where they received organisational information on a regular basis, including clinical updates and changes to policy and procedures.

Information governance training was part of the annual mandatory training requirement for all staff working at the service. All staff had completed this. However, on the day of inspection, we found one laminated piece of patient feedback sent by email to the service on a noticeboard in a public area, which contained the email address of a patient. We raised this with the nominated individual, who removed the feedback from the noticeboard immediately.

Information management systems protected patients against breaches of confidentiality and to prevent data loss. This included controlled access to paper records in the service. Electronic patient records were kept secure to prevent unauthorised access to data. Staff were aware of how to use and store confidential information. During our inspection, staff locked computer terminals when not in use to prevent unauthorised persons from accessing confidential patient information.

Engagement

Leaders had some engagement with patients and staff to plan and manage services. However, response rates to patient surveys tended to be low.

The service captured patient views about care and treatment using a patient feedback survey. The service recognised return rates had been low and had been exploring ways in which to improve levels of patients completing these, as well as PROMS returns. In December 2019 and January 2020, only 13 feedback forms had been completed from patients across both of the provider's locations. This was included on the service's risk register, which reported some improvement in levels of feedback forms returned in recent months.

Patients could post reviews onto the service's website. All patient feedback we saw was positive. Staff discussed patient feedback at clinical meetings. Minutes of meetings confirmed this.

Staff attended regular meetings, designed to foster staff engagement, share information and drive forward improvement. We viewed minutes of staff meetings, where staff were able to raise issues and discuss suggestions for improvement as needed. There was no formal mechanism for staff feedback other than team meetings, and there was no staff survey due to the small size of the service. Staff told us they would be comfortable suggesting improvements to the service to leaders within the clinic. The service did not conduct formal exit interviews for those leaving the service.

Learning, continuous improvement and innovation

Staff were committed to continually learning and improving services, although no formal quality improvement training had been provided.

The service encouraged staff to make suggestions for improvements to the service, although the service had not formally trained staff in quality improvement methodology. Staff attended conferences appropriate to their roles and regularly reviewed and updated policies and guidance accordingly. The provider was responsive to the feedback from our inspection and made some improvements following immediate feedback, such as the addition of a lock to the main consultation room door and the introduction of a prescription serial number log.

Outstanding practice and areas for improvement

Outstanding practice

- In August 2019, the provider introduced a comprehensive bespoke core competency framework and training programme for registered nurses working in the perioperative environment at the service. The core competency framework and training programme were based on national guidance and consisted of 47 modules covering topics relating to professional, ethical and legal practice, perioperative care and practice, interpersonal relationships and communication, managerial and leadership skills, and education and professional development. Nursing staff completed a mixture of observation, e-learning, one to one training, group training and external sessions. The whole programme was completed over a period of three months, with a plan for nurses to repeat the programme every two years to ensure their skills were kept up to date.

Areas for improvement

Action the provider **SHOULD** take to improve

- The provider should review all policies and ensure none contain outdated or incorrect references.
- The provider should consider how to clearly define and document a measurable strategy relating to the service.
- The service should consider how to further improve response rates to patient surveys.