Chiltern Medical Clinic, Goring on Thames

Quality Report

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

Ratings

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

Overall summary

Chiltern Medical Clinic, Goring on Thames is operated by Medical Skin Clinics Ltd. The service sees patients on a day case basis and has no overnight beds. Facilities include three treatment rooms and two consulting rooms. There are two waiting areas for patients.

The service provides cosmetic surgery to patients over the age of 18. The clinic provides some treatments not regulated by the Care Quality Commission (CQC) for children. We inspected surgery services.

Summary of findings

We inspected this service using our comprehensive inspection methodology. We carried out a short notice announced inspection on 27 February and 9 March 2020.

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

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

We rated this service as **Requires improvement** overall.

- Leaders did not operate effective governance processes, throughout the service. There was limited local clinical audit to make improvements and achieve good outcomes for patients. The service did not have systems to identify and manage service risks to reduce their impact.
- Storage of medicines was not in line with clinic policy or best practice.
- The clinic did not make an assessment of the need to carry out disclosure and barring service checks on their administration and support staff as part of their recruitment process.
- Not all equipment had an electrical safety check in line with the local policy. Emergency equipment was not stored in one location so we were not assured staff would know how to locate this..
- The service did not have a protocol for the recording of patient psychological assessments and the subsequent need for referral.
- The service did not provide mandatory training in key skills for all staff. On the second day of inspection we did see arrangements were being made to purchase on line training for all staff.
- There were gaps in the support arrangements for staff including an annual appraisal. On the second inspection day we saw one appraisal was complete and plans were in place to complete this process for all staff.
- The service did not have arrangements in place for people who need translation services.

However:

- The design, maintenance and use of facilities and premises kept people safe. Staff used control measures to protect patients, themselves and others from infection. They kept equipment and premises visibly clean.
- Staff completed and updated patient assessments. The service had enough staff with the right qualifications, skills and experience to keep patients safe from avoidable harm and to provide the right care and treatment. Staff recognised and reported incidents and near misses.
- The service provided good care and treatment, gave patients enough to drink and gave them pain relief when they needed it. Staff worked well together for the benefit of patients, advised them on how to lead healthier lives, supported them to make decisions about their care, and patients had access to good information.
- Staff treated patients with compassion and kindness, respected their privacy and dignity, took account of their individual needs, and helped them to understand their conditions. They provided support to patients, families and carers.
- The service planned and provided care in a way that met the needs of local people, took account of patient's individual needs and made it easy for people to give feedback. People could access services when they needed, and the service was flexible to patient requests for appointments and treatments.
- Leaders had the skills to run the service. Staff understood the service's vision and values and how to apply them in their work. Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. Staff were clear about their roles and accountabilities. The service engaged with patients, staff and the public and staff were committed to developing their skills.

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Surgery	Requires improvement 	Surgery was the main activity of the service. We rated this service as requires improvement in safe, effective and well led. We rated it as good in caring and responsive.

Summary of findings

Contents

Requires improvement

Chiltern Medical Clinic

Services we looked at: Surgery

Summary of this inspection

Background to Chiltern Medical Clinic, Goring on Thames

Chiltern Medical Clinic, Goring on Thames is operated by Medical Skin Clinics Ltd. The service was established in 2002 and moved to its current location in 2006. It is a private clinic in Goring on Thames, Berkshire. It serves the local community and accepts patients from outside this area. There is a second clinic located in Reading, Berkshire also managed by Medical Skin Clinic Ltd which shares some services and staff with Chiltern Medical Clinic. The Reading Clinic was not inspected.

We inspected surgery. The service provides cosmetic surgery such as mole and other skin lesion surgery, blepharoplasty (surgery to remove excess skin or fat from the eyelids) and earlobe repair. All surgery is performed as a day case under local anaesthetic. Pre and post-operative consultations take place at the clinic.

The clinic offers a range of services including laser hair removal, skin fillers, cosmetic treatments and other laser treatments. We did not inspect these services, as they are not regulated by the Care Quality Commission (CQC).

The clinic has had a registered manager in post since 2007. The current manager has been in post since March 2019.

The clinic offers services to self-pay and privately insured patients.

The service was previously inspected in 2014 when four out of five standards were met. A follow up desk based review found appropriate actions were taken and all standards were met.

Our inspection team

The team that inspected the service comprised a CQC lead inspector,an assistant CQC inspector, and a specialist advisor with expertise in cosmetic surgery. The inspection team was overseen by Catherine Campbell, Head of Hospital Inspection.

Information about Chiltern Medical Clinic, Goring on Thames

The clinic is registered to provide the following regulated activities:

- Surgical procedures
- Treatment of disease and disorder
- Diagnostic and screening procedures

During the inspection, we visited all areas within the Chiltern Medical Clinic. We spoke with five staff including doctor's assistants, reception staff, medical staff, and manager. We spoke with three patients and one relative. During our inspection, we reviewed five sets of patient records. We also reviewed information on policies, guidance, performance and feedback provided to us before and during the inspection.

There were no special reviews or investigations of the hospital ongoing by the CQC at any time during the 12 months before this inspection.

Activity (February 2019 to January 2020)

- There were 272 day case episodes of care recorded at the clinic.
- There were 662 clinic appointments.
- All patients were self-pay.

Five surgeons worked at the service under practising privileges (a process whereby medical practitioners are granted permission to work in an independent hospital/ clinic). The service employed a clinic manager, six therapists, three doctor's assistants, three administrators and one accounts person who worked at the Reading Clinic. The clinic manager was the registered manager.

Summary of this inspection

Track record on safety (February 2019 to January 2020)

- No never events.
- Two clinical incidents graded as no harm.
- No serious injuries.
- No incidences of healthcare associated Meticillin-resistant Staphylococcus aureus (MRSA), Meticillin-sensitive staphylococcus aureus (MSSA), Clostridium difficile (C.diff) or E. coli
- No complaints.

Services provided at the hospital under service level agreement:

- Clinical and or non-clinical waste removal
- Cleaning
- Laser protection service
- Pathology and histology

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?

Requires improvement

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

- The service did not provide mandatory training for all staff in key skills including basic life support, however on our second visit we could see this was being put in place.
- Not all staff had training on how to recognise and report abuse.
- The service had not risk assessed all staff roles as to whether a DBS check would be necessary.
- The storage of medicines was not in line with clinic policy or best practice.
- Not all equipment had safety checks in line with the clinic policy.
- Emergency equipment was present but not stored in one location and we were not assured staff would know where to locate this equipment.
- The service did not have a protocol for the recording of patient psychological assessments and their subsequent need for referral.

However:

- Staff were trained to use equipment. Staff used equipment and control measures to protect patients, themselves and others from infection. They kept equipment and the premises visibly clean.
- The service did use systems and processes to safely prescribe and administer medicines.
- The design, maintenance and use of facilities and premises kept people safe. Staff managed clinical waste well.
- Staff completed a preoperative risk assessment for each patient and removed or minimised risks.
- The service had enough staff with the right qualifications, skills 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.
- Staff recognised and reported incidents and near misses by completing an adverse report.

Are services effective?

Requires improvement

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

Summary of this inspection

- There was limited evidence that the service regularly reviewed patient outcomes and the effectiveness of care and treatment through local audit.
- There were gaps in the support arrangements for staff, such as appraisals.

However:

- The service provided care and treatment based on national guidance and evidence-based practice. A wide range of in date policies were available to staff.
- Staff gave patients enough fluids to meet their needs.
- Staff assessed and monitored patients regularly to see if they were in pain. They gave additional pain relief when needed.
- Doctors and all those responsible for delivering care worked together as a team to benefit patients. They supported each other to provide good care.
- The services opening hours and out of hours arrangements supported timely patient care. There was flexibility in appointment times and out of hour arrangements supported patient need.
- Staff supported patients to make informed decisions about their care and treatment. They followed national guidance to gain patients' consent.

Are services caring?

Good

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. There was a strong visible person-centred culture and patient feedback was positive.
- Staff provided emotional support to patients and those close to them to minimise their anxiety. They understood patients' personal, cultural and religious needs. The clinic had a friendly and calm atmosphere.
- Staff supported and involved patients and those close to them to understand their condition and make decisions about their care and treatment.

Are services responsive?

Good

We rated it as **Good** because:

- The service planned and provided care in a way that met the needs of local people and those patients travelling to them. Staff spoke about their pride in their positive relationships with the local community.

Summary of this inspection

- The service was inclusive and took account of patients' individual needs and preferences. Staff made reasonable adjustments to help patients access services.
- People could access the service when they needed it and was flexible to accommodate patient preferences.
- It was easy for people to give feedback and raise concerns about care received. This was clearly explained on the provider's website. The service committed in its policy to treat concerns and complaints seriously, investigate them and share lessons learned with all staff.

However:

- There was no translation service available for patients.

Are services well-led?

Requires improvement

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

- Governance processes were not effective with no regular overview of patient outcomes and limited clinical audit.
- Policies were not always followed for example the need for mandatory training, staff appraisal and the storage of medicines.
- The service did not have the systems to identify and manage risks to reduce their impact. There was no evidence of completed environmental risk assessments.
- There was limited evidence that the service gathered information in order to improve and innovate.

However:

- 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. They supported staff to develop their skills.
- The service had a vision for what it wanted to achieve and a strategy to turn it into action. The vision and strategy were focused on sustainability of services and staff understood that.
- 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.
- Staff at all levels were aware about their roles and accountabilities.
- Staff could find the data they needed, in easily accessible formats, to understand performance and make decisions. The information systems were integrated and secure.

Summary of this inspection

- Leaders and staff actively and openly engaged with patients, staff, the public by use of the website to plan and manage services.
- Staff were committed to learning and developing their skills.

Detailed findings from this inspection

Overview of ratings

Our ratings for this location are:

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

Requires improvement

Surgery

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

Are surgery services safe?

Requires improvement

We rated Safe as **requires improvement.**

Mandatory training

The service did not provide mandatory training in key skills to all staff.

- There were no records of mandatory training for non-medical staff. We looked at staff records and found records of competence in the use of equipment and carrying out procedures, however there was no schedule of mandatory training. The last recorded mandatory training took place in 2017 when staff undertook fire safety training.
- The clinic manager had completed on line mandatory training, during the last year to include fire safety, control of substances hazardous to health, infection prevention and control, health and safety, safe handling of medicines and safeguarding. All medical staff working at the clinic under practising privileges had on file, copies of their professional development and training from their NHS employment.
- On our second inspection day, we saw evidence that online mandatory training was being organised for all staff to include basic life support, information governance, infection prevention and control and safeguarding to cover both adults and children. A start date was to be confirmed.

Safeguarding

The service had not risk assessed all staff roles as to whether a disclosure barring service check was required. Not all staff had training on how to recognise and report abuse. Staff understood how to protect patients from abuse.

- The service had an in date safeguarding policy for adult and children that reflected national and local guidance. Staff could access the policies via the clinic's intranet and a hard copy was available in the main office which meant staff could access it easily. The policy stated that the clinic manager should be contacted if the staff had any safeguarding concerns. The policy contained contact phone numbers for the local safeguarding board.
- Staff were aware of the safeguarding policy and were able to explain their responsibilities. Staff could not recall any instances where they had to report a concern.
- There had been no safeguarding concerns reported to CQC in the reporting period January 2019 to January 2020.
- The clinic provided treatments for a small number of children for procedures such as hair removal and facial treatments outside CQC regulated activities. We did see a policy for the care of children and that no child was seen without a parent or guardian present.
- The clinic manager was the safeguarding lead for the clinic and had completed level three adult safeguarding and level three child protection training. Doctor's assistants, therapy and administration staff had not completed training, this was not in line with the Intercollegiate Documents in Roles and Competencies for Healthcare Staff for Adult Safeguarding (August 2018)

and Safeguarding for Children and Young People (January 2019). On our follow up visit, we observed that on line level two safeguarding training for both adults and children was being organised for all staff.
- Medical staff submitted information of their Disclosure and Barring Service (DBS) checks, however no other staff had these checks. At the time of inspection, we asked why no checks had been made and it was stated that it was thought not to be necessary. This did not give assurance that the service had risk assessed all staff roles as to whether a DBS check would be necessary and that local policies were reviewed accordingly.

Cleanliness, infection control and hygiene

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

- The premises was visibly clean and tidy. The service employed a cleaner through a third-party contract. Cleaning schedules and checks were made daily to ensure all areas were kept clean.
- Flooring in all clinical areas such the procedure rooms met with national requirements (Department of Health, Health Building Note 00-10 Part A: Flooring 2013). Treatment rooms floors appeared clean and following the inspection the clinic submitted evidence that the floors had been deep cleaned in August 2019.
- The service had an in-date cleanliness and infection control policy which reflected national guidelines. Staff were aware of the policy and the daily cleaning that they needed to undertake to minimise the risk of spreading infection. Daily checks of cleaning were recorded.
- Staff told us there had been no surgical site infections. Surgical procedures were carried out in any of the treatment rooms which meant staff were unable to track the location of an actual procedure in case of surgical site infections as there was no specific record of where each patient treatment was carried out.
- Staff were bare below the elbow and washed their hands in line with the five moments for hand hygiene from the World Health Organisation (WHO). Staff wore washable theatre clothes when assisting with procedures. There were notices to remind staff to maintain good levels of hygiene.
- Staff had access to personal protective equipment such as gloves, masks and disposable aprons which were available throughout the clinic. We observed staff using this equipment appropriately when caring for patients.
- The service used surgical instruments that were single use only. Stock checks showed these to be in date. This eliminated the risk of cross infection.
- The service had a current 'Decontamination and Sterilisation' standard operating procedure for reusable equipment. Two members of staff had received training from the manufacture and on the day of inspection one staff member was able to describe the process followed for decontamination and sterilisation. The steriliser was not used frequently but we observed that relevant checks were current, equipment was clean and there was a service record. Processes were in line with Department of Health Technical Memorandum HTM 01-01: Management and decontamination of surgical instruments (medical devices) used in acute care.

Environment and equipment

Not all equipment had electrical safety checks in line with the clinic policy. Emergency equipment was not stored in one location so we were not assured staff would know how to locate this. The design, maintenance and use of facilities and premises kept people safe. Staff were trained to use equipment. Staff managed clinical waste well.

- Some general equipment such as suction equipment, light source, illuminated magnifying glass and six other pieces of equipment that we checked had not been safety checked since 2017. This was raised with the manager at the time of the inspection as the clinic health and safety policy stated that equipment should be checked every two years. We did see evidence that staff visually checked there were no overloaded sockets, no frayed wires or electrical cables causing a trip hazard.
- Records showed that equipment such as lasers were kept under a service contract and servicing and safety checks were carried out in line with manufactures recommendations.
- There was an automated external defibrillator, used to help resuscitate a patient in cardiac arrest, located in the main office close to the waiting areas and three treatment rooms. Portable oxygen used for the same purpose was stored in an emergency bag with an oxygen mask, tubing and rescue mask. This was located

in the back corridor. Not all staff knew where all the equipment was located which did not give assurance that staff could respond appropriately to a deteriorating patient.

- The clinic was located on the ground floor of a building with ramp access for patients living with a disability. The entrance was secured with a keypad lock and visitors to the building requested access using an intercom, maintaining security for staff and patients.
- The premises was well maintained and had adequate facilities for the purpose of carrying out minor cosmetic surgery. The reception and waiting area had a private office where consultations took place. Three treatment rooms were located at the end of a short corridor. Beyond the treatment rooms was a second waiting area for patients All areas were tidy, furnishings were clean and equipment was stored either in the treatment rooms or at the back of the second waiting room. Corridors were clear and uncluttered.
- To the rear of the building was an area used as a staff kitchen and the adjoining corridor had storage cupboards and a separate room where the steriliser was located. Two fire exits were at the rear of the building and one was located to the front, all exits were clear of any obstruction.
- Single sex toilets were located at the front of the building, one of these being appropriate for patients living with a disability.
- Stock was kept in the treatment rooms and a separate storage cupboard. All stock checked was in date and there was evidence of stock rotation.
- All treatment rooms had warning notices displayed to show that lasers were used in that area. An external laser advisor provided support and audited the service. Local rules were in place and signed. Personal protective equipment including goggles were available for staff using lasers.
- The service had a current policy for the disposal and collection of clinical waste. A service level agreement was in place for the collection of clinical waste and details of collection dates and times were clearly displayed for staff. Staff segregated waste correctly. This was in line with the Department of Health Technical Memorandum (HTM) 07-01, Management and disposal of healthcare waste.
- General and clinical waste was stored in a locked compound outside the back of the building. Bins were secure and the area was clean and tidy.
- Sharps were observed to be managed safely with sharp bins being dated and not overfilled. Notices reminded staff about correct sharps disposal. The service had a service level agreement in place for the collection and safe disposal of sharp bins.
- The service had a policy for the collection, labelling and handling of specimens. A service level agreement was in place with an external provider to process all specimens. Staff were able to describe the process of recording and transporting specimens. There was a clear electronic audit trail detailing the specimen process, the outcome and how the patient was contacted with results and any other actions taken.

Assessing and responding to patient risk

Non clinical staff had not received basic life support training and there was a risk that staff might not recognise or know how to respond to signs of a patient's deteriorating health. An assessment of patients psychological state was not always formally recorded. Staff completed other risk assessments for each patient and minimised risks.

- Non clinical staff had not received basic life support training. This was not in line with the clinic's resuscitation policy which stated that staff with regular patient contact should be given annual resuscitation training and refreshers and the training should be recorded on each member of staff's training records. This did not meet the Resuscitation Council (UK) guidelines which recommends that all staff, including non-clinical, should undergo regular training in adult and child resuscitation appropriate to their role. All medical staff had completed resuscitation training. On our second visit, we saw there were plans to have all staff undertake basic life support training. The resuscitation policy which specified that in the case of a patient collapse the staff should call 999.
- An appointment and consultation policy outlined the process the patient followed if requesting treatment. A pre-operative consultation for cosmetic surgery was carried out by one of the medical staff. This included a risk assessment of the patient's suitability for surgery, including the medical history, existing diseases and disorders, medicines and previous surgery. The medical director told us that patients were assessed to ensure their vulnerabilities and psychological needs were

appropriately considered however this was not formally recorded in patient records. This was not in line with the Royal College of Surgeons (RCS) professional Clinical Standards for Cosmetic Surgery.

- All procedures were carried out under local anaesthetic and were day cases, no patients stayed at the clinic overnight. Patients seen at the clinic were day cases and had a very low risk of developing a blood clot, patients were asked if they had any blood clotting disorders and whether they were on any blood thinning medicines.
- On the day of the procedure, the patient was taken through to the treatment room. Patient identity and site of surgery were checked by the surgeon with an assistant present. Five patient records were reviewed and showed the surgery site was identified and checked. This was the only checking stage of the World Health Organisation (WHO) surgical checklist completed by staff. The clinic used a modified checklist in line with the minor surgery carried out.
- The clinic only carried out minor cosmetic procedures that could be performed under local anaesthesia. Therefore, the service had no agreement with the local acute NHS provider for the transfer of patients who required a higher level of care.
- Fire safety risk assessments were carried out by an external provider with alarms and emergency lighting being checked every six months and extinguishers checked yearly. We saw this had been completed in the last 12 months.
- Patients were verbally informed and given written post-operative instructions relevant for the procedure done. We observed several patient information sheets which all contained information on who to contact in the case of any concerns and included the phone number of the doctor responsible for their care and the clinic number. The clinic provided a 24 hour on call system.
- Following discharge home, patients were contacted by phone the following day to check that they were well and had no concerns.

Support staffing

The service had enough 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 did not employ nurses but did have three support staff who after a period of training acted as assistants to the doctors. The manager told us that on any day, one or two assistants would be working with one of the doctors to facilitate the procedure and patient care.
- The service employed six therapists who worked independently delivering cosmetic and other treatments.
- Other support staff included three administrators and the clinic manager who was also the registered manager.
- There were two staff vacancies due to maternity leave. Recruitment to these posts were ongoing.

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 was led by the doctor who had established the clinic and was the medical director. Four other surgeons worked at the clinic under practising privileges.
- All surgical care was doctor led and surgery was carried out under local anaesthetic, with no use of sedation.
- Surgeons would give patients their personal phone number so they were contactable post operatively. The clinic also operated an on-call service with either the clinic manager or medical director being available to take any patient calls out of hours.

Records

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

- All the information needed to deliver safe care and treatment was available to relevant staff in a timely and accessible way. Records were both paper based and electronic. The aim was to get all notes on the electronic system as soon as possible. The provider had a server at each location so if there was a malfunction with one server, staff would always be able to access patient records.

- We looked at five sets of records during our inspection. The service reported that no patients were seen without the relevant notes being available. All records were stored securely in line with the Data Protection Act (DPA) 2018 and General Data Protection Regulation policy.
- The electronic records were only accessible through a password protected system to authorised staff. The electronic notes we looked at showed appropriate pre-operative consultation and assessment including clear evidence of encouraging the patient to 'cool off' before agreeing to the surgery. There were clear operation notes and evidence of comprehensive post-operative care. This was in line with RSC Professional Standards for Cosmetic Surgery 2016.
- Patients were given information about the surgery performed, post-operative advice, contact numbers and any follow up appointment arrangements. Patients were asked for their consent to share records with their GP. The medical director stated that if the patient consented and there were matters of concern the GP would be written to.
- The service had an in-date records management policy covering security, data protection and staff responsibility in the management of all patient information. The clinic website contained information for patients on access to health records.
- A yearly audit of 20 patient records was last completed in September 2019 and showed that records were 100% compliant to local standards. Team meeting minutes showed that staff were reminded to complete records accurately.

Medicines

Storage of medicines was not in line with clinic policy or best practice. The service used systems and processes to safely prescribe and administer medicines.

- The service had an in date medicine management policy, specifying the ordering, storage and management of medicines. The clinic manager maintained stock levels and prescribing and administration of medicines was the sole responsibility of the medical staff at the clinic.
- The clinic held a small stock of medicines comprising of injections, ointments and tablets which were kept in a filing cabinet which could be locked. Other compartments of the filing cabinet also stored items which meant the cabinet would be opened on a regular basis. This was not in line with the clinic policy which stated medicines would be kept in a locked cupboard solely for this purpose in the treatment room. Best practice guidance from the Royal Pharmaceutical Society recommend dedicated cupboards for medicines storage. This was raised with the clinic manager at the time of the inspection.
- There was a stock list present, but it was not clear that regular stock checks were made as there were no records of this. All medicines checked at the time of inspection were in date.
- Emergency medicines were labelled and stored in the treatment room. The medicines were stored in bag which was not tamper proof. All medicines checked were seen to be in date.
- A medicine storage audit covering handling procedures: storage, disposal, error and incident reporting was completed in September 2019 results showed complete compliance and did not reflect the clinic not following policy for storage.
- Some medicines were ordered from a pharmacy supplier. If patients required other medicines a prescription was written by the medical staff on headed paper, only authorised persons had access to prescriptions as they were kept electronically. There was a local pharmacy located close to the clinic.
- Some ointments might be dispensed by the service and there was evidence of a process in place to prescribe, label and dispense.
- A fridge was in the main treatment room for the storage of a small supply of injectable medicines. Fridge temperatures were checked daily and were maintained within the correct range.
- The five patient records checked showed that patient allergies were always recorded, and notes reflected medicines given.

Incidents

Staff recognised and reported incidents and near misses.

- The service had an in date policy covering the reporting and investigation of incidents. There was information for staff on the need to exercise duty of candour.

Requires improvement

Surgery

- The service kept an adverse event log which recorded any incidents or complaints. There were two incidents during the period January 2019 to January 2020 and were graded as having caused no harm. There was evidence of actions taken.
- In the same reporting period, the service reported no never events. Never events are serious patient safety incidents that should not happen if healthcare providers follow national guidance on how to prevent them. Each never event type has the potential to cause serious patient harm or death but neither need have happened for an incident to be a never event.
- Staff spoke about being open and honest with patients, apologising if something went wrong and keeping contact with the patient to ensure there was a good outcome.

Safety Thermometer (or safety performance)

- The service told us that any patient safety information such as infection rates would be captured on the adverse event log and that there had been none in the last year.

Are surgery services effective?

Requires improvement

We effective rated it as **requires improvement.**

Evidence-based care and treatment

The service provided care and treatment based on national guidance and evidence-based practice.

- Patient's suitability for treatment was assessed in line with professional and expert guidance 'Royal College of Surgeons Professional Standards for Cosmetic Surgery April 2016'.
- The surgeon considered each patient's medical history, general health and history of previous cosmetic surgery before agreeing to carry out any surgery. Expected outcomes were discussed.
- Policies were available for staff. All policies were in date and referenced national guidelines. These were available to staff either on line or in hard copy.
- We observed patients being told when they may need to seek further help or advise and this was discussed verbally and incorporated into the patient information sheets.

Nutrition and hydration

Staff gave patients enough drink to meet their needs.

- All of the procedures carried out at the clinic were minor and did not require the patient to fast. This was in line with the national recommendations for patients having local anaesthetic.
- Complimentary hot and cold drinks were available for patients and relatives and if food was required this could be purchased from local shops and relatives were directed to a local café.

Pain relief

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

- Staff managed and assessed patients for pain. The minor surgical procedures were carried out under local anaesthetic and checks were made with the patient to ensure they were comfortable. Additional local anaesthetic was given if necessary.
- Patient information sheets given to the patient following the procedure advised on taking pain relief if necessary and other measures for example, anti-inflammatory gel that could be used and any precautions that should be taken if following this advice.

Patient outcomes

There was limited evidence of audit of surgical outcomes for patients. There was limited evidence that the service regularly reviewed the effectiveness of care and treatment through local audit.

- Local clinical audit was limited to a review of the conversion rate for one doctor's consultations to actual treatments. There was no evidence of audit being carried out to demonstrate the service reviewed the effectiveness of all care and treatment.
- The service did not collect quality patient reported outcome measures (QPROMS) for patients undergoing blepharoplasty (surgery to remove excess skin or fat

from the eyelids). The Royal College of Surgeons recommend the collection of this data and supply questionnaires to be completed pre and post operatively.
- As evidence of audit, the service submitted a case review the medical director had undertaken as part of his appraisal process. There was no other formally recorded patient outcome data.
- All patient undergoing minor surgery had a follow up appointment at six weeks when outcome of the surgery was reviewed. The manager told us that this gave staff an opportunity to both assess and discuss the outcome with the patient. Staff told us that many patients made repeat visits and that this indicated patients were satisfied with the outcome.
- Patient satisfaction with the care they received was monitored using a questionnaire about their experience of the service, however this did not include an assessment of their treatment outcome. Patient records showed outcomes were recorded for some individual patients at their follow up appointment.
- As the clinic was performing minor surgery under local anaesthetic there was no requirement for the service to engage with Private Healthcare Information Network (PHIN).
- From January 2019 until January 2020, there were no patient unplanned revisits to the clinic following treatment and no unplanned revision of treatment.

Competent staff

There were gaps in the support arrangements for staff, such as appraisals. The service supported the induction of staff

- The service had a HR policy which stated annual appraisals should be undertaken. On checking with the manager, we were told that therapist and reception staff had not had an appraisal completed in the last year. On our return visit one appraisal had been completed and it was planned that all other staff would be supported with an appraisal of their performance.
- We did not see records showing that staff underwent training in how to chaperone patients. Staff told us they did act as a chaperone when requested to do so.
- An induction process was in place, on employment staff were given a handbook which contained information about the service and summarised relevant policies. Staff training and professional development was identified when each member of staff joined the team and was part of the induction process. Staff described a process of being mentored and supported by a more senior staff member when they started work at the clinic.
- Staff at the clinic had defined roles either as assistants to the surgeons or as therapists and completed competencies relevant to their roles. We looked at three staff records and saw competencies were in place relating to procedures carried out and equipment used.
- The surgeons working at the clinic had the skills and experience to perform the treatments and procedures provided. Four of the five surgeons performed cosmetic surgery for privately funded, self-insured or NHS patients. One surgeon was on the specialist register.
- The Medical Director had experience as a GP and within the NHS as a clinical assistant in dermatological surgery. There was evidence on record of continuing practice development comprising mainly of conference attendance.
- There were arrangements in place to ensure all surgeons worked at the clinic in line with the clinic's practising privileges policy. We checked three medical staff files and surgeons had signed this policy and submitted relevant information of their qualifications, appraisals and revalidation status.
- We saw the doctors had current medical indemnity insurance. It is important for a doctor or surgeon to have adequate cover to protect patients, if they suffered harm because of doctor's or surgeon's negligence. This was in line with general medical council (GMC) guidance.

Multidisciplinary working

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

- The team worked together well. We observed positive working relationships between the medical, therapy and administration staff. Staff told us they enjoyed working as a team and supported each other.
- All minor surgery carried out at the clinic was led by the medical staff. Therapists led some cosmetic treatments but knew they could ask clinical staff for advice if they needed to do so. All staff knew who had responsibility for each patient's care.

- There were documented staff meetings when all therapy, administration and management staff came together to discuss current treatments, patient needs and patient records.
- The surgeon shared patient information with the GP if the patient gave consent and if there were any adverse outcomes. The five patient records reviewed did not show any correspondence to the patient's GP.

Seven-day services

The services opening hours and out of hours arrangements supported timely patient care.

- The clinic was open 9am to 6pm on Monday, Wednesday, Friday and Saturday and 9am to 8pm on Tuesday and Thursday.
- The clinic undertook planned minor surgery with appointment lists depending on the doctor's availability and patient request.
- The operating doctor would advise their patient to contact their personal work number if they had any concerns. Alternatively, the patient could ring the clinic which had a 24-hour telephone answering service. Out of hours there was a contact phone number for the on call manager. This service was managed by the clinic manager or medical director. The clinic manager told us that there were few out of hours calls.

Health promotion

- Patient records showed that patients were asked their history of smoking at their pre procedure assessment and we were told advice would be given at that time. There was no patient information displayed about smoking cessation or moderating alcohol intake.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

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

- The service had an in-date consent policy which referenced the relevant consent and decision making requirement of legislation and guidance including the Mental Capacity Act 2005. Staff understood the process and documentation of consent.
- The service had a standard consent form for minor surgery containing a one-page assessment form, the remainder being a pre-printed consent form with tick boxes to indicate which procedure and possible complications. All the consent forms included details of the planned surgery, intended benefits, potential risks and complications. Consent was obtained for the taking of photographs pre and post-surgery.
- We looked at five sets of notes and consent forms. They were fully completed, signed and dated by the patient and operating surgeon. We saw consent forms that were relevant to procedures such as blepharoplasty (surgery to remove excess skin or fat from the eyelids) and vascular procedures which detailed risks particular to those procedures.
- There was good evidence in the patient records of the two-stage consent process with a cooling off period between initial consultation and treatment being carried out. This was in line with the Royal College of Surgeons Professional Standards for Cosmetic Surgery, April 2016. Most patients undergoing cosmetic surgery waited a minimum of two weeks between consultation and surgery. Patients formally gave written consent on the day of surgery. The operating surgeon always took consent.
- We saw staff gained verbal consent before undertaking interventions and treatments.

Are surgery services caring?

Good

We rated it as **good.**

Compassionate care

Staff treated patients with compassion and respected their privacy and dignity. Feedback from patients confirmed that staff treated them well and with kindness.

- The service sought patient feedback via feedback forms which were handed to patients at random during their visit to the clinic at a given point in the year. The clinic kept a file of these forms and presented the results in charts for each doctor. A collated chart of the responses from 22 patients showed that 96% of patients strongly agreed to questions about the practitioner being polite, involving patients in decisions about their treatment and listening to them.

Requires improvement

Surgery

- We spoke with three patients who told us staff treated them with respect and dignity. We saw staff answered patient enquiries and interacted with patients in a friendly and sensitive manner. Doors were closed when patients underwent treatment and staff knocked before entering ensuring privacy for the patient.
- We saw patients had written thank you cards praising the staff and the service. One patient wrote "Thank you massively for a wonderful and generous job. You are an amazing and kind practitioner'.
- Chaperones were available if requested. The service's website stated that the clinic encouraged the concept of patient chaperone and staff we spoke with during the inspection told us this was offered to patients should they request it.
- The service had a patient confidentiality policy which included staff's responsibilities for ensuring confidentiality of patient related data and requirements under the General Data Protection Regulation (GDPR) and Data Protection Act (DPA) 2018.
- The service also had a privacy and dignity policy which stated patients at the clinic should always expect to be treated with dignity and respect and their privacy fully respected .
- The service offered a free review consultation at six weeks after the procedure which allowed feedback in person on outcomes and the treatment itself.
- The registered manager told us that negative feedback would be acted on to change and improve the practice, however there had been no negative feedback for us to review during inspection.

Emotional support

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

- Staff understood the impact a patient's care and treatment could have on their well being and were empathetic to patients who were anxious about their surgery. Staff told us that they would reassure and use the waiting room at the back of the clinic to speak to patients who were anxious, this would give the patient some privacy if they were upset.
- The service gave patients relevant and timely support and information. Patients were given the contact details for the surgeon who they could contact if they had any concerns
- Patients we spoke with told us that they were given information regarding aftercare at the time of their discharge and the patient was clear about what to expect. Patients told us they didn't feel rushed and staff were polite and made them feel at ease.

Understanding and involvement of patients and those close to them

Staff supported and involved patients, families and carers to understand their condition and make decisions about their care and treatment.

- Staff communicated well with patients, so they understood their care, treatment and any advice given. Patients we spoke with told us a good explanation was given of what was to happen and staff communicated to them in a way they could understand.
- Patients told us they felt involved in their care and had received the information they needed to understand the treatment.
- We did not observe a discussion between the doctor and a patient about the cost of the procedure, however staff told us they advised patients of the cost of their planned treatment at the consultation stage and referred them to the clinic's website which contained a price list for all the procedures they offered. The clinic also offered patients a range of finance options to help pay for their treatment.
- A family member we spoke with told us they felt involved in their relatives care and had received the information they needed to understand their treatment.

Are surgery services responsive?

Good

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 patients.

- The service provided a range of minor cosmetic treatments and specialised in dermatology surgery,

laser treatments for vascular lesions, pigment and laser hair removal. The clinic also offered cosmetic skin procedures such as microdermabrasion, light skin peels and blepharoplasty ((surgery to remove excess skin or fat from the eyelids) and sclerotherapy for leg veins.
- The facilities and premises were appropriate for the services delivered. There were small waiting areas at the front and back of the clinic, two reception offices and three consultation rooms. There was adequate seating for patients and visitors.
- The service was located on the ground floor and was wheel chair accessible. Patients and visitors could also access the service by public transport with the nearest rail station being a five-minute walk. The clinic informed their patients of their private car park with limited spacing and a public car park was also available and located across the road from the clinic. All information was clearly set out on the clinic's website.
- Staff told us they rang patients the day before their procedure to confirm their attendance and sent directions by email if patients requested this.

Meeting people's individual needs

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

- The service considered their patient's needs. The clinic was accessible to wheelchair users. Being located on the ground floor there was ramp access to the building. There were male and female toilets with one toilet being adapted for patients living with a disability.
- All patients we spoke with told us they had a consultation before their treatment and were informed of a follow up appointment which was arranged at a convenient time for the patient but no later than six weeks after surgery at no additional cost.
- The waiting area displayed a range of information and leaflets on different kinds of procedures the clinic offered. The service offered complimentary hot drinks and water to patients, relatives and visitors and there was reading materials such as lifestyle magazines.
- There were no leaflets available in different languages and no arrangements for patients who required translation services. The service used staff and family members to interpret and translate as needed. This did not give assurance that correct information would be given to the patient.
- The medical director told us they took patient psychological needs into account and would not continue with surgery if they had any concerns about its effect on the patient. There were no formal arrangements in place to refer patients on to mental health services.

Access and flow

People could access the service when they needed it.

- All patients self-referred to the clinic and booked their first appointment by email or telephone. Patients could get appointments quickly and at a time to suit them.
- Patients could access care and treatment at a time that suited them. The service offered evening and Saturday appointments, which offered patients flexibility and promoted patient choice. Evening appointments were available up to 7 pm. The clinic also referred patients to their clinic in Reading should they be fully booked at Goring on Thames.
- The service only cancelled or delayed appointments and treatments at the request of the patient. The service had no cancelled procedures in the last 12 months.
- Services generally ran on time. The service informed patients of any delays. The patients we spoke with said they had timely access to appointments and treatment and were always informed of delays.
- Patients had access to a central telephone number for the clinic, this was available 24 hours seven days a week and gave details of which manager was on call.

Learning from complaints and concerns

It was easy for people to give feedback and raise concerns about care received and there was a complaints policy in place. There had not been any official complaints to review.

- The service had an in-date complaint policy and process document stating the roles, responsibilities and processes for managing complaints. The policy set out timelines for feedback to the complainant and aimed to provide a full written acknowledgement within two working days of receipt. A summary of the policy was

included on the clinic's website so that patients could easily see what action they should take in the case of a concern. The clinic manger was responsible for dealing with all complaints.

- There were no formal complaints in the current year to review to see if the policy had been followed. Staff told us that they would attempt to resolve the issue immediately if the complaint was raised in the clinic and would speak to their manager to resolve this.
- The service kept an adverse reaction record where any concerns raised by patients were recorded, action taken was recorded and only two issues were raised for 2020. Neither of these led to a formal complaint being raised.
- Patients we spoke with told us they would speak to a member of staff if they wished to make a complaint or raise concerns. The clinic's website contained information on how patients could complain and the timelines for feedback. The website also referred patients to the local government ombudsman, or the Care Quality Commission should the clinic fail to provide a satisfactory resolution for the patient.

Are surgery services well-led?

Requires improvement

We rated it as **requires improvement.**

Leadership

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 medical director who established the clinic was supported in leading the service by the clinic manager who was the registered manager. There was a management structure with clear lines of responsibility and accountability.
- The clinic manager had responsibilities for overall management of the clinic in Goring on Thames and was supported by an administrator based at Reading to ensure all processes and service contracts were in place across the two sites.
- All therapy and reception staff identified the clinic manager as the person they reported to. Staff reported that the clinic manager and medical director were both approachable. Meeting minutes showed they both attended team meetings which meant staff could raise and discuss issues with them.

Vision and strategy

The service had a vision for what it wanted to achieve and a strategy to turn it into action, the vision and strategy were focused on sustainability of services.

- The vision of the clinic was to deliver the best patient care. On the website the clinic described itself as a safe, welcoming and non-corporate environment where patients could be confident, they were being looked after by experienced medical professionals.
- The manager told us the aim of the service was to maintain the good reputation of the service that was established seventeen years ago. To develop the staff and keep up to date with new clinical developments in an environment that was fit for purpose.
- Staff understood the aim of the service was to deliver the best patient treatments and care so that patients would want to return to the service. The aims of the service were discussed at team meetings.

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.

- Staff we met at the clinic were friendly and helpful. We observed staff were supportive of each other and were told the culture was open and friendly. Staff were positive about working at the clinic. We were told that members of staff who had left, had asked if they could return.
- All staff had a copy of the staff handbook which contained information about how to whistle blow if there was an issue of concern. There was information about who to report this to within the service and if necessary, how to report concerns outside the service.
- The service also had policies on expected performance of staff. There was a capability process including a disciplinary process detailing how that would be conducted and the appeals process.
- On the clinic's website the service offered some incentives for certain treatments but not for cosmetic

surgery, this was in line with the guidance from the Committee on Advertising Practice and industry standards of the Royal College of Surgeons Professional Standards for Cosmetic Surgery April 2016. They did not offer financial incentives that might influence the patient's decision, such as time-limited discounts or two-for-one offers.

- The service had arrangements to promote the safety and well being of staff. Access to the building was secure. The staff handbook covered a range of human resource policies including an employee assist programme that was accessible on line or by phone, staff could use this service for work or personal concerns

Governance

Leaders did not operate effective governance processes, throughout the service. There were few opportunities to meet, discuss and learn from the performance of the service.

- The service had an up to date governance policy setting out the procedures and processes that should be in place. On inspection we found that not all policies were fully implemented, for example the need for mandatory training, regular staff appraisals and safe medicine storage. Therefore, there was no assurance that there was management oversight of requirements as set out in policy.
- The governance policy set out the need for clinical audit and patient outcome measures however there was no yearly clinical audit process and no governance meetings to review patient outcomes relevant to each surgeon. There was no documented review of incidents, complaints, performance, policies and processes. There was no assurance that there was management oversight of the service.
- The service held on file copies of the surgeon's current appraisal. The service had indemnity insurance in place and staff working under practising privileges had adequate level of professional indemnity insurance.
- The service level agreements the clinic had in place were reviewed. All seen were in date and were managed by the cross-site administrator and were the responsibility of the clinic manager.

Managing risks, issues and performance

The service did not have the systems to identify, manage risks in order to reduce their impact.

- The governance policy outlined the requirement to carry out risk assessments. There were environmental assessments under the title of slips and trips general risk assessment. This was not signed for the year 2019/2020 so there was no evidence that this had taken place.
- The service did not have a process to identify and manage risk. Staff told us the only risk to the service was recruitment. This did not give assurance that the service conducted internal risk assessment of the service enabling planning for service and process improvement.
- The service did not have a strategy for continuous improvement in infection control including accountable leadership.
- The service was registered with the medicines and healthcare products regulation agency (MHRA) central alerting system in order to receive medical device and medicine alerts that may be relevant to the services being delivered. When asked staff told us that in the case of medical device malfunction, they would report this to the manufacture.
- We did see that weekly checks were made of fire safety, lasers including protective eyewear checks. Procedural risk assessments were in place.

Managing information

The service collected and used information to support its activities. The information systems were integrated and secure.

- The service collected information from the patient questionnaires to assess the service provided.
- The service had an established electronic information and patient record system and were able to demonstrate that all their systems were password protected. A third-party company was employed to provide the service with online security and support. All phones displayed an emergency contact number for IT services in the case of any interruption in service or if staff needed advice.
- The service had a range of in date IT policies including general data protection, information security and server data recovery.
- Staff had access to up-to-date, accurate and comprehensive information on patients' care and treatment. Arrangements were in place to ensure the confidentiality of electronic patient information. Staff had access to an in date General Data Protection Regulation policy.

Requires improvement

Surgery

- During our inspection, we found computer terminals were locked when not in use to prevent unauthorised persons from accessing confidential patient information. However, at the time our inspection, staff had not completed training in information governance, however we were told there was a plan for staff to undertake this.

Engagement

The service engaged well with patients, staff and the public.

- The service collected people's feedback by questionnaire yearly and verbally on an ongoing basis to help assess and improve their services. The feedback was positive, staff told us that patients appreciated the opportunity to feedback about the service.
- The clinic website was easy to navigate with clear information on the services provided, staff at the clinic and how to contact the service. There was a lot information about the treatments carried out and photographs showing expected outcomes. The website had a glossary of terms, with an explanation of what they meant enabling the public to understand basic medical terminology. The website contained a summary of some policies which informed the public how the service worked.
- The clinic submitted three months team meetings minutes which showed discussion with all staff present. Topics included patient selection, appointment times, completion of consents, patient records and general business issues. There was no formal agenda to these meetings, patient feedback and outcomes were not discussed.
- The clinic had a small number of staff, but from discussions and observations we saw there was good staff engagement and that this included some social events.

Learning, continuous improvement and innovation

- There was limited evidence that the service gathered information in order to improve and innovate.

Outstanding practice and areas for improvement

Areas for improvement

Action the provider MUST take to improve

- The service must follow policies and procedures relating to the safe storage of medicines.
- The service must ensure their audit and governance systems remain effective and formalise governance arrangements for the assessment of patient outcomes.
- The service must have systems and processes to risk assess the service and to assess the risks to the health, safety and welfare of people who use the service.

Action the provider SHOULD take to improve

- The service should continue to ensure all staff attend appropriate mandatory training for their role.
- The service should risk assess all staff roles including non-clinical role, whether to have DBS checks completed as appropriate to their role and review local policies accordingly.
- The service should follow their policy and continue to support all staff including an annual appraisal of performance.
- The service should locate emergency equipment where it is accessible for all staff.
- The service should follow their policy to safety test electrical items every 2 years.
- The service should have a protocol for the recording of patient psychological assessments and the subsequent need for referral.
- The service should keep a room specific record of where patient treatment is carried out.
- The service should take into account the patient's need to access translation services.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Diagnostic and screening procedures Surgical procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment 12(2)(g) the proper and safe use of medicines

Regulated activity	Regulation
Diagnostic and screening procedures Surgical procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance 17(2)(f) providers must ensure that their audit and governance systems remain effective. 17(2)(b) Providers must have processes to minimise the impact of risks on people who use the service.