

## Coppergate Clinic (Formerly Face Etc) Ltd

# Face etc medispa

### Inspection report

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

### Ratings

Overall rating for this location	Good	
Are services safe?	Good	
Are services effective?	Good	
Are services caring?	Outstanding	
Are services responsive to people's needs?	Good	
Are services well-led?	Good	

# Summary of findings

## Overall summary

This service had not previously been inspected. We rated it as good 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 effectively. The service controlled infection risk well. Staff assessed risks to patients, acted on them and kept good care records. They managed medicines safely. The service managed safety incidents well and learned lessons from them. Staff collected safety information and used it to improve the service.

Staff provided a high standard of care and treatment and gave patients 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, supported them to make decisions about their care, and had access to comprehensive information. They followed the two-stage consent process.

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, families and carers.

The service planned care to meet patients' individual needs and made it easy for people to give feedback.

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. They were focused on the needs of patients receiving care. Staff were clear about their roles and accountabilities. The service engaged well with patients to plan and manage services and all staff were committed to improving services continually.

However:

Two policies we reviewed contained information which was not relevant to the service.

The service kept an equipment log with details of servicing and expiry dates; however, this had not been fully updated for all items of equipment.

# Summary of findings

## Our judgements about each of the main services

### Service

#### Surgery

### Rating Summary of each main service

Good



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- Staff provided a high standard of care and treatment and gave patients 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, supported them to make decisions about their care, and had access to comprehensive information. They followed the two-stage consent process.
- 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, families and carers.
- The service planned care to meet patients' individual needs and made it easy for people to give feedback.
- 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. They were focused on the needs of patients receiving care. Staff were clear about their roles and accountabilities. The service engaged well with patients to plan and manage services and all staff were committed to improving services continually.

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# Summary of findings

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# Summary of findings

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# Summary of this inspection

## Background to Face etc medispa

Face etc medispa is operated by Coppergate Clinic (Formerly Face Etc Ltd). The service registered with CQC in 2017 and rebranded as Coppergate Clinic in 2021 following a change in service provision; due to a decrease in demand as a result of the COVID-19 pandemic, the focus of the clinic has move towards providing additional surgical procedures under conscious sedation and general anaesthetic.

The clinic is located in the centre of York and provides independent plastic surgery and aesthetic treatments to members of the public on a self-referral basis. A specialist skin lesion service is also offered. The non-surgical treatments do not fall within the CQC scope of registration and will not be reported on.

The clinic has a spacious reception area, a range of offices, consultation and treatment rooms, and two operating theatres, set out over two floors.

The service is registered to provide the following regulated activities:

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

Surgery is predominantly on a day case basis, however, when procedures require overnight admission, the clinic is able to accommodate this. There is a thorough pre and post-operative care pathway in place and care is tailored to each individual patient. The clinic does not treat children under the age of 18 years old.

There has been a registered manager in post since 2017. The service has not been previously inspected.

## How we carried out this inspection

The team inspecting the service comprised a CQC lead inspector, a CQC team inspector, and two specialist advisors with expertise in surgery. The inspection was overseen by Sarah Dronsfield, Head of Hospital Inspection.

During the inspection, we visited all areas of the clinic, including consultation and treatment rooms and the operating theatres. We spoke with eight staff members including surgical staff, the theatre manager, the registered manager, and the company director. We observed clinical practice, spoke with four patients and reviewed eight sets of patients' records. We also reviewed information relating to service activities, company policies, performance, and patient feedback, both during and following the inspection.

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

# Summary of this inspection

## Outstanding practice

We found the following outstanding practice:

- There was a wide-ranging use of technology which facilitated efficient service delivery, streamlined information sharing for patients and staff, and a high standard of communication.
- The service was flexible and responsive to people's needs. It was clear that staff and managers all strived for excellence in the care they provided.
- Patient feedback was continually and overwhelmingly positive; patients felt truly valued and included, and said staff went the extra mile to provide a consistently high standard of care, from initial assessment to post-operative review.
- The clinic had a focus on teaching and training delivery and had been invited to become a national training centre for a specialist surgical technique. It was also enrolled on the British Association of Aesthetic Plastic Surgeons (BAAPS) mentor programme to provide post-qualification plastic surgery training and was the only clinic of its kind to host the BAAPS training day.

## Areas for improvement



### Action the service **SHOULD** take to improve:

- The service should ensure all policies contain only information relevant to the clinic
- The service should ensure the equipment log, which contains details of servicing and expiry dates, is fully completed for all items.

# Our findings






## Overview of ratings

Our ratings for this location are:

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



# Surgery

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

## Are Surgery safe?

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 mandatory training; this was delivered 'in-house' and by external providers, both face-to-face and through eLearning. The mandatory training was comprehensive and met the needs of patients and staff. All staff we spoke with understood their responsibility to complete mandatory training and felt they received all training necessary to enable them to work effectively.

The theatre manager was responsible for monitoring training for all clinical staff and the clinic manager for the reception and therapy staff; this included ensuring compliance with mandatory training and refresher courses, and alerting staff when they needed to complete updates.

We reviewed staff records and saw information regarding mandatory training compliance was recorded, along with evidence of course completion such as certificates. Training was comprehensive and included: infection prevention and control (IPC); fire safety; equality, diversity and human rights; handling medication and avoiding drug errors; complaints handling; conflict resolution; information governance; mental health and mental capacity; and manual handling. Further role specific training was also completed and recorded.

### Safeguarding

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

All staff received training appropriate to their role, which included how to recognise and report abuse; this reflected national guidance. Training included safeguarding vulnerable adults and children, preventing radicalisation, and female genital mutilation (FGM), and this was refreshed during their appraisal. Staff knew how to make a safeguarding referral and who to inform if they had concerns.

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Safeguarding policies and procedures were easily accessible in both electronic and paper formats, and staff knew where to find them; we saw flowcharts displayed in staff areas. We reviewed the service's safeguarding policy, which was version controlled. The policy contained details of the safeguarding lead, appropriate definitions, information regarding FGM, processes to follow, and where additional information could be found. It also gave details of the relevant Disclosure and Barring Service (DBS) checks required for staff members.

The service's safeguarding lead, who was the clinic manager, and the medical staff working at the clinic, had all received level three safeguarding training. All other clinic staff, including bank staff, had received level two training, with refresher training delivered as appropriate. At the time of our inspection all staff were compliant with safeguarding training requirements.

The service promoted safety in recruitment procedures and ongoing employment checks. We reviewed four staff records and saw evidence of appropriate DBS checks.

The clinic did not treat children under the age of 18 years old. If there was any concern about a patient's age, photographic identification would be requested and reviewed; this would then be scanned and uploaded to the patient's digital record.

There had been no safeguarding concerns reported to CQC from March 2021 to February 2022.

## Cleanliness, infection control and hygiene

**The service controlled infection risk well and used systems to identify and prevent surgical site infections. Staff used equipment and control measures to protect patients, themselves and others from infection. They kept equipment and the premises visibly clean.**

All areas of the clinic, including reception areas, offices, storage rooms and patient treatment areas, were clean and had suitable furnishings which were clean and well-maintained. The service employed an external cleaning company but maintaining cleanliness and hygiene was seen as the responsibility of all staff; we viewed cleaning in progress at the time of our inspection by several different staff members and saw daily checklists had been completed. Flooring throughout the clinic was well-maintained and visibly clean. Ventilation systems were in use in the reception area and in both operating theatres which complied with health technical memorandum (HTM) 03-01 .

Staff used records to identify how well the service prevented infections. Infection prevention and control (IPC) audits were scheduled every six months and we saw cleaning and legionella safety checks were carried out and recorded daily; annual water safety management was overseen by an external contractor. IPC training was mandatory for all staff.

Staff followed infection control principles including the use of personal protective equipment (PPE) and aseptic techniques when required; we saw PPE was readily available and used effectively in different areas of the clinic. We saw staff were bare below the elbows and all wore uniforms displaying the clinic logo. During surgical procedures, staff wore appropriate theatre attire. The service had an identified IPC lead, who was the theatre manager. Hand washing facilities and hand sanitising gel dispensers were available in all clinic areas for staff, patients and visitors to use.

Staff worked effectively to prevent, identify and treat surgical site infections; none had been reported at the time of our inspection. All surgical patients were required to shower using an antibacterial soap prior to admission, and all were monitored for signs of infection during surgery and recovery. At the time of discharge, patients were given advice leaflets

# Surgery

with information about how to prevent infection occurring as well as signs and symptoms to be aware of, and this was also discussed during follow up calls and appointments with the clinic. Any surgical site infection identified would be discussed at the clinic's quarterly medical advisory committee (MAC) meeting and we were told a date had been set for August 2022 to perform an audit once there was enough data to give an accurate reflection of infections (if any).

All surgical instruments used at the clinic were single patient use only and were disposed of or recycled after use; this eliminated the risk of cross contamination. However, should the clinic require any decontamination or sterile service provision at any time, there was a service level agreement (SLA) in place with a local NHS hospital.

Patients were not routinely screened for methicillin-resistant staphylococcus aureus (MRSA), which is a bacteria resistant to certain antibiotics, unless they were deemed to be at risk during the surgical pre-assessment process. This was in line with national guidance. We asked managers if MRSA data had been audited and were told this was planned when a full year of data had been collected.

We reviewed the service's IPC policy and saw that it had been recently modified and was version controlled. The policy referenced the appropriate guidance and outlined procedures including decontamination, legionella control, personal hygiene, PPE, waste disposal, training and audit. It also directed staff to further information and advice.

## Environment and equipment

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

The design of the clinic environment, including treatment rooms, operating theatres and the recovery room, followed national guidance and all areas were well maintained. The clinic rooms and theatres were arranged over two floors; there was no access to the first floor for those unable to use the stairs. Managers told us this had not posed a problem as there were treatment rooms and toilet facilities located on the ground floor. In the event of a patient requiring a surgical procedure in theatre, staff were trained to use a carry chair up and down the stairs, but this had not been necessary at the time of our inspection. A staff training session and emergency evacuation simulation had been undertaken, with no issues identified.

Staff carried out daily and weekly safety checks of specialist equipment and we saw records of the checks had been completed. All refrigerator and freezer temperatures had been regularly checked and recorded by staff. Portable appliance testing (PAT) had been carried out on relevant equipment and all tests were in date. The anaesthetic equipment logbook was completed and signed. The service kept an equipment log with details of servicing and expiry dates; however, this had not been fully updated for all items. Following the inspection, the provider explained that the items identified by the inspection team had been newly purchased and were still within warranty.

The service employed an external contractor to carry out air quality testing, electrical systems maintenance, fire safety assessments, water checks and portable appliance testing. Daily water and fire safety checks were carried out by staff, and weekly fire alarm tests took place.

The service had enough suitable equipment to help them safely care for patients. We checked a selection of consumable equipment in different areas of the clinic and all items checked were within their expiry date. All implants purchased by the clinic were safety compliant and only one brand was used; managers told us this was a trusted company and they had experienced very few defects as they were of a high quality.

# Surgery

We discussed the processes in place should the service experience power failure and were told the theatre equipment and anaesthetic machines had their own back-up electrical supply; there were also head torches and portable lamps available so any procedures in progress could be completed safely. All electrical circuits in the building had been rewired and separated, meaning problems elsewhere in the building would not affect the operating theatres.

Staff disposed of waste, including clinical waste and sharps, safely, and we saw containers for sharps' disposal were in date, had been signed appropriately and were not overfilled, which was in line with national guidance. Managers told us they strived to be as environmentally friendly and carbon neutral as possible, and recycling was actively promoted; we saw disposable equipment and consumables in use, much of which could be recycled. Waste disposal practices and principles were outlined in the service's health and safety risk assessment, which we reviewed and saw it was comprehensive, within its specified review date, and version controlled. It contained information such as hazard identification and management including IPC issues, sharps' related injuries, contact with bodily fluids, waste disposal, and issues relating to staff welfare. There was an SLA in place with an external company for the disposal of clinical waste.

## Assessing and responding to patient risk

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

Staff completed risk assessments for each patient at consultation, during admission and prior to discharge. Comprehensive pre-operative consultations and assessments for all patients were carried out in line with national guidance and included a risk assessment of the patient's suitability for the procedure. Any risks identified, including concerns regarding a patient's psychological wellbeing, were escalated and referred accordingly. Patients were provided with a range of information and advice at their initial consultation relating to their specific procedure; this was generated automatically as part of the electronic patient record.

We observed a surgical consultation and saw the procedure was discussed in detail along with associated risks. Patients were required to complete an extensive medical history questionnaire which was discussed and documented. Pre-operative assessments were completed by the theatre manager and the clinic manager corresponded with other healthcare providers if further information was required. There was an SLA in place with the nearby NHS trust for the provision of laboratory haematology, biochemistry and pathology services; any blood test results obtained were reviewed by the surgeon and anaesthetist.

Staff knew about and dealt with any specific risk issues. Managers told us patients who attended the clinic were generally very low risk, and they were careful about their selection of patients for surgical procedures; inclusion and exclusion criteria were based on the American Society of Anaesthesiologists' (ASA) classification of physical health and only those classified ASA one (completely healthy) or ASA two (with a history of mild disease) were accepted.

We discussed the risk of venous thromboembolism (VTE) with staff and they told us all patients attending theatre were assessed both in their initial medical questionnaire and prior to surgery as part of the World Health Organisation (WHO) surgical safety checklist. All patients undergoing surgery were asked to wear compression stockings to minimise this risk; a pneumatic compression device was also used during surgical procedures and in the recovery room. The clinic had reported no patients with VTE.

During our inspection, we observed staff completing a WHO safety checklist and saw it was done thoroughly. We reviewed checklists and VTE assessments in four patients' records: all documentation had been completed appropriately.

# Surgery

Staff safety briefs and debriefs were held regularly before and after each surgical procedure. Surgeons also met weekly to discuss procedures and developments. Theatre clinical meetings were held monthly to discuss upcoming and previous surgeries, processes and improvements.

Staff used the national early warning score (NEWS) tool to promptly identify deterioration in a patient's condition; this involved monitoring of clinical observations including heart rate, respiratory rate, blood pressure, oxygen saturations and temperature. Any concerns identified were immediately escalated to the surgeon for review. Staff completed clinical observations on patients during and following surgery; the follow-up observations were completed at 15-minute intervals for two hours, then every 30 minutes until patients met the discharge criteria. We saw these had all been recorded in the patients' records we reviewed.

We reviewed the service's referrals and sepsis policy and saw it was version controlled and was last modified on 21 February 2021. The policy gave information about when and how external referrals could be made, including in the event of an emergency such as trauma or sepsis. Should such an event occur, and the patient required emergency treatment, they would be transferred to the local NHS hospital by ambulance; relevant contact details were included in the policy.

All anaesthetists working with the clinic were employed at a local NHS teaching trust and had intensive care experience; they would be involved with making the decision about when to transfer patients and maintained close working relationships with the NHS hospital, situated only minutes from the clinic. Staff received training on transferring patients safely; at the time of our inspection there had been no emergency transfers from the clinic. All patients had consultant-led care and a consultant surgeon was present in the clinic at all times until the last surgical patient had been discharged.

An electronic Smartboard was utilised in the operating theatre which connected to each staff member's electronic tablet; this had the capacity to alert staff to conditions such as anaphylaxis and provided guidance for treatment. At the time of our inspection, it was being updated to contain all theatre documentation, along with alerts and guidance for other emergency conditions and resuscitation. In theatre, we saw there were intubation and difficult intubation trolleys set up ready for use; the anaesthetic equipment had been regularly checked and the logbook signed.

The recovery room also doubled as a high dependency unit (HDU) and was equipped with standard HDU equipment including a resuscitation trolley, oxygen, suction and emergency drugs. We saw evidence of daily checks being completed. The resuscitation trolley contained laminated cards with emergency algorithms, and we saw there was lipid emulsion available for use in the event of local anaesthetic toxicity. Staff told us a theatre case would not be started if there was still a patient in recovery.

We discussed potential risks following surgery including haematoma and bleeding; managers told us there were standard operating procedures in place and there was a manager on call at all times, should a patient need urgent support following discharge. There had been one instance of a patient experiencing a post-operative bleed in the previous four years. There had been no requirement for a patient to return to theatre for intervention.

Should a patient be required to stay overnight following surgery, they would be cared for in the recovery room by a nurse and responsible medical officer (RMO). Service managers told us they would also remain on site. We reviewed records for three patients who had stayed overnight and saw comprehensive notes were made throughout the night, which demonstrated patients had been assisted where necessary, partners had visited, nutrition and hydration needs were well attended to, and clinical observations were completed hourly during the night. Surgical reviews had taken place in the morning, and patients were discharged when all criteria had been met. Discharge checklists had been completed.

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Patients were discharged once they had recovered fully from their procedure and anaesthesia; staff ensured their clinical observations were within normal parameters, they had eaten and drunk, they had passed urine, and there were no adverse symptoms. Comprehensive post-operative advice was given, along with any necessary medicines or equipment, and a follow-up appointment.

Staff completed, or arranged, psychosocial assessments and risk assessments for patients thought to be at risk of self-harm or suicide. We saw the clinic used a cosmetic procedure pre-operative screening tool to identify any psychological issues which may affect a patient's decision to have surgery. Managers told us they would refer any patients they were concerned about for a more in-depth psychological assessment.

## Staffing

**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. Managers reviewed staffing levels and skill mix and gave bank staff a full induction.**

The service had enough medical, nursing and support staff to keep patients safe. Staffing levels could be adjusted according to the needs of patients, for example if a patient was required to stay overnight following a procedure. Managers ensured the correct numbers and grades of staff were present in line with national guidance and clinic policy and told us the operating theatre was staffed according to need. There was a standard operating procedure in place for theatre staffing; we reviewed this and saw it was comprehensive and set out guidance for minimum safe numbers of staff required for different procedures and types of anaesthetic, along with risk assessments, escalation processes and incident reporting information.

There was always a staff member assigned to the recovery room for general anaesthetic cases, who was a qualified operating department practitioner or registered nurse, with a second qualified person available in the clinic if required. Managers told us there was a strict 'no staff, no start' policy which meant a procedure could only begin when the agreed minimum number and skill mix of staff were present; we did not see evidence of this during our inspection, as all required staff were present. Anaesthetic rotas were planned up to a year in advance to ensure adequate cover was available.

All patients seen at the clinic had consultant-led care and a consultant surgeon was present in the clinic at all times during a surgical patient's admission.

The service had no staff vacancies at the time of our inspection. Two full-time reception staff and a theatre manager had recently been employed, and there was a low staff turnover rate. No staff sickness had occurred since the service provision change in September 2021.

The service utilised ten regular bank staff who were familiar with the clinic's policies and procedures; no agency or locum staff were employed at the time of our inspection.

## Records

**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 recorded all cosmetic implants on the Breast and Cosmetic Implant Registry (BCIR).**

# Surgery

Patients' notes were stored electronically and were comprehensive; all staff had timely access to the information needed to deliver safe care and treatment as they all carried a personal issue electronic tablet. Managers told us access to records was tailored to each staff member so they could only view information relevant to their role, and access to the electronic system was protected with individual log-in details and passwords.

We reviewed six sets of patient documentation and saw that all patients had a comprehensive electronic record which contained: their individual profile; appointments; consultation, pre-assessment and admission documentation; account information; medical records; photographs and all communication; surgical documentation and checklists; completed NEWS charts; anaesthetist notes and charts; evidence of a post-operative care recorded, with any follow-up treatment; completed discharge checklists approved by the surgeon and anaesthetist; a record of the discharge treatment and advice given; and evidence of a follow up call being arranged. Any written notes had been scanned and added. Patients could view notes and diagrams made during their consultation, as the surgeon's electronic notes were projected in real time onto a screen in the consulting room.

Records were stored securely; the majority of patient and clinic records were electronic, but we saw those still on paper were stored in line with relevant guidance. There was a records audit underway at the time of our inspection. The service was registered with NHS Digital for submission to the Breast and Cosmetic Implant Registry (BCIR).

We reviewed the service's records' management policy and record retention policy. We saw both documents were version controlled. The records' management policy gave details of relevant definitions, guidelines and responsibilities. The record retention policy included information regarding the different types of record, the length of the retention period, and the relevant guidance followed. This was very comprehensive, but we saw some of the information related to dentistry, which did not apply to this service.

## Medicines

### **The service used systems and processes to safely prescribe, administer, record and store medicines.**

Staff followed systems and processes to prescribe and administer medicines safely. We reviewed the service's policy for managing prescription drugs and saw it was version controlled and had been modified on 21 September 2021. The policy was comprehensive and gave information regarding: the prescribing, storage, and dispensing of medicines; controlled drugs (CDs); antibiotics; record keeping; adverse drug reactions; and audits. However, not all information in the policy was relevant as there were references to dentistry and NHS patients, which the clinic did not treat.

Managers told us the service was very conscious of not over-prescribing, particularly in relation to antibiotics. Surgeons prescribed a 24-hour regime of antibiotics prior to and during surgery, with a course following discharge if indicated. Managers told us they ensured effective compliance with the service's antibiotic policy and standardised prescriptions were issued for procedures to prevent variance. At the time of our inspection, an audit was underway to assess the current antibiotic regime and an annual antimicrobial audit was planned to commence when enough data had been collected.

Staff reviewed each patient's medicines prior to surgery as part of the safety brief and explained to patients what they would be given and any potential side effects. Anti-sickness medication, pain relief and antibiotics, when required, were prescribed to take home and we saw staff provided detailed advice about medicines before discharge; patients told us they understood what their medicines were for, how they should take them, and how to contact the clinic if they had any concerns. The service ordered medicines from a pharmacy provider as and when required.

We reviewed patients' records and clinic documentation and saw staff completed medicines records accurately and kept them up to date.

# Surgery

Staff stored and managed all medicines and prescribing documents safely and securely in locked cupboards in treatment rooms, storerooms and the operating theatres, in line with national guidance. Refrigerators and freezers were also secure. Only the necessary clinical staff had access to medicines, and this was strictly controlled. The service kept controlled drugs (CDs) at the premises and these were stored in the operating theatre in line with national legislation. There was an appointed controlled drugs accountable officer (CDAO) responsible for the management of CDs. We reviewed the CD register during our inspection and saw all entries and checks had been completed appropriately and in line with guidance. We checked a range of medicines and all were in-date.

The service received medicine safety alerts, and these were shared with all clinicians by email and during staff meetings and safety briefs.

## 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. When things went wrong, staff apologised and gave patients honest information and suitable support. Managers ensured that actions from patient safety alerts were implemented and monitored.**

Staff knew what incidents to report and how to report them. They raised concerns and reported incidents and near misses clearly, in line with the service's policy. The service had not reported any serious incidents prior to our inspection. We discussed examples of incidents with managers and observed they had been investigated appropriately, with involvement of patients and families when necessary. Feedback from incidents was shared with staff to facilitate improvement and learning.

Any issues identified in the service were discussed as a team and regular safety briefings and theatre meetings took place where information was shared. Staff were not aware of any recent near misses or incidents but told us they would feel comfortable and confident to report them and knew they would be investigated and discussed appropriately. The service used an electronic incident reporting system and an external representative had provided training and refresher updates.

Incidents and concerns were also discussed at clinical governance and MAC meetings and actioned appropriately. We discussed an example with managers of a complication a surgeon had experienced with a patient following surgery, and saw that it was escalated, managed and shared. Staff received feedback from investigation of incidents, both internal and external to the service, and discussed this to determine how it could drive improvements in patient care. Managers told us they would debrief and support staff after any serious incident.

Staff learned from safety alerts and incidents to improve practice and received relevant medical device and medicine safety alerts through the central alerting system (CAS); managers told us these were shared with all clinicians by email and during staff meetings and safety briefs.

The Duty of Candour requires healthcare providers to be open and transparent, and to notify patients (or other relevant persons) of certain 'notifiable safety incidents' and provide reasonable support to that person, under Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Staff understood the Duty of Candour and knew their responsibilities in relation to it; they told us they would be honest, apologise, and give patients and families a full explanation if and when things went wrong. They would discuss the circumstances and kept them informed of any actions taken. The service had not reported any incidents which met the threshold for application of the Duty of Candour.



# Surgery

We reviewed the service's Duty of Candour overview and Duty of Candour policy, both of which were version controlled. The overview gave appropriate definitions, details of notifiable incidents, how to notify, and references for further information. The policy summarised the service's Duty of Candour process and responsibilities and highlighted links to other related policies.

We reviewed the service's safety incident reporting policy and saw it was version controlled. The policy contained definitions of incidents, reporting procedures, actions to be taken, recording of information and how incidents were shared for learning purposes. Information was also included directing staff to other, relevant, policies, to be read in conjunction, including the Duty of Candour policy.

## Are Surgery effective?

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. The service met cosmetic surgery standards published by the Royal College of Surgeons.**

Staff followed up-to-date policies to plan and deliver high quality care according to best practice and national guidance. This included guidance from the Royal College of Surgeons (RCS) Professional Standards for Cosmetic Surgery 2016, RCS Good Surgical Practice (September 2014), the Association of Anaesthetists of Great Britain and Ireland (AAGBI) and the National Institute for Health and Care Excellence (NICE). All documents were available electronically, updated regularly and disseminated appropriately.

The clinic held regular clinical, MAC and governance meetings both internally and with other similar services and healthcare professionals. Managers told us this encouraged discussion and the sharing of good practice, along with updates in relation to national guidance. The clinic subscribed to an external company providing compliance software, so all policies, procedures and pathways were updated automatically upon receipt of information.

Staff holistically assessed people's suitability for proposed treatments. During consultations, surgeons reviewed and assessed each patient's medical history, general health, mental health and any previous cosmetic surgery. Expected outcomes and potential risks were discussed openly and honestly, in line with national guidance and professional standards.

Staff used a range of technology and equipment to enhance the delivery of effective care and treatment. For example, the service offered virtual consultations and utilised viewing screens in surgical consultations to enable patients to view notes and diagrams as they were being written.

We saw the clinic had up to date guidance for staff relating to the management of medical emergencies, including resuscitation guidelines and management of anaphylaxis. These were in line with national clinical guidance.

### Nutrition and hydration

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

# Surgery

Nutrition and hydration needs were monitored and met for patients during the day and overnight when required. Staff purchased items for patients from local shops and they could choose what they wanted to eat and drink, depending on personal preference or dietary and cultural needs.

Patients and those accompanying them could access drinks' machines on the ground floor which was a complimentary service.

Staff monitored patients for nausea and vomiting during and after their procedure and prior to discharge. Patients were prescribed anti-sickness medication to take home with them and this was reviewed during follow up calls and appointments.

## Pain relief

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

Staff prescribed, administered and recorded pain relief accurately. In the patients' records we reviewed all documentation relating to the prescription and administration of pain relief was completed and signed appropriately.

Staff assessed patients' pain using a recognised tool and gave pain relief in a timely manner, in line with individual needs and best practice. The patients we spoke with told us their pain had been managed very well during and after the procedure, and they had been provided with appropriate pain relief on discharge. They were also asked during follow up calls and appointments if their pain continued to be well managed, and all patients knew how to contact the clinic following discharge if they experienced pain which they were unable to control.

## Patient outcomes

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

The service participated in relevant national clinical audits; we saw there was contribution to the breast implant audit but, at the time our inspection, the service did not submit data to the Private Healthcare Information Network (PHIN). Audits of specific surgical procedures were planned to commence when a full year of data had been collected.

Outcomes for patients were positive, consistent and met expectations, such as national standards. Questionnaires were sent to patients following consultation and procedures. The service reviewed the results of patients' surgery at different stages of the healing process and, at the time of our inspection, was in the process of adapting the current patient satisfaction survey to enable measuring specific patient outcomes.

The clinic offered skin cancer treatment and assessment of benign and malignant skin lesions; one of the surgeons employed by the clinic was the melanoma lead for Yorkshire and worked in this specialism at a large teaching hospital trust. All lesions were assessed in line with national guidance and information was stored securely in the patient's electronic record. The clinic did not have onsite histology services; however, clinic had a service level agreement with the local hospital for histopathology services and samples were sent on the day of surgery.

Managers and staff carried out a comprehensive programme of repeated audits to check improvement over time. The service participated in the Association of Anaesthetists of Great Britain and Ireland (AAGBI) audits and data collection was ongoing for: total intravenous anaesthesia; use of target-controlled infusion for propofol administration; intra-operative patient temperature control and monitoring; recovery scoring systems; and nausea and vomiting. At the time of our inspection, a clinical note audit was underway which involved 20 patients' records selected randomly from each of the

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three surgeons, looking at GMC guidelines, content, consultations and patient information. IPC and cleaning audits were also being completed; all audits were overseen by an external company. Managers used information from the audits to improve care and treatment, and shared relevant information with staff. Results were used to improve patients' outcomes.

Managers told us they had researched outcomes relating to patient recovery and believed discharging patients home as soon as safe to do so was the best way to aid recovery from surgery; good pain control, aftercare and follow-up were ensured for all patients.

From September 2021 (when service provision changed) to February 2022, there had been no unplanned readmissions within 28 days of discharge and no unplanned returns to theatre. Patients signed an agreement prior to surgery which contained details of the surgical revision policy; managers told us thorough preparation, consultation and sharing of detailed information were essential to manage patients' expectations and likely outcomes. If revision surgery was necessary, it would generally be performed without cost if the surgical team felt it would improve the outcome.

## Competent staff

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

Staff were experienced, qualified and had the right skills and knowledge to meet the needs of patients. There were five consultants working at the clinic, three of whom were on the specialist register as plastic surgeons; all anaesthetists employed were also consultants and all recovery staff had intensive care training and experience. At the time of our inspection, managers told us they were considering working with additional consultants specialising in different fields.

Consultants were trained in advanced life support (ALS) and all other staff in basic life support (BLS). ALS training was checked by the registered manager at the time of application and during revalidation; we saw documented evidence of this in the staff records we reviewed.

Managers gave all new staff a full induction tailored to their role before they started work. A local induction was completed for bank staff; however, we were told all were regular staff who were familiar with the clinic's processes and procedures. A small team of anaesthetists was employed regularly in order to build familiarity and consistency in practice.

The surgeons had the skills, competence and experience to perform the treatments and procedures they provided. They each performed specialist surgical procedures at independent or NHS hospitals, in addition to their work at the clinic, and participated in training demonstrations and teaching.

Managers had arranged training days for the surgeons, with a national expert, to learn a specialist liposuction technique. They told us that, following on from this, the clinic had been invited to become a national training centre for this procedure. Visits from product representatives occurred regularly, to facilitate training in new equipment and techniques.

We asked managers about practicing privileges and fit and proper person checks; they discussed the list of requirements they had during recruitment and all items were present in the staff records we checked. We reviewed each of the surgeons' staff records and saw they had current medical indemnity insurance in line with General Medical Council (GMC) guidance. This was necessary in order to protect patients, should they suffer harm as a result of negligence.

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Managers supported staff to develop through yearly, constructive appraisals of their work; all appraisals were carried out by the clinic manager other than the surgeons' appraisals, which were done externally. We saw documented evidence of this in the files we checked. The training leads and managers supported the learning and development needs of staff and made sure they received any specialist training for their role. Any training needs were identified, and we saw all staff were supported and funded to develop their skills and knowledge, and to contribute to the development of the service.

At the time of our inspection, the clinic had recently enrolled on the British Association of Aesthetic Plastic Surgeons (BAAPS) mentor programme to provide post-qualification plastic surgery trainees with three-month placements to receive specialist training in aesthetic surgery.

We reviewed the service's recruitment and selection policy and saw it was version controlled. The policy was comprehensive and gave details of recruitment processes, shortlisting, interview, employment checks, and storage of personnel files. All staff files we reviewed had recruitment information and employment checks included, in line with the policy. We also reviewed the service's fit and proper check and action lists for both employees and directors, which detailed the checks to be completed at the recruitment stage, details of induction, and processes to be followed in the event of misconduct or concerns being identified. In the staff files we reviewed, including that of the clinical director, we found checklists were present and completed appropriately.

The clinical director was a member of BAAPS and attended their annual meetings, providing feedback to the other surgeons on updates and new techniques. The service subscribed to the Cosmetic Surgery Journal which was available in the clinic office for staff to read, along with various aesthetic surgery textbooks and reference materials. The clinic also hosted a BAAPS aesthetic surgery training day annually, to promote best practice in the field, encourage collaborative working and provide a supportive network to discuss and help others with more challenging cases.

Managers told us they had processes in place to identify and manage poor staff performance promptly and to help staff improve; however, it had not been necessary for them to implement these processes since the change of service provision at the clinic.

## Multidisciplinary working

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

Staff held regular and effective multidisciplinary meetings to discuss patients and improve their care. We saw the team worked very well together and delivered care and treatment in a co-ordinated way. There were positive working relationships between all staff, and they told us they were all focused on providing the best care possible to patients. Managers told us they were careful to select the right staff, who would work well with the rest of the team and believe in the clinic ethos.

Treatment provided was consultant-led. All team members knew who had overall responsibility for each patient's care. Staff worked across health care disciplines and with other agencies when required to care for patients.

There service had a range of clinical specialists for example there were two consultants able to offer a full private skin cancer treatment service. Both consultants within the regional NHS plastic surgery centre and attended specialised skin cancer, sarcoma, and melanoma multidisciplinary team meetings.

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We saw there was excellent multidisciplinary communication at all times. Theatre safety briefings and debriefs took place before and after surgical procedures, attended by all staff, and we saw there was inclusive and supportive discussion. Briefings included an overview of the planned procedure, medication likely to be needed, potential risks and plans for discharge.

## Seven-day services

**Patients could contact the service seven days a week for advice and support after their surgery.**

The clinic was open from 9am to 8pm Monday to Friday and from 9am to 5pm on alternate Saturdays. Surgical lists were planned in advance, with consultations and procedures requiring local and general anaesthetic taking place on set days. Managers told us they would accommodate patients' needs as much as possible and would do their best to arrange early or late consultation appointments if required.

The service provided all patients with a 24-hour telephone number to call if they if they had any problems or concerns. This was covered mostly by the company director, with support from other clinicians when needed. Any concerns requiring escalation could be discussed with a surgeon. Patients told us the follow up care and support they received from the clinic had been excellent and very responsive.

## 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 and ensured that patients gave consent in a two-stage process with a cooling off period of at least 14 days between stages. They understood how to support patients.**

Staff understood how and when to assess whether a patient had the capacity to make decisions about their care. They gained consent from patients for their care and treatment in line with legislation and guidance and made sure patients consented to treatment based on all the information available. Staff clearly recorded consent in the patients' records. Managers told us it was very unlikely a patient lacking capacity would seek treatment at the clinic, and there had been none to date.

All staff received and kept up to date with training on the Mental Capacity Act, Mental Health Act and Deprivation of Liberty Safeguards, and they understood the relevant consent and decision-making requirements from legislation and guidance. Staff could tell us how they would access relevant policies, and who they would contact for further advice or support

Managers told us the patient pathway had been designed to ensure compliance with national guidance on consent. The electronic patient record contained automated processes which ensured necessary documentation was completed and checked. All patients automatically received relevant emailed information sheets at the time of their initial enquiry and there were automated electronic processes in place to ensure a second consultation, two-stage consent process and 14-day cooling off period in line with national guidance; an audit of patients' records was in progress at the time of our inspection to corroborate this.

We observed the consultation process and saw detailed pre-operative information was shared with the patient, their expectations were realistically, and sensitively, managed, and potential risks and outcomes were explained. Psychological assessments were completed, and staff told us further psychological support would be sought if necessary. All patients we spoke with told us the pre-operative information and support they received had been excellent and very thorough.

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We reviewed the service's consent policy saw it was version controlled. The policy gave details of the regulatory guidelines and the importance of ensuring consent was gained properly, with patients given information and support to make an informed decision about care. The policy also gave information regarding mental capacity and advised staff where they could find further information. Staff received training in consent relevant to their role, in line with the policy.

At the time of our inspection the service did not have enough data to evaluate and perform an audit in relation to consent, due to the relatively recent change in service provision. The clinic and theatre managers had set a date for August 2022 to perform this audit once enough data had been collected to give an accurate reflection. All patient records we reviewed contained documented consent in line with national guidance.

We reviewed the service's policy relating to the Mental Health Act, Mental Capacity Act and Deprivation of Liberty Safeguards and saw it was version controlled. The policy gave detailed descriptions of each area and advised staff of the relevant principles and processes to be followed. It also gave information regarding staff training and how further information and guidance could be accessed.

## Are Surgery caring?

Outstanding



### Compassionate care

**Staff treated patients with compassion and kindness and respected their privacy and dignity. People were truly respected and valued as individuals and were empowered as partners in their care, practically and emotionally, by an exceptional and distinctive service.**

There was a strong, visible person-centred culture and all staff were highly motivated and inspired to offer care that was kind and promoted people's dignity. Relationships between people who used the service, those close to them and staff were strong, caring, respectful and supportive. These relationships were highly valued by staff and promoted by leaders. Staff recognised and respected the totality of people's needs and found innovative ways to meet them.

All staff we spoke with, including managers, had a clear focus on patient care and aimed to provide the highest standard of care possible to all patients at the clinic. This was reflected in the comments we received and feedback we reviewed from patients. Staff were discreet and responsive when caring for patients; privacy and dignity was promoted at all times and we saw procedures and personal information were not discussed in public areas. The clinic appeared welcoming and calm, and all staff we observed were kind and considerate when speaking with patients.

Feedback from people who used the service was continually positive about the way staff treated people; they thought staff went the extra mile and their care and support exceeded expectations. We spoke with four patients, one of whom had stayed overnight at the clinic following surgery, and all were overwhelmingly positive about the care they received and their experience as a whole; they told us staff were 'lovely', 'very caring', and 'amazing'. The service subscribed to an independent feedback service and we reviewed comments posted on its website. These included: 'everyone is so welcoming and professional'; 'nothing is too much trouble'; 'all the team at Coppergate Clinic - they're just truly wonderful'; and 'such fabulous people'.

We observed two patient consultations with the clinic's surgeons during our inspection and saw that patients were given plenty of time to ask questions and discuss any issues; information and answers were provided clearly and sensitively and

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the surgeon took time to ensure that all the patient's needs and expectations had been addressed. Prior to surgery, patients were seen several times both virtually and face-to-face. This meant they had time to discuss and evaluate options, and the decision-making process took place in stages rather than in one consultation. At post-operative reviews, patients were again given the time they needed.

We also observed a surgical procedure during our inspection and saw all staff worked hard to ensure the patient's experience was comfortable and positive. Staff provided reassurance, information and support throughout their episode of care; they actively encouraged patients to ask questions throughout their procedure. Patients told us they had been comforted and put at ease if they felt anxious and felt safe at all times. The service was able to provide patients with a chaperone if required.

Staff followed policy to keep patient care and treatment confidential. Paper and electronic records and documentation were stored securely, and patients received assurance that any information or photographs they shared for the purposes of assessment would be secure or encrypted.

Staff understood and respected the individual needs of each patient and showed understanding and a non-judgmental attitude; emotional and social needs were seen as being as important as physical needs. Patients told us they felt their initial assessments had been planned sensitively and they were not rushed or pressurised into choosing particular treatments or procedures; doctors took time to explore the most appropriate individual options, offer alternatives, and were honest about expectations and outcomes. One patient commented they were surprised at the length of their initial consultation and said they felt as though they had been truly listened to and understood. Patients also said they had been pleasantly surprised to have been offered their own choice of music in the operating theatre, and food in the recovery room.

## Emotional support

**Staff provided emotional support to patients, their families and those accompanying to minimise their distress. They took time to understand patients' individual needs.**

People who used the service and those close to them were active partners in their care and were empowered to make decisions based on the best possible information. Staff were fully committed to working in partnership with people and making this a reality for everyone; patients and those close to them were offered help, advice and emotional support when they needed it.

Patients told us: 'I was always made to feel safe'; 'I was worried on arrival but was soon made to feel comfortable and at ease'; and 'staff held my hand during the procedure when I felt anxious'. Staff told us they did everything they could to make patients comfortable and worked hard to make everyone's experience at the clinic positive. We saw comprehensive advice was given at all stages of the patient journey.

Staff demonstrated empathy when having difficult conversations. We discussed examples of surgeons speaking openly with patients about procedures they felt weren't right for them, and they told us that this had sometimes not been well received, but they took pride in the fact they were clear and honest with patients when they felt treatment was not necessary or appropriate. Patients' comments included they felt they weren't pressured or encouraged to undergo a certain procedure, their expectations and perceived outcome were managed sensitively and openly, and they didn't feel clinic staff were trying to sell them something they didn't want or need.

We saw staff understood the emotional and social impact that a person's care, treatment or condition had on their wellbeing and on those close to them and they took time to empathise and reassure when needed. We saw patients were

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supported at all times from the very first stage of consultation, and the support given to each patient was timely and tailored to their individual needs. The support continued after discharge as all patients were given a 24 hour telephone number they could contact if they had any queries or concerns and the company director took personal responsibility for answering these calls whenever possible, and also for carrying out regular follow-ups and welfare checks.

Patients' relatives and those accompanying them told us they also felt supported and had been involved in the process should the patient wish them to be. We reviewed the records for a patient who had stayed at the clinic overnight and it was recorded their partner had visited and been able to stay as long as they needed. One patient's partner told us they had been given the number of the company director so they could call for updates during the procedure. Another told us the procedure had initially been postponed due to the patient requiring medication; this had been hand delivered by the clinical director and explained thoroughly.

## **Understanding and involvement of patients and those close to them**

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

Staff made sure patients and those close to them understood their care and treatment and supported patients to make informed decisions about their care. Patients told us they had been provided with as much information as they needed prior to, during, and after their procedure and all those we spoke with said communication and documentation from the clinic had been excellent.

We reviewed patient documentation and saw that all patients had a comprehensive electronic record which contained their individual profile, appointments, account information, medical records, photographs and all communication; any written notes were scanned and added. Patients said they had been surprised at the detail involved in consultation and assessment; they told us they had been fully involved and informed at all times and staff took time to ensure they and those close to them understood all aspects of care and treatment.

Although some pre-operative appointments were held virtually, all patients were required to attend a face-to-face appointment prior to the procedure for examination and to discuss planning. Patients were given as much time as they needed post-operatively and had time to rest and sleep; when they were deemed ready and safe for discharge, staff ensured they understood all aftercare and medicine regimes, and had all the necessary follow-up information.

Staff talked with patients, families and carers in a way they could understand, using communication aids where necessary. We saw procedures were clearly explained to patients and those accompanying them, with diagrams used where appropriate. During the surgical consultation, all notes were made electronically and projected onto a screen behind the surgeon, so the patient was able to view them. Patients told us being able to view notes and diagrams was extremely helpful in aiding their understanding.

Prior to surgery, patients were seen several times both virtually and face-to-face. This meant they had time to discuss and evaluate the options available to them, and the decision-making process took place in stages rather than in one consultation.

Patients and their families could give feedback on the service and their treatment and staff supported them to do this. Questionnaires were automatically sent to patients following treatment and they contained free-text boxes along with



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questions, enabling patients to provide comments if they wished. The clinic subscribed to an independent feedback service which we saw was well utilised by patients who had attended, and managers responded to all comments received. Complaints' information was displayed should it be required and the complaints' manager for the service told us responding to and resolving a complaint would always be prioritised.

Patients gave overwhelmingly positive feedback about the service. Those we spoke with said their whole experience at the clinic had been excellent and staff were friendly, caring and approachable. We viewed independent feedback for the service online and saw, out of 1000 comments, 96% of patients said the service was 'excellent' and 2% said it was 'great'. The remaining 2% had rated the service as 'average', 'poor' or 'bad'; this equated to less than 1% for each of these ratings.

A selection of positive feedback we reviewed stated: the clinic was 'truly magnificent', 'spotless', 'very welcoming and comfortable', 'more like a spa than a clinical setting' and 'a six star experience'; staff were described as 'such fabulous people', 'warm, welcoming, and professional', 'an amazing team' and 'fantastic at what they do'. One patient said the surgeon was 'the best they had met' and was 'very honest, supportive and caring' and many of the patients' comments stated they would, or had already, recommended the clinic to friends and family. Patients also commented on the very high standard of communication, involvement, support and aftercare they received.

We reviewed all negative comments made online and saw they related to appointments and planning rather than the care and treatment received; each comment had been responded to personally and the complaints' manager told us about improvement work which had taken place following receipt of this feedback, including a more efficient telephone answering system.

It was clear from our observations, interviews and review of patient feedback all clinic staff went above and beyond expectations to ensure patients and those close to them were fully involved, informed and had realistic expectations of the procedure at all stages of their journey; there was a common goal to make each patient experience the best it could be. There were appropriate and sensitive discussions about the cost of treatment and surgeons were honest when advising patients about procedures; advice was clearly driven by what was in the best interests of the patient rather than cost.

## Are Surgery responsive?

Good 

### Meeting people's individual needs

**The clinic was inclusive, and services were tailored to meet patients' individual needs and preferences. They were delivered in a way to ensure flexibility, choice and continuity of care. Staff made reasonable adjustments to help patients access services and there was a system for referring patients for psychological assessment before starting treatment, if necessary.**

The service had an equality, dignity and human rights policy in place and staff told us they worked hard to create a supportive, caring and inclusive environment for patients and colleagues; it was clear the diversity and dignity of patients and staff were respected and valued by all and the patient feedback we reviewed supported this.

The services were flexible, provided informed choice and ensured continuity of care. Managers and staff planned and delivered care in a way that reflected people's needs, and patients told us they had been given choices of appointment times and consultation methods to suit them.

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Following our observations of clinical assessments and discussion with patients, we saw detailed discussions took place between surgeons and patients prior to them making any decisions; this included information about how the procedure would be performed, cost, and any potential risks or complications. We saw surgeons would also explore the possibility of non-surgical options or not performing a procedure at all, if they felt this was more appropriate for the patient. All patients said they had been fully informed and supported at all stages of treatment.

Facilities and premises were innovative and met the needs of a range of people who used the service. Staff had access to communication aids to help patients become partners in their care and treatment. We saw procedures were clearly explained to patients, with diagrams used where appropriate. Managers made sure staff, and patients, loved ones and carers could get help from interpreters or signers when needed and the clinic had access to an online translation service.

We discussed patients who had attended the clinic with psychological and emotional needs. Managers told us how these needs were assessed and how they would refer patients to other services when required; surgery would not be undertaken if there was any doubt about the procedure being appropriate.

The clinic was situated in the centre of York and was easily accessible by public transport, with ample car parking also available a few minutes' walk away. The building was set out over multiple floors and, although there was access to treatment rooms and toilets on the ground floor, the operating theatres were located on the first floor and there was no lift available for people who were unable to use the stairs. Managers told us they had purchased a folding chair which staff could use to carry patients up and down stairs if necessary, but this had not yet been required.

Patients told us they would not hesitate to recommend the clinic and they felt all their needs had been met; they said staff went above and beyond to ensure high standards. One patient told us they had been surprised at the length of the initial consultation; it was much more detailed than they had expected. Another told us they were very well cared for and not rushed post-operatively; they were given plenty of time to rest and recover before they felt ready for discharge. All patients said the follow up care and support had been excellent.

## Access and flow

**People could access services and appointments in a way and at a time that suited them. Technology was used innovatively to ensure people had timely access to treatment, support and care.**

Managers monitored waiting times and made sure patients could access services when needed and receive treatment within agreed timeframes. We saw the clinic had identified patients were having to wait for calls to be answered as the service was very busy. Managers had reviewed call response times and felt they were unacceptable; as a result of this, call handling had been outsourced to an external provider, and internal phone lines had been split to allow direct transfer to the appropriate department. Managers also monitored missed calls as they wanted to avoid these occurring.

We discussed patient feedback relating to delays in appointments and confusion with times. Managers had previously identified issues were due to the call volumes, which had directly impacted the quality of customer services. They told us this had now improved, and the clinic manager was in the process of implementing a new theatre booking process to ensure the system was robust and worked smoothly. Monitoring of this was ongoing. We reviewed patient feedback and saw there had been no further concerns around appointments or waiting times since the change to service provision in September 2021.

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Patients were able to make appointments by telephone or through the service's website. Patients who had used the online form said it was easy to use and they had not experienced any issues. The clinic was flexible in providing appointment times suitable to individual patients and could arrange consultations out of hours or on weekends if requested.

Managers told us they would only cancel or rearrange appointments if absolutely necessary, and with a full explanation to the patient. There had not been any cancellations since the service provision changed. There were planned theatre and consulting sessions each week for the three surgeons and we were told these ran on time; patients would be promptly informed of any delays.

The patients we spoke with, and the feedback we reviewed, demonstrated patients were happy with the flexibility of the service and the timely access to consultation and treatment they had received. The service effectively used a range of technology to support this, determined by patient preference, and offered initial virtual consultations to patients who found it difficult to attend the clinic or had a long distance to travel.

All suspected cancer patients would be offered timely treatment at the clinic or urgent referral to an NHS hospital. The clinic had direct access to all relevant multi-disciplinary services and pathways within the NHS.

Managers and staff worked to make sure patients did not stay in the clinic longer than they needed to, but patients were also given the time they needed to rest and recover following surgery. Managers told us they had researched outcomes relating to patient recovery and believed discharging patients home as soon as it was safe to do so was the best way to aid recovery from surgery. Good pain control, effective aftercare and follow-up appointments were ensured for all patients. Staff planned patients' discharge carefully, and specific criteria were required to be met before patients left the clinic.

## Learning from complaints and concerns

**It was easy for people to give feedback and raise concerns about care received. The service treated concerns and complaints seriously, investigated them and shared lessons learned with all staff. The service included patients in the investigation of their complaint and asked for feedback about how it had been managed. The service had a system for referring unresolved complaints for independent review.**

Patients, relatives and carers knew how to complain or raise concerns and those we spoke with told us, if they had experienced any problems, they would have been happy to raise them with the service. Information about how to complain was displayed in the clinic reception and on its website. Managers told us the complaints' policy and related information was shared with all patients in their initial correspondence with the clinic. Staff told us ensuring a positive patient experience was at the heart of what they did, and they took complaints and concerns very seriously. They knew where to find the policy and how to handle complaints.

Managers investigated complaints and identified themes. The complaints' lead was the clinic manager and they were aware of their roles and responsibilities in relation to this. Patients could complain verbally or in writing; verbal complaints received were often dealt with quickly and informally. Written complaints received a response in writing, with an acknowledgment sent within two working days of receipt and a full written response within 20 working days wherever possible. Patients would be offered a meeting to discuss any potential solutions and would be kept informed of the progress of the investigation. Ongoing complaints which could not be resolved would be referred to the Independent Sector Complaints Adjudication Service (ISCAS), an independent service to which the clinic subscribed should a complaint require further intervention. It had not been necessary for them to utilise this service at the time of our inspection.

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The clinic received very few complaints and managers told us those received were not usually related to surgery or treatment and could be dealt with quickly and to the patient's satisfaction. We discussed the only formal complaint received since the service provision changed in September 2021 and were assured it had been dealt with appropriately.

All complaints and related information were stored securely; written information in a locked cabinet, and electronic information on the clinic's secure online system. Only the necessary staff had access.

Managers told us they shared feedback from complaints with staff and learning was used to improve the service; there would be detailed discussion at team and clinical governance meetings. Staff we spoke with confirmed this. The service could also demonstrate where improvements and learning were shared with other services, through external governance meetings and membership of national bodies.

We reviewed the service's complaints, problems and events reporting process which was version controlled. The document gave relevant definitions relating to incident management. It directed staff to the complaints' manager and gave comprehensive guidance around the complaints' management process.

We also reviewed the complaints' handling policy which was version controlled. The policy outlined the complaints' handling framework, how complaints should be recorded, response timescales and information regarding ISCAS.

## Are Surgery well-led?

### 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. They supported staff to develop their skills and take on more senior roles.**

The service was led by the company director, the clinical director was a consultant surgeon, and they were supported by the clinic manager who was the CQC registered manager. All had significant previous experience in their respective areas and understood the priorities of the service and any issues which may affect it. There was a clear organisational structure with defined lines of responsibility, for examples in terms of clinical governance, risk management, operational procedures and administration. All staff we spoke with were clear about their roles and accountabilities.

During our inspection, we saw the management team were visible, supportive and had good working relationships with staff. They told us they encouraged an open culture and actively sought staff feedback and opinion. Managers held regular staff meetings and participated in social media groups and activities away from work, in order to communicate and engage with staff regularly.

All staff spoke very highly of the management team and felt they were always approachable and actively involved in all aspects of the service. Staff told us they were encouraged to develop their knowledge and skills and were supported to attend training courses.

We reviewed the service's fit and proper person policy and saw it was version controlled. The policy referenced the regulations relating to directors and employees and gave appropriate definitions, details of checks to be completed and information regarding where further information could be found.

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We also reviewed the service's fit and proper check and action lists for both employees and directors, which listed checks to be completed at the recruitment stage, details of induction, and processes to be followed in the event of misconduct or concerns being identified. In the staff files we reviewed, including that of the clinical director, we found checklists were present and completed appropriately.

## Vision and Strategy

**The service had a vision for what it wanted to achieve and a strategy to turn it into action, developed with all relevant stakeholders. The vision and strategy were focused on sustainability of services and aligned to local plans within the wider health economy. Leaders and staff understood and knew how to apply them and monitor progress.**

Managers told us they aimed to run a business where all staff felt valued and as though they were 'part of the family', with no hierarchy, just a culture of mutual respect and teamwork. They gave us an example of action taken, prior to the service changes, when staff had demonstrated disrespectful behaviour to each other, and explained this would not be tolerated.

The service's vision was to provide an excellent service for patients in a safe, caring, and modern environment. Managers aimed to make every patient feel well looked after and ensured their journey through the clinic was as safe and pleasant as possible; they provided a personal service with a small core of staff.

Staff strived to give patients honest opinions about likely outcomes and perform surgery in a way that delivered this. Two consultants from a large teaching trust had recently joined the service and had worked with existing staff to develop a strong team approach with a culture of mutual learning and support. The clinical director told us they were working towards the clinic becoming a national centre of excellence for aesthetic surgery, training the next generation of surgeons. The clinic was enrolled on the BAAPS mentor programme to provide plastic surgery trainees with three-month placements to receive specialist training in aesthetic surgery.

Managers were planning to expand the clinic in the near future, taking over a vacant building adjacent to the clinic, to allow for more clinical and administration space and with a room dedicated to clinical photography using the latest technology; the purpose of this was to standardise photography allowing for better patient education and analysis of results. Managers also planned to invest in a research and development centre.

## Culture

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

All staff we spoke with told us they felt respected, supported and valued. Managers told us they operated an 'open door' policy and were always happy for staff to discuss, challenge and raise ideas. Staff corroborated this and said they always felt comfortable discussing ideas and raising concerns; they felt confident any issues would be responded to positively and dealt with appropriately. They told us they felt listened to and actively contributed to changes and developments within the service. They felt proud to work for the service and were committed to providing the best possible patient experience.

The service had an equality, dignity and human rights policy in place and aimed to provide a supportive, caring and inclusive environment for patients to receive treatment and for staff to reach their full potential. Managers told us they were committed to ensuring equality, diversity and dignity of patients and staff was respected and valued by all, with

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patients and staff treated fairly and respectfully without discrimination. Managers encouraged feedback, and all external feedback from patients was responded to personally; we saw only positive comments about the culture of the service. Staff were encouraged to share their ideas and were given opportunities to learn and develop; staff satisfaction was explored and discussed as part of the appraisal process.

We saw staff belonged to private messaging groups for both work and social discussion; there were different groups for each specialty, overseen by managers, and they were encrypted so clinical information could be shared securely.

The service considered and promoted the safety and wellbeing of staff. Access to the building was controlled remotely by reception staff and clinical areas were secured with keypads. There was a lone worker policy in place and managers told us they would complete regular welfare checks should a colleague be working out of hours at the clinic.

Managers told us they took time to recruit staff who they felt would be the 'right fit' and shared the ethos of the service to provide a high standard of patient care; clinic values were shared during staff induction.

## Governance

**Leaders operated effective governance processes, throughout the service and with partner organisations. 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.**

There was a defined governance structure within the service and staff at all levels were clear about their roles, responsibilities and accountabilities. Although some governance processes, such as audits, were still being developed following the changes in service provision, managers were able to clearly articulate their plans and what they aimed to achieve in terms of development and performance.

The clinic held shared quarterly clinical governance meetings with another, similar clinic. Within the service, there were quarterly MAC meetings where clinical governance was also discussed. We reviewed minutes of both meetings and saw they were well attended. There was detailed discussion of relevant topics, such as best practice, risks and complications, infection control, compliance, case reviews, and sharing of lessons learned; both meetings had a set agenda and attendees took actions from the meeting to address any issues identified.

The service used compliance software to maintain oversight of risk, audits and policies; this ensured all information and documents were up to date. The policies we reviewed were all comprehensive and easily accessible, however two contained information which was not directly relevant to the service.

We asked managers about the management of practicing privileges and fit and proper person checks; they told us of the list of requirements they had during recruitment and these were all present in the senior staff records we checked, in line with Schedule 3 of the Health and Social Care Act 2008 (Regulated Activity) Regulations 2014.

The clinical director was a member of the Consortium of Aesthetic Plastic Surgery Clinic Owners (CAPSCO); this was a registered organisation formed by a group of aesthetic surgery clinic owners at the beginning of the COVID-19 pandemic, to develop and share policies, best practice and guidance.

## Management of risk, 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. Staff contributed to decision-making to help avoid financial pressures compromising the quality of care.**

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The service had a risk register in place, which we saw was thorough and reviewed regularly. Risks, actions, mitigations and designated responsibilities of staff were recorded clearly. We discussed the risk register with managers, and they had comprehensive oversight of issues which accurately reflected those recorded. Risks included the loss of main premises, difficulties obtaining essential supplies, failure to meet staff members' health and wellbeing needs, data breaches, and loss of essential utility supplies. All risks were rated according to likelihood and impact, and actions to reduce risks were documented; these involved liaison with external services where appropriate.

Risks and performance were discussed regularly at clinical governance, MAC and team meetings and took into account issues highlighted by incidents, complaints and other occurrences. All staff were involved, could contribute, and were aware of actions.

The service had a business continuity plan in place, and we saw a business impact analysis had been carried out in January 2021. Managers told us they had become much more focused on the need to plan effectively for unexpected events, due to the impact of the COVID-19 pandemic on service provision.

The service had a planned programme of clinical and internal audit. Although some audits were yet to be completed and were awaiting further data collection, we saw the programme was detailed and would enable managers to effectively monitor and review the quality of care and clinical processes, and to identify where improvements were needed. Managers had clear oversight of audit processes and progression.

## Information Management

**The service collected reliable data and analysed it. Staff could find the data they needed, in easily accessible formats, to understand performance, and make decisions and improvements. The information systems were integrated and secure. Data or notifications were consistently submitted to external organisations as required.**

The service subscribed to an external software provider and, at the time of our inspection, had almost completed the digitisation of company documents and records, including staff and patient information and policies, in order to become completely paperless.

Staff could easily access all the information they required in relation to patient care and clinic processes; all had access to the digital system using individual tablets. Access was limited to the scope of their role within the service. We saw tablets were password protected and locked when not in use. Staff also wore watches enabled with an intercom device, enabling them to easily communicate with others elsewhere in the building. All had completed training on information governance and were aware of data protection regulations. Patient records and clinic documents were stored securely.

We saw there was a theatre register completed with patient details, type of anaesthetic administered, procedure start and finish times, and attendees. There was also an implant register fully completed and including patient details; the service was registered with NHS Digital for submission to the Breast and Cosmetic Implant Registry (BCIR).

The clinic had a website and employed a social media, marketing and website manager who was responsible for ensuring all information was kept up to date. Information on the website relating to the clinic, its staff and treatments offered was very detailed and enabled patients to complete thorough research and book consultations.

The service collected and monitored data regarding patient outcomes, and this was being developed further at the time of our inspection following changes to service provision. Patient feedback was a vital part of maintaining quality and improving services.

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The service did not advertise the procedures and treatments it provided. Patients who attended had either completed a search on the internet or the clinic had been personally recommended to them.

## Engagement

**Leaders and staff actively and openly engaged with patients, staff, the public and others to plan and manage services. They collaborated with partner organisations to help improve services for patients.**

Managers and staff routinely gathered feedback from patients, and it was welcomed at all stages of their treatment journey. This was used to maintain quality and improve services. Feedback forms were automatically sent to patients following post-operative review and the clinic subscribed to an independent feedback service which we saw was well utilised by patients who had attended; managers responded personally to all comments received. We saw feedback provided was overwhelmingly positive, but also saw examples where negative feedback relating to the management of appointments had been used to make improvements. Managers told us they frequently received thank you cards and emails from patients.

Complaints' information was easily accessible should it be required and the complaints' manager for the service told us responding to and resolving a complaint would always be prioritised and again utilised to drive improvement.

There were several private social media and messaging groups utilised by staff, for both work and social purposes. Managers also contributed to these, and communications between the whole team were open and positive, with all staff feeling engaged and valued. All team members were actively involved in meetings and briefings.

The service engaged regularly with other organisations and similar service providers, including for the purposes of joint clinical governance and training. The clinical director was an active member of several external organisations specific to the service which allowed information sharing, discussions around best practice, and promoting service development.

## Learning, continuous improvement and innovation

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

Staff of all levels were supported to learn and develop, and managers encouraged them to suggest further training they wished to pursue. Recent training had included the use of a specialist liposuction technique and post-operative liposuction protocols to include lymphatic drainage techniques and ultrasound to help with scar tissue. The ethos of the practice was to provide the highest level of care to patients in a safe and modern environment; managers told us they were always looking for techniques to help improve the patient experience and give the best possible result. They had been approached by external training specialists to become a national training centre and had also been asked to be key opinion leaders for some of the products they used.

At the time of our inspection, the clinic had enrolled on the British Association of Aesthetic Plastic Surgeons (BAAPS) mentor programme to provide post-qualification plastic surgery trainees with three-month placements to receive specialist training in aesthetic surgery and was due to accept the first trainees.

Managers told us the clinic was the only one of its kind to host the BAAPS training day; the training they provided included the use of simulated models to teach marking of surgical sites for difficult procedures, such as mastopexy augmentation (breast uplift and implant) which required detailed demonstration. The clinical director was a specialist in this area and was able to guide trainees through the procedure; a training video had also been produced to support this.



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The clinic used a wide range of technology to assist and improve service delivery and patient care, which included: the projection of patients' notes onto a screen during consultation to help with explanation and understanding; an interactive Smartboard in theatre which was being developed to include the WHO surgical safety checklist, all theatre documentation, and emergency treatment guidance; the use of individual issue electronic tablets to enable staff members to easily access records and documentation, and the use of watches with intercom ability for ease of communication; and the electronic patient record system which had been adapted to automatically generate individualised information and advice to patients at each stage of the consultation, treatment and follow-up process.

All staff were committed to improving services and we saw evidence of this during inspection and following review of clinical governance and MAC meeting minutes. We discussed further examples of improvements with managers and they told us the anaesthetic team was continually honing their day case techniques to include the use of local anaesthetic blocks and modified analgesic regimes. They had developed a facelift technique which could be performed effectively under local anaesthetic. Also, the service was planning to expand into vacant premises adjacent to the clinic and would utilise some of the additional space for a research and development facility. They aimed to be a centre of excellence and wished to develop and train a young team of staff to advance the service in the future.