BYC Surgery Limited

Be Younger Cosmetics Clinic

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	Inadequate
Are services safe?	Inadequate
Are services effective?	Inadequate
Are services caring?	Good
Are services responsive to people's needs?	Good
Are services well-led?	Inadequate

Summary of findings

Overall summary

We carried out a comprehensive inspection of Be Younger Cosmetics Limited, as part of our inspection programme. We inspected all our key questions: safe, effective, caring, responsive and well led. This was our first inspection of the service.

Following the inspection, the provider was served a warning notice under Section 29 of the Health and Social Care Act 2008, requiring them to make significant improvements to the design of the location, governance processes and employment processes.

After the inspection the provider sent assurances they were resolving the issues within the breaches and told us they would suspend their regulated activities until these had been rectified.

This was the first time we inspected the service. We rated the service as inadequate because:

- Managers did not make sure staff were competent. The service did not have processes to monitor the professional registration of nursing staff working at the service. They did not have processes to provide assurance that staff had up to date training in key skills, understood how to protect patients from abuse, and managed safety well.
- Information required to support safe recruitment of new staff was not all collected and in line with legislation.
- Medicines were not always managed safely, and the service did not have a policy for antimicrobial prescribing.
- The service did not control infection risk well.
- Governance processes were not effective to demonstrate oversight of patient safety and outcomes and risks were not captured. There were no written documents to show evidence-based care.
- Leaders did not have the necessary knowledge, skills or abilities to run the service. Leaders did not operate effective governance processes throughout the service. Staff did not use systems to manage performance effectively. They did not identify, review or manage risks and issues effectively.
- Information about how to make a complaint was not available on the service's website.

However:

- People could access the service when they needed it. The service planned and took account of patients' individual needs. Staff were focussed on the needs of the patients receiving care.
- The service engaged well with patients and gave them contact details to provide 24/7 support if required.
- Staff treated patients with compassion and kindness, respected their privacy and dignity, took account of their individual needs, and helped them understand their conditions. Staff worked well together for the benefit of patients, advised them on how to lead healthier lives, supported them to make decisions about their care, and had access to good information.
- The service planned care to meet the needs of local people and made it easy for people to give feedback.
- Staff felt respected, supported and valued. Staff were clear about their roles and accountabilities.

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Surgery	Inadequate	

Summary of findings

Contents

Summary of this inspection

Background to Be Younger Cosmetics Clinic

Be Younger Cosmetics Clinic is a small private clinic offering a range of cosmetic treatments under local anaesthetic. The clinic provides cosmetic surgery services for private patients over the age of 18 years. Treatments include botox injections, dermal fillers, removal of lumps and bumps, hernia repairs, liposuction and thread lifts (a procedure that uses dissolvable sutures to rejuvenate and lift sagging skin). They also see patients for pre and post-surgery consultations. Major surgery is performed at another location. Most of the cosmetic treatments fall out of the scope of regulation under the Health and Social Care Act 2008 (Regulated Activities), Regulation 2014. Of the treatments carried out, only lumps and bumps removal, hernia repairs, liposuction and PDO thread lift fall into the scope of CQC regulation.

Care was delivered by the provider who was a doctor with a license to practise. The clinic had a clinic manager and an assistant director, they employed a registered nurse and, a self-employed beauty therapist.

There is a registered manager, who is also the owner of Be Younger Cosmetics Clinic. The service was registered with the Care Quality Commission (CQC) in 2020. This was the first inspection we carried out for the provider at this location. The service is registered to provide the following regulated activities:

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

The service had not reported any never events or serious patient safety incidents in the 12 months before our inspection.

The service had carried out 68 procedures within the scope of CQC regulation between 1 April 2022 and 1 April 2023.

How we carried out this inspection

We inspected this service using our comprehensive inspection methodology. We announced the inspection 48 hours before we attended to ensure the clinic would be open.

One inspector and 1 specialist advisor carried out an onsite visit on 30 March 2023. During the inspection we spoke with the registered manager, the clinic manager, and the assistant director. We reviewed the clinic environment, staff records, policies and procedures and looked at 7 patient records. We observed 1 patient consultation.

Following the onsite visit, we reviewed information and data about the service, spoke with the registered nurse and spoke with 3 patients who had received treatment from the provider.

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

Areas for improvement

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

Action the service MUST take to improve:

- The service must have effective systems to assess, monitor and improve the safety and risks of the services provided in carrying on of the regulated activity. There was no formal risk register to demonstrate potential risks or risks to the service, setting out mitigations to reduce these. There was no evidence to demonstrate how patient outcomes were monitored. The service must ensure infection prevention and control audits are carried out and action is taken on findings. Regulation 17(1)((2)(a)(b))
- The service must ensure all required information is held in respect of persons employed or appointed for the purposes of regulated activity. Regulation 19 (2) (3)
- Systems and processes must be established and operated to prevent abuse of service users. The service must ensure staff have completed safeguarding training and identify a safeguarding lead. The service must ensure the safeguarding policy includes the contact details of the local authority safeguarding team. Regulation 13 (2)
- The service must ensure all staff receive training necessary to enable them to perform the duties they are employed to do. Providers must ensure staff have an induction programme that prepares staff for their role. Staff must complete basic life support training. Regulation 18 (2)(a)
- The service must ensure dispensed medicines are labelled appropriately and contain appropriate patient information leaflets in line with the relevant legislation and best practice. The service must ensure the premises used are safe for their intended purpose. The service must assess the risk of, and prevent, detect and control the spread of infections. Regulation 12 (2)(d)(h)(g)

Action the service SHOULD take to improve:

- The service should have an antimicrobial prescribing policy.
- The service should consider adding the details of their complaints process on their website.
- The service should ensure staff have training on recognising and responding to patients with mental health needs, learning disabilities, autism and dementia. Regulation 18.
- The service should ensure the resuscitation council algorithms, these provide specific instructions for how resuscitation should be practiced and should be available in case of an emergency. Regulation 12.
- The service should assess whether they require oxygen in the case of an emergency.
- The service should ensure processes are in place to identify any medicines that passed their in-use expiry dates. Regulation 12.
- The service should have a defined or documented set of values or vision.
- The service should have guidelines for accessing an interpreter if needed.
- The service should use a tool to identify if patients are deteriorating.

Our findings

Overview of ratings

Our ratings for this location are:

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

Inadequate

Surgery

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

Is the service safe?

Inadequate

This was the first time we inspected the service. We rated safe as inadequate.

Mandatory training

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

There was no training matrix that identified the training staff were expected to complete and the staff training policy did not set out what the requirements were for each role, such as which modules should be completed, how often and by whom.

Staff completed mandatory training and refresher training by completing e-learning modules in key topics such as infection control, fire safety, manual handling and health and safety awareness. Some staff had completed face-to-face first aid training, this included cardiopulmonary resuscitation and use of the defibrillator.

However, not all staff had training in basic life support (BLS), and safeguarding.

Staff received and kept up-to-date with their online mandatory training, this was monitored and staff were alerted when they needed to update their training.

There were no records of the mandatory training completed by the registered manager.

Clinical staff had not completed training on recognising and responding to patients with mental health needs, learning disabilities, autism and dementia. In July 2022 it became a legal requirement to ensure all health care providers provided staff with training in learning disability and autism, including how to interact with autistic people and people who have a learning disability.

Safeguarding

Inadequate

Surgery

Staff had not had training on how to recognise and report abuse and procedures were not clear on who to contact in the event of concerns.

The registered manager had safeguarding adults level 2 training. The service had a safeguarding policy, and the registered manager was identified as the safeguarding lead who should have safeguarding training to level 3. Not all staff knew who the safeguarding lead for the service was.

Staff training records did not include evidence that any other staff had completed safeguarding training. However, staff said they would report any concerns to the registered manager. Following the inspection, we were told staff had been booked on to the appropriate level of training for their role. Nursing staff received training specific for their role on how to recognise and report abuse. They told us they had level 3 safeguarding training for adults and children but there was no documented evidence of this.

Cleanliness, infection control and hygiene

The service did not control infection risk well. Control measures were not consistently in place to protect patients, staff and others from infection. They kept equipment and the premises visibly clean.

The environment appeared clean. There was a daily clinic preparation routine checklist, this included a daily cleaning schedule that was completed and signed. However, there were no cleaning audits.

There was access to personal protective equipment such as gloves and aprons, but these were not always used correctly. We saw a staff member not performing hand hygiene before putting gloves on or after their removal and not wearing an apron during procedures. No hand hygiene audits were carried out.

There was a fan in the room used during one procedure. This posed a potential risk of circulating dust particles and an increased infection risk.

Infection prevention and control (IPC) audits were not carried out. The service told us they had completed one surgical site infection audit after two patients had an infection. Following this all patients receiving surgery were prescribed a three-day course of antibiotics to prevent surgical site infections.

Staff cleaned equipment after patient contact using supermarket multi-surface wipes which was not in line with their policy or current guidance.

We did not see evidence of staff vaccinations against Hepatitis B.

Environment and equipment

The design, maintenance and use of facilities, premises and equipment did not keep people safe. Staff managed clinical waste well.

The clinic was in an office building on the second floor. There was a locked door with access to the landing from which there was a door to the clinic room. The room was mostly carpeted with a desk in one corner. There was an autoclave and blood spinning machine in another corner, there was a laminate floor area for the theatre with screens that could be pulled around for patient privacy.

Inadequate

Surgery

The design of the environment did not follow national guidance. The flooring was non-compliant with HBN 00-10 which is the NHS England guidance for the design for flooring, walls, ceilings, sanitary ware and windows. The laminate flooring area did not have curved skirting for effective cleaning.

The room contained a temporary sink which was non-compliant with HBN 00-09 'Infection control in the built environment'. There was no record of water flushing, temperature checks, legionella testing or a risk assessment that covered the water supply in the clinic.

Staff used single use disposable surgical instruments where possible. Decontamination of reusable surgical instruments was completed onsite in the same room as the theatre. The autoclave was situated in the corner of the carpeted area of the room and its use was non-complaint with HTM 01-01 which is the NHS England guideline for the decontamination of surgical instruments. There was no evidence of staff competencies for the use of the autoclave and the service did not follow their infection control policy for the validation of the autoclave. We reported this to the registered manager who said they would stop using the autoclave and have since told us that it has been removed.

A fire risk assessment of the clinic had been completed by a third party. There was a fridge situated on the carpeted floor which was a fire risk. Following the inspection, we were told that the fridge had been moved.

There was no resuscitation trolley but there was an automated defibrillator (AED). The AED was out of date for its calibration/service, which was due in December 2022, to make sure it was safe and ready to use in an emergency situation.

Staff disposed of clinical waste safely. There was a separate bin for clinical waste and sharps bins that were signed, dated and assembled correctly. The service had a service level agreement for the collection of clinical waste which was stored securely in a locked waste disposal bin outside the clinic.

Assessing and responding to patient risk

Staff did not completeupdated risk assessments for each patient. The service made sure patients knew who to contact to discuss complications or concerns.

There was no written set criteria or policy for selection of people who used the service. The doctor made a clinical judgement based on the information obtained from the patient. This included the completion of a health questionnaire and the identification of risk areas. The doctor was clear about who they could provide safe treatment for and patients who were accepted for treatment were generally fit and well with a low risk of developing complications. Patients had to have a body mass index (BMI) below 35, American Society of Anaesthesiologists (ASA) classification 1 (defined as a normal healthy patient) and had to stop smoking for 6 weeks prior to surgery. We observed a patient who was refused their procedure as they had not stopped smoking.

Procedures were done under local anaesthetic, there were two members of staff present when cosmetic surgery procedures were carried out (the doctor and a chaperone/nurse). Staff told us they would monitor blood pressure, pulse rate and oxygen saturations for long procedures. They did not use a nationally recognised tool to identify deteriorating patients.

Inadequate

Surgery

The service had an unwell patient policy and in a clinical emergency, staff told us they would ring the emergency services for assistance. The surgeon told us he would use an EpiPen (this is an autoinjector of adrenaline) in the event of anaphylaxis but there were no written emergency protocols in the event of a severe allergic reaction. We did not see any information, such as the Resuscitation Council algorithms, available to follow in the case of an emergency. There was a risk patients would not receive the necessary treatment in an emergency until the emergency services attended.

The doctor told us he completed psychosocial assessments as part of the patient assessment prior to undertaking the procedure. We saw the cosmetic surgery worksheet which included this assessment. Staff told us about a patient who had been refused surgery as the patient thought she had body dysmorphia; this is a mental health condition where a person spends a lot of time worrying about flaws in their appearance. These flaws are often unnoticeable to others and the doctor contacted the patient's GP to obtain further information.

Following their procedure, patients were given contact details for the clinic and a mobile telephone number. They were told to use these contact details if they had any concerns. Staff told us patients were given verbal and written information about aftercare.

Staffing

The service had enough staff to provide care and treatment.

The service employed one registered nurse, if the nurse was on leave the clinic manager would act as a chaperone while patients were having their surgery.

The service did not use bank or agency staff.

The service had enough nursing and support staff to keep patients safe.

Medical staffing

The service had enough medical staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment. However, records of training were not consistently maintained.

The service did not directly employ any additional medical staff. The provider was a doctor who undertook all cosmetic procedures. If they were not available, appointments would be cancelled and rescheduled as soon as possible.

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.

Patient notes were comprehensive and all staff could access them easily. Patient paper records were stored securely in locked filing cabinets in a locked office. Electronic records were also used and were password protected.

The service had not completed any records audits.

Inadequate

Surgery

We were told no discharge letter was sent to the GP and patients were advised to inform their GP about their procedure themselves.

Medicines

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

The medicines fridge temperature was checked daily and recorded. The fridge contained vials of medicines that had been opened and half used but not dated when they had been opened.

The service had a medicines management policy which included the dispensing process. Staff training for the dispensing of medicines were not kept. Staff told us they wrote the patient initials on the medicines box when dispensing. Therefore, the dispensed medicine contained insufficient information for the patient to take the medicine safely.

Staff completed medicines records accurately and kept them up-to-date.

The service prescribed 3 days of antibiotics to all surgical patients to help prevent infections. There was no antimicrobial policy or guidelines including evidence-based practice to support this.

Whilst the service held 2 small oxygen cylinders, the service lacked a risk assessment to assess both the need for medical oxygen or the safe quantity to have. Therefore, if required we were not assured sufficient oxygen would be available to treat the patient.

Staff stored all medicines and prescribing documents safely.

Incidents

The service had processes to record patient safety incidents. The doctor would investigate incidents should they arise and reflect on lessons learnt. There had not been any reported incidents in the 12 months before our inspection.

Staff knew what incidents to report and how to report them. There was an incident reporting book and an incident management and reporting policy.

The service had no never events or recorded incidents. Never Events are defined as Serious Incidents that are wholly preventable because guidance or safety recommendations that provide strong systemic protective barriers are available at a national level and should have been implemented by all healthcare providers.

Staff told us they had weekly meetings, these were not recorded, and would discuss any incidents at these meetings.

The surgeon understood the duty of candour. The service had a duty of candour policy. They knew they had to be open and transparent and give patients and families a full explanation if and when things went wrong.

Is the service effective?

Inadequate

Surgery

Inadequate

This was the first time we inspected the service. We rated effective as inadequate.

Evidence-based care and treatment

The service did not always provide care and treatment based on national guidance and evidence-based practice.

There were policies in place, but these had been prepared by a third party who were not named on the policies. Clinical policies were reviewed, version controlled and dated; however, they did not all reference up to date best practice and national guidance. For example, the medicine policy did not include the regulations for the labelling of medicines. The infection control policy did not reference the latest guidelines from the Health and Social Care Act 2008 which were updated in December 2022. There was no evidence staff had read and understood the policies.

Effective systems were not in place to audit compliance with national guidance and evidence of its effectiveness. There had only been one surgical site infection audit and there was no clear audit programme.

There were no written procedure guidelines in line with National Safety Standards for Invasive Procedures 2 (Centre for Perioperative Care, 2023). These are national standards that cover all invasive procedures to improve patient safety and team-working.

Nutrition and hydration

Patients were not required to fast prior to procedures, staff provided food and drink if required.

All patients had their procedure with local anaesthesia, so no patients were nil by mouth.

The provider had water and hot drinks available for patients.

Pain relief

Staff assessed and monitored patients regularly to see if they were in pain and gave pain relief in a timely way. They supported those unable to communicate using suitable assessment tools and gave additional pain relief to ease pain.

Staff assessed patients' pain using a recognised tool and gave pain relief in line with individual needs and best practice.

Patients received pain relief soon after requesting it.

Staff prescribed, administered and recorded pain relief accurately.

Patient outcomes

Inadequate

Surgery

Managers did not monitor effectiveness of care and treatment and therefore, they could not use findings to improve the service. They did not compare local results with those from other services to learn from them.

Staff told us they did not document patient outcomes but told us out of 68 procedures in the last 12 months, there were 2 patients who developed infections post procedure. We did not see a record of these recorded as incidents.

Staff told us they used patient feedback as an outcome measure. However, we did not see a policy, process or written documentation to demonstrate this. Information was captured using online feedback (internet review linked to their website and social media site or via a secure online form) and outcomes for patients reported this way were positive and consistent.

Staff told us they phoned all patients two days after their procedure as a follow up.

The service did not report any adverse incidents in the 12 months before our inspection. However, this information was based on patient feedback only. There were limited opportunities to learn if patients experienced any complications unless the patients informed the service.

Competent staff

The service did not always make sure staff were competent for their roles. There were no records to demonstrate that managers appraised staff's work performance.

The service had a staff training policy and a staff performance appraisal policy. Staff told us they had an annual appraisal but there was no documented evidence of this. However, if any training needs were identified and discussed, staff were given the time and opportunity to develop their skills and knowledge.

The surgeon received an annual appraisal through third party arrangements. There were no records to show compliance with annual appraisals and revalidation requirements as set out by the General Medical Council.

The service had an induction policy, but staff did not receive a full induction tailored to their role before they started work. Staff told us they were shown around by the assistant director when they started working for the service.

Managers made sure staff attended team meetings or had access to full notes when they could not attend. We saw notes from team meetings available in a file for staff to access.

Staff had the opportunity to discuss training needs with their line manager and were supported to develop their skills and knowledge. However, there was no evidence that any staff competencies had been completed.

Multidisciplinary working

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

The service told us they would contact the patients GP, with their consent, to obtain information to inform assessment and treatment if needed. The surgeon and assistant director gave examples of when they had informed patients they could not offer them any treatment that would benefit their condition.

Inadequate

Surgery

Staff held regular weekly multidisciplinary meetings to discuss patients and improve their care.

There was no established network working with other healthcare professionals to provide support and advice about care for patients with specific needs such as psychological needs. This was not in line with national guidance as set out in the Professional Standards for Cosmetic Surgery (2016).

Seven-day services

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

Patients were provided with a phone number they could call for advice or if they had any concerns.

Health promotion

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

Staff assessed each patient's health when admitted and provided support for any individual needs to live a healthier lifestyle. Patients with a high body mass index were encouraged to lose weight and smokers were advised to give up smoking for 6 weeks prior to their surgery.

Patients were provided with an information sheet for dietary advice before and after surgery. The patient information booklet also provided pre and post operative advice.

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 2-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. However, there were no records of staff having mental capacity act training.

Staff gained consent from patients for their care and treatment in line with legislation and guidance. The surgeon told us that they had a 2-stage process with a cooling off period of at least 14 days between stages.

Records showed patients consented to use of before and after procedure photographs and for these to be used by the consultant when discussing procedures with prospective patients.

Staff made sure patients consented to treatment based on all the information available. Patients were provided with written information prior to surgery.

Staff clearly recorded consent in the patients' records.

Is the service caring?

Inadequate

Surgery

Good

This was the first time we inspected the service. We rated caring as good.

Compassionate care

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

Staff were discreet and responsive when caring for patients. Staff took time to interact with patients and those close to them in a respectful and considerate way. We observed interactions between staff and patients and saw staff were kind, caring and considerate of the patient's needs.

Patients said staff treated them well and with kindness.

Staff followed policy to keep patient care and treatment confidential.

Staff understood and respected the individual needs of each patient and showed understanding and a non-judgmental attitude when caring for or discussing patients with mental health needs.

Emotional support

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

We were told staff gave patients and those close to them help, emotional support and advice when they needed it.

Staff we spoke with understood the emotional and social impact that a person's care, treatment or condition had on their wellbeing and on those close to them.

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. They provided them with written information about the procedure they were considering. Staff talked to patients in a way they could understand.

Patients and their families could give feedback on the service and their treatment and staff supported them to do this.

Staff supported patients to make informed decisions about their care.

Patients gave positive feedback about the service. Patients we spoke with gave positive feedback about the service.

Inadequate

Surgery

Is the service responsive?

Good

This was the first time we inspected this service. We rated responsive as good.

Meeting people's individual needs

The service was inclusive and took account of patients' individual needs and preferences. Staff made reasonable adjustments to help patients access services. There was no system to refer patients for psychological assessment before starting treatment, if necessary.

Patients could access the service either through a recommendation, word of mouth, or through an internet search. The clinic did not do any NHS work and did not receive any referrals from the NHS.

The provider undertook cosmetic surgery, outpatient consultations and treatments at the location. The service did not carry out treatments that required an overnight stay.

All patient consultations, pre-assessments, and minor treatments were carried out at the clinic. Procedures that could not be undertaken at the clinic due to requiring general anaesthetic were carried out at a larger independent hospital. There was a lift and accessible toilets available for patients who had limited mobility.

The service had not needed to use interpreters, but we saw that, if required, this was incorporated into service policies such as consent. However, there were no guidelines on how to access an interpreter if needed.

Staff told us they would refer patients to their GP if they had concerns following the psychological assessment however, there was no policy or procedure for referring to another service.

Access and flow

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

All patients self-referred to the clinic and booked their appointments by email or telephone. Patients could get appointments quickly and at a time to suit them.

The service arranged for face to face follow up appointments a few days after the procedure. We were told all patients were followed up over the telephone 2 days after surgery.

Learning from complaints and concerns

It was easy for people to give feedback and raise concerns about care received.

Inadequate

Surgery

The service had no complaints in 12 months before our inspection. The service's social media page offered an opportunity to leave feedback. Patients knew how to complain or raise concerns. The service provided patients with information about how to raise a concern through information leaflets during their consultation or treatment. However, the service did not display information about how to raise a concern in the clinic area or their website.

The clinic manager was the complaints lead for the service and had completed training in how to deal with complaints. Staff understood the policy on complaints and knew how to handle them. The complaints policy set out timeframes for timely investigation and responses to be shared with patients who made a complaint.

Is the service well-led?

Inadequate

This was the first time we inspected the service. We rated well-led as inadequate.

Leadership

Leaders did not have the skills and abilities to run the service. They had not managed the priorities and issues the service faced. They were visible and approachable in the service for patients and staff. They did not support staff to develop their skills.

The service had a clear leadership structure, the doctor was the registered manager supported by the assistant director and clinic manager.

The service was led by the surgeon who had the clinical skills, knowledge and experience to provide the care and treatment the service offered. They were visible and approachable to staff and patients,

Staff training had not been sufficiently prioritised. There were no records of staff induction training or staff competencies.

Leaders did not demonstrate an understanding of the challenges to quality and sustainability for the service. They had not identified the issues picked up at this inspection. We had concerns procedures had been carried out in the service without adequate Infection Protection Control (IPC) measures.

Vision and Strategy

The service did not have a vision for what it wanted to achieve.

There was no clear vision and values in place. Staff told us patient satisfaction was their main priority. However, the service did not have a defined or documented set of values or vision.

Culture

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

Inadequate

Surgery

Staff felt supported, respected, valued and were positive and proud to work in the organisation. They worked well as a team. The culture was centred around the needs and experience of people who used the services.

Staff told us they were able to make suggestions for changes or improvements to the service.

Patients we spoke with, had confidence in the surgeon and their opinion about their treatment.

Governance

Governance systems were not always effective to review performance and identify service improvement. Required information for safe recruitment was not consistently obtained. However, staff were clear about their roles and accountabilities and had regular opportunities to meet.

Staff we spoke with were clear about their roles and accountabilities. Staff told us they had weekly informal meetings and documented formal meetings bimonthly.

Employment procedure and information required for safe recruitment of staff did not meet the requirements as set out in Schedule 3 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We found there was no satisfactory evidence of conduct in previous employment concerned with the provision of services relating to health and social care or children and vulnerable adults. Following the inspection, the registered manager took immediate action to resolve these issues.

The service did not follow their own policies for example, the quality assurance policy listed audits that should be scheduled, and these had not been completed.

There were no audits undertaken. There was no clinical audit plan in place and no benchmarking of practice. It was noted that any changes of practice for example, all surgical patients being prescribed antibiotics was decided by the doctor with no documented rationale.

Policies did not always contain up to date current guidance. For example, the unwell patient policy did not reference the resuscitation council guidelines for resuscitation or anaphylaxis.

Management of risk, issues and performance

The service did not use systems to manage performance effectively. They had not identified and escalated relevant risks and issues.

The structures, processes and systems of governance were not always effective to support the delivery of a safe service. There was no formal risk register or established methods to review mitigating actions to minimise risks. The registered manager identified the main risks as the potential for infection. However, this was not clearly documented with risk assessments and plans to reduce or eliminate this risk. We identified several risks on this inspection which had not been identified by the provider.

Inadequate

Surgery

There were no environmental or IPC audits carried out. We were therefore not assured the service monitored their systems and used results to improve patient safety. Minutes from a meeting in September 2022 documented 'the sink is not fit for purpose' but there was no risk assessment, timeline, or action plan to mitigate the risk. Following our inspection, the service said they were completing an infection control risk assessment and were stopping their regulated activities until this had been completed.

Staff at all levels were clear about their roles and understood what they were accountable for, and to whom.

Information Management

The service collected only limited data. However, the information systems were secure.

The service used paper and electronic records. Patient paper records were locked in filing cabinets that were only accessible to authorised staff. Electronic records of consultations were also held. Photographs were transferred securely to the electronic system.

The service had a data breach, a records retention policy, and an information governance and data protection policy.

The service did not submit any data externally or had a reason to submit any notifications externally in the 12 months before our inspection.

Engagement

Leaders and staff actively and openly engaged with patients to plan and manage services.

Feedback from patients was gathered using an electronic web-based tool, the website or social media page. Patients told us they were encouraged to leave reviews on a web-based tool linked to the services' website.

The doctor engaged with patients to ensure their views and expectations were reflected in the planning and delivery of services.

Learning, continuous improvement and innovation

There was limited evidence that the service was committed to learning and continuous improvement.

The doctor told us he attended conferences and read journals as part of his continual professional development. However, we did not see evidence of this.

Staff had completed some mandatory training but there was no evidence of any further learning or that competencies had been assessed for their roles.

There was no participation in learning from internal and external reviews. Evidence of learning and improvement opportunities was limited.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Treatment of disease, disorder or injury Surgical procedures Diagnostic and screening procedures	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment The service must ensure dispensed medicines are labelled in line with relevant legislation. Regulation 12 (2)(g)

Regulated activity	Regulation
Treatment of disease, disorder or injury Diagnostic and screening procedures Surgical procedures	Regulation 18 HSCA (RA) Regulations 2014 Staffing The service must ensure all staff receive training necessary to perform the duties they are employed to do. Providers must ensure staff have an induction programme that prepares staff for their role. Regulation 18 (2)(a)

This section is primarily information for the provider

Enforcement actions

Action we have told the provider to take

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

Regulated activity	Regulation
Diagnostic and screening procedures Surgical procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment The service must ensure the premises used by the service provider are safe. The service must assess the risk of, and prevent, detect and control the spread of infections. Regulation 12 (2)(d)(h)

Regulated activity	Regulation
Diagnostic and screening procedures Surgical procedures Treatment of disease, disorder or injury	Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment The service must ensure staff have safeguarding training and identify a safeguarding lead. Regulation 13(2)

Regulated activity	Regulation
Diagnostic and screening procedures Surgical procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance The service must have effective systems to assess monitor and improve the safety and risks of the services provided in carrying on of the regulated activity. Regulation 17 (1)((2)(a)(b))

Regulated activity	Regulation

This section is primarily information for the provider

Enforcement actions

Diagnostic and screening procedures

Surgical procedures

Treatment of disease, disorder or injury

Regulation 19 HSCA (RA) Regulations 2014 Fit and proper persons employed

The service must ensure all the required information is held in respect of persons employed or appointed for the purposes of the regulated activity.

Regulation 19(3)