M Sarwar Limited

Centre for Surgery - Baker Street

Inspection report

95-97 Baker Street
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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?	Good
Are services responsive to people's needs?	Good
Are services well-led?	Requires Improvement

Summary of findings

Overall summary

The service had not previously been rated. We rated it as good:

- The service had enough staff to care for patients and keep them safe. Staff had training in key skills and managed safety well. Staff assessed risks to patients, acted on them and kept good care records. They managed medicines well. The service managed safety incidents well and learned lessons from them.
- Staff provided good care and treatment and gave them pain relief when they needed it. Managers monitored the effectiveness of the service. 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 information. Key services were available six days a week.
- Staff treated patients with compassion and kindness, respected their privacy and dignity, took account of their individual needs, and helped them understand their conditions. They provided emotional support to patients, families, and carers.
- The service planned care to meet the needs of local people and made it easy for people to give feedback. People could access the service when they needed it.
- Leaders 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 were committed to improving services continually.

However:

- The service needed to make some improvements in its governance processes to ensure it had all the guidance and records in place to provide appropriate levels of assurance.
- The service did not have copies of the records of the mandatory training undertaken by consultants working under practising privileges.
- The service did not have a written protocol for staff to follow in the event of the need for an emergency transfer of a patient.
- The service did not have a formally constituted Medical Advisory Committee (MAC).
- The service did not audit the World Health Organisation (WHO) safer surgery checklist to ensure it was always completed correctly.
- The service did not have cleaning schedules in place although the service was visibly clean.
- The service did not have copies of records to confirm that the appropriate staff were trained to adults safeguarding level 3.
- The services mandatory training matrix did not record the dates when training had been completed.
- Staff did not have access to communication aids to help patients become partners in their care and treatment.

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Surgery	Good	

Summary of findings

Contents

Summary of this inspection

Background to Centre for Surgery - Baker Street

Centre for Surgery – Baker Street is operated by M Sarwar Ltd and provides plastic and cosmetic day surgery to self-funding patients aged 18 years of age and over. All patients receiving treatment at the centre are under the care of surgeon operating under practicing privileges.

The service offers facial plastic surgery, aesthetic breast surgery, body contouring, gynaecological surgery, skin surgery (skin lesion removal, scar revision surgery, and surgical tattoo removal), Varicose veins treatment and hair transplant surgery.

The service opened in January 2022. At the time of the inspection, there was a registered manager in post. The registered manager had been in the post since December 2021.

This is the first time this service had been inspected.

How we carried out this inspection

We inspected this service using our comprehensive inspection methodology. We carried out the unannounced part of the inspection on 23rd February 2023. On the day of the inspection the service was undertaking 2 surgical procedures, and patients were attending for consultations and aftercare appointments.

Following the inspection, we conducted a telephone interview with 1 member of staff on the 27 February 2023.

We spoke with 6 patients and 9 members of staff including the registered manager. We reviewed a range of policies, procedures, patient records and observed patient care.

The inspection team comprised of a lead CQC inspector and a CQC specialist advisor. The inspection team was overseen by Nicola Wise, Deputy Director of Operations.

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

Areas for improvement

Action the service MUST take is necessary to comply with its legal obligations. Action a trust 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 ensure they have systems in place to regularly review the records for consultants working under practising privileges. This would ensure that they had the evidence available to confirm they had completed all the necessary mandatory training. (Regulation 17(1) (2) (a): Good Governance)

Summary of this inspection

- The service must ensure they have the appropriate written procedures and associated learning in place to provide staff guidance in the event of an emergency transfer of a patient. (Regulation 17 (1) (2) (a): Good Governance)

Action the service SHOULD take to improve:

- The service should review the terms of reference for the Medical Advisory Committee to ensure it is formally constituted with the roles and responsibilities set out and available. (Regulation 17 (1) (2) (a): Good Governance)
- The service should have processes in place to comprehensively audit the World Health Organisation (WHO) safer surgery checklist. (Regulation 12: Safe care and treatment)
- The service should have systems in place to ensure cleaning schedules are in place and comprehensively carried out. (Regulation 17: Good Governance)
- The service should have a process to ensure appropriate staff have a record to confirm they are trained to safeguarding level 3. (Regulation 12: Safe care and treatment)
- The service should ensure staff have access to communication aids to help patients become partners in their care and treatment. (Regulation 9: Person centred care)
- The service should consider including dates for when mandatory training is completed. (Regulation 17: Good Governance)

Our findings

Overview of ratings

Our ratings for this location are:

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

Good

Surgery

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

Is the service safe?

Good

The service had not previously been rated. We rated it as requires improvement.

Mandatory training

The service provided mandatory training in key skills to all staff and made sure everyone completed it. However, the service could not be assured consultants working under practising privileges had undertaken mandatory training.

Staff received mandatory training. Data provided showed mandatory training completion was 100% for medical, nursing and non-medical staff. However, there were no dates to indicate when the training had been completed or when it was due for renewal.

Mandatory training met the needs of patients and staff. The training included a range of topics such as equality, diversity and human rights, fire safety, moving and handling, infection prevention, introduction to sepsis, health and safety.

Consultant's working under practising privilege were not required to provide evidence they had undertaken mandatory training, which meant the provider was not assured their mandatory training was up to date. The provider's practising privilege policy had identified they were required to undertake basic life support, fire safety, health and safety, infection prevention, information governance, manual handling and protection of vulnerable adults. Following the inspection, the provider has advised they have asked consultants to provide evidence that the mandatory training as per the policy has been completed but they did not provide evidence that information had been obtained.

The service had a policy for the recognition and management of sepsis which was reviewed in December 2022.

Safeguarding

Staff understood how to protect patients from abuse. Staff had training on how to recognise and report abuse and they knew how to apply it. However, it was not clear if appropriate staff were trained to safeguarding level 3.

Not all staff received training specific for their role on how to recognise and report abuse. Safeguarding children and adults formed part of the mandatory training programme for staff. Records showed 100% of staff had received training in both safeguarding children and adults. However, the provider's training and development policy stated senior clinical staff are required to complete adult safeguarding level 3; however, information provided did not detail this.

Staff knew how to identify adults at risk of, or suffering, significant harm. The service had a policy for safeguarding adults which had been reviewed in November 2022. Staff knew who to inform if they had concerns and could access support from the services safeguarding lead if needed.

Relevant recruitment checks had been completed for all staff who had commenced working for the provider within the last 12 months. These included a disclosure and barring service (DBS) check and professional registration checks.

Cleanliness, infection control and hygiene

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

Clinic areas were visibly clean and had suitable furnishings which were clean and well-maintained. Cleaning was also outsourced to an external cleaning company which also undertook a nightly clean when the service was open. A ''deep clean'' was undertaken by an external company and the certificate showed the service was last cleaned in January 2023. However, the service was unable to provide cleaning schedules which detailed what staff and the external cleaning company should undertake on a daily, weekly or monthly basis. Following the inspection, the provider provided daily cleaning check lists for staff to complete but these were not comprehensive. The provider has since provided a more detailed cleaning schedule based on the specification agreed with their external cleaning company.

Staff followed infection control principles including the use of personal protective equipment (PPE). Staff followed the provider's policy on IPC, which included being 'bare below the elbow'. There were adequate supplies of PPE in the theatres and on the day ward. To reduce the risk of infection the service used single use theatre gowns which were disposable. Hand gel dispensers were evident, and staff were observed using them. There were hand washing facilities in the consultation room and in theatres. The service had a Covid 19 policy which had been reviewed in November 2022.

The service performed well for infection prevention. Monthly infection prevention and control audits included the consulting rooms, day ward, and the two theatres showed compliance was 100% in the period November 2022 to January 2023.

Hand hygiene was audited as part of monthly infection prevention and control audits. In the period November 2022 to January 2023, compliance was 100%.

Patients were routinely screened for Methicillin-Resistant Staphylococcus Aureus (MRSA) prior to admission.

Environment and equipment

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

The service had suitable facilities to meet the needs of patients. The surgical day unit comprised of a day ward which was both the admissions and recovery area. The day ward comprised of 6 beds with curtains to provide privacy, lockers for

patient's belongings and a nurse's station. There were two theatres with integrated scrub areas, all the equipment looked visibly clean and was still under warranty. However, we observed the equipment did not have 'I am clean' green stickers as adopted by both NHS and independent health care providers. Each theatre had a designated dirty utility area. The day ward and the theatres were well organised and appeared clean and tidy.

The provider had a contract with an external provider for sterilisation of surgical instrumentation. Following surgery, instrumentation would be stored in sealed containers and collected twice a week.

Medical equipment and electrical appliance safety testing was undertaken annually. A random check of equipment found electrical testing had been undertaken in the last 12 months. The service had a back-up generator for use in the event of a mains failure.

Staff carried out daily safety checks of specialist equipment. A resuscitation trolley, difficult airways trolley and anaphylaxis trolley were located to be easily accessible to the day ward and the theatre. All the emergency equipment and defibrillators were checked daily by staff. Staff completed a checking chart, and the seal tag number was recorded, and the contents of drawers were checked. This ensured the resuscitation equipment was safe and ready for use in an emergency. Laminated current emergency protocols were displayed over the trolleys.

Staff disposed of clinical waste safely. Clinical and non-clinical waste were correctly segregated and collected separately, either in clinical waste bins or sharps instrument containers, which were not over filled. All waste was kept in bulk storage bins on the clinic premises and collected by a specialist waste company on a weekly basis.

In clinical governance minutes we saw a national patient safety alert regarding the use of cylinders, where patients not having access to medical gases pipeline systems was discussed and saw this had been followed up in the nurses meeting.

Assessing and responding to patient risk

Staff completed and updated risk assessments for each patient and removed or minimised risks. However, there was no written protocol for staff to follow on how staff should assist in the transfer in the event of an emergency transfer of a patient. Adult life support training was not identified as mandatory training.

The service had a policy for the emergency transfer of patients which was reviewed in February 2023. However, there was no written protocol for staff to follow on how staff should assist the transfer in the event of an emergency transfer of a patient and no practical training had been undertaken.

Mandatory training records provided did not include training in immediate life support (ILS) or basis life support (BLS) for clinical staff. The provider's training and development policy did not identify advance life support (ALS, immediate life support (ILS) or basis life support (BLS) as mandatory training for clinical staff. Following the inspection, we were advised 2 nurses had ILS, 1 nurse had BLS and the medical director had advanced life support (ALS). We were also advised refresher training had been planned for August / September 2022 but had been delayed until March 2023 due to staff shortages and long-term sick leave. The provider has since provided evidence that 4 members of the clinical team have completed BLS.

Staff completed risk assessments for each patient on admission. Venous thromboembolism (VTE) risk assessments were completed on admission. Key safety areas such as hydration and pain were monitored using national risk assessment tools.

Good

Surgery

Staff used a recognised tool to identify deteriorating patients and escalated them appropriately. Patient records we reviewed, showed people were assessed using the New Early Warning System (NEWS2). Each chart recorded the necessary observations such as pulse, temperature and respirations. The service had a policy for the recognition and management of the deteriorating patient which was reviewed in November 2022.

Staff used the World Health Organisation (WHO) safer surgery checklist in theatres, which was designed to prevent avoidable mistakes. In patient records we reviewed we saw WHO safety checks were undertaken as per national guidelines during. Leaders advised WHO checklists were audited as part monthly records management tool audit, however the audits only referred to a safety checklist. Following the inspection, the provider provided a WHO Checklist audit for staff to complete which covered the five steps to safer surgery.

Nurse staffing

The service had enough nursing and support staff with the right qualifications, skills, training and experience to keep patients safe and to provide the right care and treatment. Managers reviewed and adjusted staffing levels and skill mix, and gave agency staff an induction.

Staffing was planned to ensure staffing levels and the skill mix of staff followed guidance from The Association for Perioperative Practice (AfPP) for safer staffing. Staff rotas were agreed a month in advance and adjusted in response to patient levels.

Since July 2022 the service had used 11 agency staff to cover the theatres. Staff told us for consistency they used the same agency staff. We saw agency staff had signed to confirm they had read the services policies including record management, confidentiality, emergency transfer policy and resuscitation policy. The provider advised agency staff formed approximately 10 -15% of support clinical staff needs (nurses, operating department practitioners (ODPs), healthcare assistants) to cover sickness, annual leave and short-term vacancies.

Medical staffing

The service did not directly employ any medical staff. The service had 9 consultants who were able to work at the service with practising privileges. Practising privileges are a well-established system of checks and agreements, whereby doctors can practise in hospitals without being directly employed by them. All patients we spoke with told us they were seen by their consultants, pre and post-surgery. Out of hours consultants were contactable for telephone advice.

The provider advised they would use an NHS approved agency with preferred supplier status for anaesthetists to assist on a per procedure or per list basis.

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.

Patients' personal data and information was kept secure and only staff had access to the information. Paper and electronic patient records were used to document patient's treatment pathway. Patients' treatment pathway commenced at pre-operative assessment prior to surgery. The pre-operative assessment, health assessment questionnaire and the WHO surgical pause safety checklist for surgery formed part of the record.

All paper records would be scanned onto the providers electronic patient record system. This included the traceability forms/ patient operation record and discharge summary which had been completed. Care records were written and managed to ensure they were accurate, complete, legible, up to date and stored securely. Staff told us the discharge summary would be sent to the patients GP if they consented.

We reviewed 5 patient records during this inspection and saw records were accurate, complete, legible and up to date.

Staff received training on information governance awareness and Caldicot principles as part of their mandatory training programme.

The service had a policy for data protection which was reviewed in December 2022.

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. Medicines were prescribed by consultants with practising privileges.

We saw controlled drugs (CD) were stored, recorded, and handled appropriately with two nurses signing when controlled drugs were being administered. We noted no discrepancy in signing in the CD book.

All medication was stored securely in cupboards and a fridge. We reviewed a selection of medicines stored which were found to be in date. Staff monitored fridge temperatures daily to confirm fridge temperatures were within the range and we saw these were recorded.

Medical gases and equipment were checked regularly, in date and readily accessible to staff. Gases were stored away from flammable materials.

The service did not hold medicines to take out (TTO).

There were 2 reports of medicines related incidents for the period February 2022 to January 2023.The provider had a use of medicines policy which had been reviewed in January 2023.

Incidents

The service managed patient safety incidents well. Staff recognised and reported incidents and near misses. Managers investigated incidents and shared lessons learned with staff.

Managers shared learning about never events and incidents with their staff. The service reported one incident classified as a never event (Cannula not removed form patient prior to discharge) for the period February 2022 to January 2023. Details of the investigation and root causes analysis showed the duty of candour had been applied, the lessons learned identified, arrangements for shared learning, and recommendations were in place to prevent a recurrence.

Staff raised concerns and reported incidents and near misses. Surgical site infections (SSIs) were monitored on the adverse events tracker. The service reported 10 SSIs and 11 adverse events the period February 2022 to January 2023; 52.3% (11) were categorised as NA (not applicable), 19 % (4) were categorised as rare, 9.5% (2) were categorised as unlikely, and 9.5% (2) were unknown.

Good

Surgery

Staff knew what incidents to report and how to report them. Clinical governance, nurses and clinical staff meeting minutes reviewed recorded adverse events and SSIs were discussed.

Is the service effective?

Good

The service had not previously been rated. We rated it as good.

Evidence-based care and treatment

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

We reviewed a sample of the providers policies and found appropriate reference to relevant National Institute for Health and Care Excellence (NICE) guidelines. All the policies and procedures we reviewed were up to date and had a scheduled review date clearly marked on them. But it was not clear what the process was for signing off approval for new policies or changes to existing policies or how this was disseminated to staff. Policies documented they had been approved by the board or at clinical governance meetings. However, in the clinical governance meeting minutes provided there were no reference to the 32 policies that had been reviewed or approved in the period September 2022 to January 2023.

All staff had access to the providers policies, procedures and guidelines, staff demonstrated they knew how to access them.

Nutrition and hydration

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

Staff monitored patients for nausea and vomiting during and post surgery. The service prescribed an anti-sickness medication to patients undergoing intravenous sedation before surgery.

Patients were advised about fasting times prior to surgery. Staff would check to ensure patients had followed the fasting guidelines. Patients were required to keep nil by mouth, six hours from food (including milk in drinks) and two hours from drinking, prior to surgery, which was line with national guidelines. Staff told us post operation they would offer patients hot or cold drinks and a snack to ensure patients were not without food and drink for long periods.

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. Staff assessed patients' pain as part of the NEWS2. This ensured pain was monitored in a timely way. Recording of pain scores in NEWS2 was audited monthly as part of the ongoing clinical audit programme.

Post-operative pain relief was discussed with patients and were prescribed pain relief medication to take at home following their surgery, unless contraindicated.

Good

Surgery

Patients received follow-up telephone calls on day 1, 3, 5 and 7 after each procedure to check their wellbeing and whether they were in any pain.

Patient outcomes

Staff monitored the effectiveness of care and treatment.

The service contributed to the Private Healthcare Information Network (PHIN). which were regulated by the Competition and Markets Authority (CMA). It is not a legal requirement but good practice to be registered with PHIN.

Following the inspection, the service provided evidence of 15 Q-PROMS (Patient-reported outcome measures) questionnaires, eight for liposuction, four for augmentation mammoplasty and three for rhinoplasty. The Royal College of Surgeons (RCS) identified the Q-PROMS used within cosmetic surgical practice as BREAST-Q – Augmentation mammoplasty, FACE-Q – Rhinoplasty, FACE-Q – Blepharoplasty, FACE-Q – Rhytidectomy, BODY-Q – Abdominoplasty and BODY-Q – Liposuction.

The service had a local audit programme which included records management to review the effectiveness of care and treatment.

Competent staff

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

The managers were responsible for ensuring that each member of staff had an individual appraisal. The service reported 66% (2) of eligible staff had an appraisal in the last 12 months.

Consultants with practising privileges were required to provide evidence of appraisals, revalidation, professional registrations and evidence of insurance or indemnity cover for the provision of services. Data provided showed 77.7% (7) of the consultants had an appraisal within the last 12 months.

All new staff had an induction tailored to their role. The provider's training and development policy set out what core training staff were required to complete within their first 2 months.

Nursing staff told us there were opportunities for learning and development, one nurse we spoke with told us the service had provided sponsorship for the nurse and midwifery council (NMC) UK exam so they could register with the NMC. Nursing staff were also required to complete a range of self-assessment competencies and practical assessments within 3 to 6 months of commencing their role and were to be reviewed every two years. Records reviewed showed further training for a SFA (Surgical First Assistant) role, competencies included perioperative care and practice, professional, ethical and legal practice.

Multidisciplinary working

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

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

Good

Surgery

The service shared relevant information with the patient's GP. The service asked patients for their consent to share information with their GP. If patients consented, the surgeon wrote to their GP following a consultation and would also send a copy of the discharge summary.

Staff described good working relationship between staff members. We observed good working relationships between all staff and staff working together to meet patients' needs.

A consultant we spoke with told us they received a consultant's newsletter and would discuss cases with colleagues.

Seven-day services

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

The service was open 6 days a week opening from 8:00am to 7.00pm Monday to Saturday with an occasional Sunday list offering consultations and surgery. All surgery was planned in advance.

Patients were able to contact their surgeon out of hours and 24 hours after following their procedures if they had any concerns.

Health promotion

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

The service advised patients to stop smoking for four weeks before surgery. This was to reduce the risk of postoperative complications including poor wound healing and pulmonary complications. Patients were also advised to avoid alcohol 2 weeks prior to surgery. This was to reduce the risk of compromising patients' post-operative immune system, which could affect the positive outcomes for patients.

On the providers website information was available for patients about how to prepare for surgery which included eating healthy and nutritious foods for optimising wound healing and keeping hydrated.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

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

Staff gained consent from patients for their care and treatment in line with legislation and guidance. Patients told us the consultants had discussed the benefits and risk of surgery before signing the signed consent forms. In all the records we reviewed, consent forms had been completed correctly. Patients signed consent forms were scanned and stored in their medical records.

Staff made sure patients consented to treatment based on all the information available. Patients had a cooling off period between the procedure recommendation and surgery. This was the minimum of 14 days, as advised by the guidance issued by the Royal College of Surgeons Professional Standards for Cosmetic Surgery.

The provider had a consent policy, which was reviewed in December 2022.

All staff received training in the Mental Capacity Act and Deprivation of Liberty Safeguards.

Good

Surgery

Is the service caring?

Good

The service had not previously been rated. We rated it as good.

Compassionate care

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

Staff were discreet and responsive when caring for patients. Staff took time to interact with patients. Patients reported staff were polite, courteous and attentive. Patients told us staff treated them with kindness and respect.

Staff were seen to be considerate and empathetic towards patients. During our inspection, we spoke with 6 patients, 2 patients undergoing surgery, 2 patients attending for follow up appointments and 2 patients attending for consultations. All were very positive about their care and treatment, they told us the staff were kind, caring and listened to their concerns. The 2 patients undergoing surgery praised the nursing and medical staff for their caring and professional attitudes.

Staff ensured patients' privacy and dignity was maintained by ensuring patient's information was kept secure, and privacy curtains were closed.

Staff encouraged patients to complete patient satisfaction questionnaires, so the organisation could review and improve patient experience. A total of 37 patients responded in the last 12 months. When asked if they would recommend the service to friends or family if they needed similar care or treatment, 75.6% (28)) said they were extremely likely or likely to recommend.

Emotional support

Staff provided emotional support to patients to minimise their distress. They understood patients' personal needs.

Staff gave patients emotional support and advice when they needed it. Staff showed sensitivity and support to patients and understood the emotional impact of them undergoing surgery. Staff told us the options were carefully explained to patients. Patients told us following their consultations they felt well informed and not rushed into making decisions.

Following the inspection, we were provided with examples of plaudits from patients. One patient wrote, 'Professional staff, I was looked after very well,' another patient commented, 'friendly and approachable staff'.

Staff told us patients were able to telephone their surgeon after discharge, for further help and advice.

Understanding and involvement of patients and those close to them

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

Good

Surgery

Staff supported patients to make informed decisions about their care. All the patients told us they were involved in their care and were actively involved in all decisions. They were given the opportunity to ask questions about care and met with their consultant prior to the operation. Post operation patients told us their consultant had seen them post operatively and for follow up appointments.

In patient satisfaction questionnaires patients were asked if the surgeon or staff member encouraged them to ask questions 64.8% (24) patients rated it as excellent or good, when asked if they felt the surgeon or staff were listening carefully 94.5% (35) patients rated it as excellent or good and when asked how patients would rate the overall care received from the provider 75.6% (28) rated their care as excellent or good.

Is the service responsive?

Good

The service had not previously been rated. We rated it as good.

Service delivery to meet the needs of local people

The service planned and provided care in a way that met the needs of local people and the communities served. It also worked with others in the wider system and local organisations to plan care.

The service provided a range of plastic and cosmetic day surgery to self-funding patients aged 18 years of age and over from the local area and other parts of the country. Managers planned services to meet the needs of the patients booked for surgery.

All surgical procedures were pre-planned so staff could assess, and plan patients care before treatment. The service offered appointments during the week for consultations, surgery, and aftercare between 8.00am and 7.00pm Monday to Saturday. The service offered appointments at the convenience of patients. One patient we spoke with told us they initially contacted the service via the internet about 3 to 4 months ago, and in the interim had been in contact with a member of the customer service team. They were attending for their first consultation.

Facilities and premises were appropriate for the services being delivered. Patients were seen in a consultation room; surgery was undertaken in the theatres and patients were taken into a separate 6 bedded day ward prior to discharge.

Meeting people's individual needs

The service did not always take account of patients' individual needs and preferences. Staff did not have access to communication aids to help patients become partners in their care and treatment.

Procedure guides were available on the providers website which was available in English only. There was no hearing loop, information, or signage suitable for visually impaired patients.

The entrance was on the ground floor and was easily accessible. Disable toilet facilities were available near the reception area. The service did have a lift for patient with limited mobility so they could access the floor below ground level where the theatres were located.

On discharge, all patients had post-operative clinic appointments booked and follow up calls on days 1, 5 and 7 following their procedures.

Staff could use a telephone interpreting service for patients whose first language was not English.

Patients had access to cold and hot drinks in the waiting room and could serve themselves whilst waiting for their appointment.

Access and flow

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

Patients were self-referring and were able to access the service by making bookings online or via the provider's customer services team. Patients we spoke with had booked their consultations online. The service was open 6 days a week.

The service had a preoperative and admission policy which set the criteria for patients to be accepted as a patient with the provider. The service had a clear exclusion criteria which included for example; patients living with cancer or undergoing radiotherapy/chemotherapy, patients who had an organ transplant, patients with a history of venous thromboembolism (VTE) in the 3 months prior to surgery, recurrent VTE, and patients under the age of 18.

All treatment was undertaken as day cases with patients discharged on the same day. Patients were given follow up appointments and were provided with an information sheet for aftercare with contact details for their surgeon which they could use to contact the surgeon out of hours if they had any concerns. During clinic opening times patients were made aware they could contact the clinic directly for advice.

Data provided for the period February 2022 to January 2023, showed the service undertook a total of 645 surgical procedures and had 938 follow up appointments. The service advised as patients self-funded their elective surgery, cancellations were rare. The patient contact set out the terms and conditions between the provider and the patient which included the patients' right to cancel.

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 and investigated them. However, it was not clear how lessons learned where shared with all staff.

The providers feedback, concerns and complaints policy set out the process for how complaints could be raised. A verbal complaint could be raised at a clinic, via email or phone. Formal complaints could be submitted to the provider's head office via email or writing. The policy set out a time frame for acknowledging and investigating complaints when handled by the head office but did not set out a time frame for complaints to be handled by clinic managers. Acknowledgements were sent within three working days of receiving a complaint. The provider aimed to respond in writing within 20 working days. Patients could access the provider's formal complaints policy online.

In the period February 2022 to January 2023, two complaints had been received. One had been closed with the complaint not upheld and the other complaint had been resolved.

Staff told us complaints were discussed within the team; however, there was no record of complaints being discussed in nurses' meetings or with the Medical Advisory Committee (MAC). In the clinical governance meeting minutes provided we saw there was reference to one of the complaints.

Medical and clinical staff had completed duty of candour as part of their mandatory training.

Good

Surgery

Is the service well-led?

Requires Improvement

The service had not previously been rated. We rated it as requires improvement.

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.

There was a clear leadership structure. The service had a managing director and a medical director with responsibilities split between the two directors. The medical director was also the registered manager, the named controlled drugs officer, safeguarding lead and Caldicott guardian. The managing director was the nominated individual, the senior information risk owner (SIRO) lead for risk and compliance, data protection, human resources, recruitment, and patient experience. The leaders had the skills, knowledge, and experience they needed for their roles.

Staff described their immediate managers as accessible and had confidence in them. Staff we spoke with were clear about the management structure and who they could contact in case of any issues. Staff described managers as approachable and supportive. Staff were visible throughout the inspection and motivated to provide high quality of care.

Consultants told us they had good working relationships with staff and the directors to deliver care and meet patients' needs. One consultant had nothing but praise for the facilities and the management regarding any issues, felt they would be listened to and with action taken if needed. Another consultant told us it was a great place to work with a good team.

Vision and Strategy

The service had a vision for what it wanted to achieve. The vision and strategy were focused on sustainability. Leaders and staff understood and knew how to apply them and monitor progress.

The provider had a clear vision for the service. The provider's focus was on cosmetic surgery and non-surgical treatments. The services vision was to create a multi-disciplinary clinic offering both cosmetic and non – surgical treatments options all under one roof with all procedures carried out by registered practitioners. This vision was delivered through the provider's core values of transparency, individuality, and passion. All the staff we spoke with were motivated and aware of their contribution in achieving this.

Culture

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

Staff told us there was good teamwork and were committed to delivering a good service. Staff were enthusiastic about the care and services they provided for patients. Staff described the service as a good place to work and were proud to work for a company who would invest in their professional development. They felt a valued member of the team. Staff felt the leaders were approachable and felt they could raise concerns with their manager.

There were opportunities for further learning and development. Staff had an annual appraisal and regular 121 meetings.

Good

Surgery

Senior staff were aware of their responsibilities under duty of candour and had systems in place to ensure compliance.

Records showed 100% of staff completed equality, diversity, and human rights as part of their mandatory training.

Governance

Leaders did not operate effective governance processes.

The service did not have an effective governance structure. The service did not have a formally constituted Medical Advisory Committee and did not meet the criteria to be considered as formal or structured as there were no agendas, no chair, meeting frequency was ad hoc. Minutes provided demonstrated the MAC was used to discuss and approve new practicing privileges applications for consultants only. MACs should review all clinical governance issues, key performance indicators (KPIs), all deaths and adverse events.

Data provided showed clinical governance meetings were held at every 2 or 3 months. Minutes did not always identify who was chairing the meeting; nevertheless, there appeared to be a standard format that the meeting followed. Minutes recorded discussions and had actions points.

Nursing team meetings were held infrequently with 3 held in the last 12 month period (4.4.22, 5.7.22, 16.2.23). Minutes provided showed there was no standing agenda; however, these meetings included discussions on incidents and patient feedback.

Management of risk, issues and performance

Leaders identified and escalated relevant risks and issues and identified actions to reduce their impact. They had plans to cope with unexpected events.

The service's risk registers identified 15 risks which were which were categorised as clinical (9), operational (3) and technical (3). The risk register was reviewed regularly with review dates. Risks were updated and there were action plans in place to reduce the risks on the register. Staff meeting minutes did not include updates on the risk register. The registers did not include the risks that were identified during the inspection.

The provider had a business continuity plan which was published in November 2022.

Information Management

Staff could find the data they needed, in easily accessible formats. The information systems were integrated and secure.

The service advised they had arrangements in place to ensure that cosmetic procedures were coded in accordance to SNOMED-CT which assisted with the PHIN submissions. SNOMED CT stands for Systemized Nomenclature of Medicine – Clinical Terms. It is a standardised, international, multilingual core set of clinical healthcare terminology that can be used in electronic health records.

The service used paper and electronic patient records, all of which were stored securely to prevent unauthorised access and could be accessed easily. Staff had secure access to the service's intranet and were able to locate and access records easily, this enabled them to conduct their day to day roles.

The service had 1 adverse event related to GDPR in the period February 2022 to January 2023. The incident was investigated, and no further action was taken.

Good

Surgery

The provider had a data protection policy, which was reviewed in December 2022. Records showed 100% of staff had completed information governance and data security training and GDPR awareness.

Engagement

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

The service gathered patients' feedback through patient satisfaction questionnaires, which were completed post procedure and 37 patients responded in the last 12 months. The service also received feedback via online review platforms which were used to populate the providers website.

The service advised that following feedback from patients, they had introduced 'well wish' phone calls the day prior to the patient's procedure and sent a 'To Do' list, so patients felt prepared. The patient contract had also been updated so that the terms and conditions were clearer regarding rescheduling, readmission, what's included in the fee, and had also made the website more accessible and easier to navigate.

All staff we met were welcoming, helpful and friendly. Following the inspection, the provider advised us they had introduced home / flexible working for some of their staff to improve work-life balance, and asked staff to remove themselves from service's 'WhatsApp' groups and sign up to another instant messaging programme to communicate during working hours.

The provider had a whistleblowing policy, which was reviewed in November 2019.

Learning, continuous improvement and innovation

All staff were committed to continually learning and improving services.

The service had a track record of investing and upskilling staff, and leaders advised they planned to build on this by having a programme to continually develop staff skills.

Leaders advised they were also planning to develop a craniofacial service for patients with congenital conditions such as cleft lip or cleft palate and syndromes that affect the facial regions, and to put safety first by implementing the patient safety incident response framework for learning and to improve patient safety.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Diagnostic and screening procedures Surgical procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance • The service did not have systems in place to regularly review all the records for consultants working under practising privileges. (Regulation 17(1) (2) (a): Good Governance) • The service did not have written procedures and associated learning in place to provide staff guidance in the event of an emergency transfer of a patient. (Regulation 17 (1) (2) (a): Good Governance)