

MS Watford

Quality Report

The Business Centre
Unit 2, Colne Way Court
Watford
Hertfordshire
WD24 7NE
Tel: 020 7993 4849
Website: www.centreforsurgery.com

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

Ratings

Overall rating for this location

Are services safe?

Are services effective?

Are services caring?

Are services responsive?

Are services well-led?

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

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

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

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

Summary of findings

Overall summary

MS Watford is operated by M Sarwar Limited. The service provides day case cosmetic surgery to self-funding patients aged 18 years and over. Facilities include a dedicated surgical suite with admission room, operating theatre and recovery room. There is also one consultation room, waiting room, offices, toilet and shower facilities.

We carried out a focused inspection because the service was taken over by a new provider in April 2020. We wanted to see if the new provider had made significant improvements to the service since our last inspection of the former provider, Acuitus Medical Ltd, in June 2019. We carried out a short-notice announced focused inspection on 22 July 2020. We gave staff one days' notice that we were coming to ensure the staff we needed to talk to were available.

To get to the heart of patients' experiences of care and treatment, we ask the same five questions of all services: are they safe, effective, caring, responsive to people's needs, and well-led? However, because this was a focused inspection, we did not look at all five key questions. Instead, we focused on the areas of concern which we identified at the last comprehensive inspection of the service. We inspected the safe and well-led key questions and some parts of the effective and responsive key questions.

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

The service only provides cosmetic day surgery.

Services we rate

We have not rated this service.

This inspection looked specifically at the concerns we identified at the last inspection. Where there is a change of ownership, any ratings awarded to a previous provider cannot be aggregated with any new ratings awarded to the new provider to produce a new overall rating. Therefore, we were unable to rate the service because we did not inspect all five key questions.

We found significant improvements to the service had been made:

- The service had enough staff to care for patients and keep them safe. Staff had training in key skills, understood how to protect patients from abuse, and managed safety well. The service controlled infection risk well. Staff assessed risks to patients, acted on them and kept good care records. They managed medicines well. The service managed safety incidents well and learned lessons from them. Managers collected safety information and used it to improve the service.
- Staff provided good care and treatment, based on national guidance and best practice. Managers monitored the effectiveness of the service and made sure staff were competent. Staff supported patients to make informed decisions about their care and treatment and followed national guidance to gain patients' consent.
- It was easy for people to give feedback and raise concerns. Concerns and complaints were taken seriously and investigated, and improvements were made in response to feedback where possible.
- Leaders ran the service well using reliable information systems and supported staff to develop their skills. Staff understood the service's vision and values, and how to apply them in their work. Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. Staff were clear about their roles and accountabilities and were committed to improving services.

However, at this inspection we found the following issues that the service provider needs to improve:

- The infection prevention and control audit lacked sufficient detail.
- Staff did not report complications of treatment unless it was a 'significant or unexpected complication of a clinical procedure/treatment'. This meant there was potentially a missed opportunity to identify trends and/or themes relating to complications. Managers took action to address this following our inspection.

Summary of findings

- Response rates to patient surveys was low. The service was taking action to address this.

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

Heidi Smoult

Deputy Chief Inspector of Hospitals (Central)

Summary of findings

Our judgements about each of the main services

Service

Surgery

Rating Summary of each main service

Cosmetic surgery is the sole core service provided at this location.

We carried out a focused inspection to review concerns we found at our last inspection of the former provider in June 2019. We inspected the safe and well-led key questions and some parts of the effective and responsive key questions. We did not rate the service but found significant improvements to the service had been made.

Summary of findings

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MS Watford

Services we looked at

Surgery

Summary of this inspection

Background to MS Watford

MS Watford is operated by M Sarwar Limited. The service originally opened in 2015 under the former provider Acuitus Medical Ltd. In 2019 the service was taken over by a new provider and was registered with the CQC as MS Watford in April 2020. The service provides day case cosmetic surgery to self-funding patients aged 18 years and over. It is located in Watford, Hertfordshire and primarily serves the communities of Hertfordshire and Greater London. It also accepts patient referrals from outside this area.

The clinic has had a registered manager in post since it was registered with the CQC in April 2020.

We have not previously inspected this service. However, we had inspected the former provider four times. The

most recent inspection took place in June 2019, where we found two key questions (safe and well-led) were inadequate, so the service was placed in special measures. We told the former provider that it must take some actions to comply with the Health and Social Care Act 2008 regulations and that it should make other improvements, even though a regulation had not been breached, to help the service improve. We also issued the former provider with two requirement notices for breaches of Regulation 12 (safe care and treatment) and Regulation 17 (good governance). This inspection focused on aspects of the service that previously fell short of the **good** standard. We found the new provider had made significant improvements to the service.

Our inspection team

The team that inspected the service comprised a CQC inspection manager, CQC lead inspector and a specialist advisor with expertise in surgery. The inspection team was overseen by Mark Heath, interim Head of Hospital Inspection.

Information about MS Watford

The service has a dedicated surgical suite with admission room, operating theatre and recovery room. The service has no overnight beds. It is registered to provide the following regulated activities:

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

During the inspection, we observed all areas of the clinic, including the waiting area, admission room, theatre, recovery room, toilets and store rooms. We spoke with six members of staff including the operations director, medical director, registered manager, one registered nurse, a health care assistant, and one consultant. During

the inspection, we reviewed eight sets of patient records and prescription charts. We also reviewed information about the service, including performance data, policies and meeting minutes.

Activity (1 April to 27 July 2020)

- From when the service was taken over by the new provider in April 2020 to 27 July 2020, the clinic reported 65 day case procedures and 452 outpatient attendances, of which 291 were virtual consultations and 161 were face-to-face consultations. All day case and outpatient consultations were privately funded. During this period, there were 30 different types of day case procedures performed, the most common of which performed at the clinic were:

Summary of this inspection

- Liposuction (removal of unwanted body fat) and fat transfer (13)
- Rhinoplasty (surgery that changes the shape of the nose) (8)
- Labiaplasty (surgery that aims to reduce the size or correct the shape of the labia) (6)
- Osteoma removal (an osteoma is a benign tumour, where a new piece of bone usually grows on another piece of bone) (4)
- Liposuction to abdomen (3)
- Tattoo excision

Four surgeons worked at the service under practising privileges. The service employed two registered nurses and one support staff. The accountable officer for controlled drugs (CD) was the registered manager.

Track record on safety:

- Zero never events
- Zero serious injuries
- Zero clinical incidents

- Zero incidences of hospital acquired MRSA, Methicillin-sensitive Staphylococcus aureus (MSSA), Clostridium difficile (C. diff) and E. Coli
- Zero complaints

Services provided at the clinic under service level agreement:

- Clinical and non-clinical waste removal
- Maintenance of medical equipment
- Air conditioning and theatre ventilation
- Decontamination of equipment
- Alarm maintenance
- Fire-related equipment
- Diagnostic services
- Pharmacy arrangements
- Maintenance and replacement of oxygen cylinders
- Psychology services
- Interpreting and translation services
- Locum anaesthetists and agency nurses and health care assistants

Summary of this inspection

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?

Our inspection was focused on the areas of concern we identified at the last inspection of the former provider. We inspected the safe and well-led key questions and some parts of the effective and responsive and key questions.

We did not rate the service. We found significant improvements to the service had been made:

- The service provided mandatory training in key skills to all staff and made sure everyone completed it.
- Staff understood how to protect patients from abuse. Staff had training on how to recognise and report abuse and they knew how to apply it.
- The service controlled infection risk well. The service used systems to identify and prevent surgical site infections. Staff used equipment and control measures to protect patients, themselves and others from infection. They kept equipment and the premises visibly clean.
- The design, maintenance and use of facilities, premises and equipment kept people safe. Staff managed clinical waste well.
- Staff completed and updated risk assessments for each patient and took action to remove or minimise risks. Staff identified and quickly acted upon patients at risk of deterioration.
- The service had enough medical, nursing and support staff with the right qualifications, skills, training and experience to keep patient's safe from avoidable harm and to provide the right care and treatment.
- Staff kept detailed records of patients' care and treatment. Records were clear, up-to-date and easily available to all staff providing care.
- The service used systems and processes to safely prescribe, administer, record and store medicines.
- Although staff had not reported any incidents since the new provider took over the service in April 2020, staff knew how to manage patient safety incidents. Staff followed the policy for reporting incidents and near misses. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support. Managers ensured that actions from patient safety alerts were implemented and monitored.
- The service collected safety information and shared it with staff.

However:

Summary of this inspection

- The infection prevention and control audit lacked sufficient detail.
- Staff did not report complications of treatment as an incident unless it was a 'significant or unexpected complication of a clinical procedure/treatment'. This meant there was potentially a missed opportunity to identify trends and/or themes relating to complications. Managers took action to address this following our inspection.

Are services effective?

We did not rate the service. We found improvements to the service had been made:

- The service provided care and treatment based on national guidance and best practice. Managers checked to make sure staff followed guidance.
- Staff monitored the effectiveness of care and treatment. They used the findings to make improvements and achieved good outcomes for patients.
- The service made sure staff were competent for their roles. Managers appraised staff's work performance and held supervision meetings with them to provide support and development.
- Staff supported patients to make informed decisions about their care and treatment. They followed national guidance to gain patients' consent.

Are services caring?

We did not review this key question as part of this inspection.

Are services responsive?

We did not rate the service. We found improvements to the service had been made:

- The service was inclusive and took account of patients' individual needs and preferences. Staff made reasonable adjustments to help patients access services.
- It was easy for people to give feedback and raise concerns about care received. The service treated concerns and complaints seriously, investigated them and shared lessons learned with all staff.

Are services well-led?

We did not rate the service. We found significant improvements to the service had been made:

Summary of this inspection

- Leaders had the integrity, skills and abilities to run the service. They understood and managed the priorities and issues the service faced. They were visible and approachable in the service for patients and staff.
- The service had a vision for what it wanted to achieve and was developing a strategy to turn it into action.
- 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.
- Leaders operated effective governance processes, throughout the service and with partner organisations. Staff at all levels were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service.
- Leaders and teams used systems to manage performance effectively. They identified and escalated relevant risks and issues and identified actions to reduce their impact. They had plans to cope with unexpected events.
- The service collected reliable data and analysed it. Staff could find the data they needed, in easily accessible formats, to understand performance, make decisions and improvements. The information systems were integrated and secure.
- Leaders and staff had some engagement with patients to plan and manage services.
- Staff were committed to continually learning and improving services.

However:

- Response rates to patient surveys was low. The service was taking action to address this.

Detailed findings from this inspection

Overview of ratings

Our ratings for this location are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Surgery	N/A	N/A	N/A	N/A	N/A	N/A
Overall	N/A	N/A	N/A	N/A	N/A	N/A

Notes

Surgery

Safe	
Effective	
Caring	
Responsive	
Well-led	

Are surgery services safe?

We have not rated this service.

Mandatory training

The service provided mandatory training in key skills to all staff and made sure everyone completed it.

The mandatory training was comprehensive and met the needs of patients and staff. Courses covered key areas such as fire safety, health and safety, information governance and infection prevention and control. Training was mostly provided through e-learning courses, with some practical face-to-face sessions, such as manual handling and life support. Staff understood their responsibility to complete mandatory training and told us the training was relevant to their roles.

The registered manager monitored mandatory training compliance through a training tracker and alerted staff when they needed to update their training. The training tracker included the date when each staff member's training was due. This meant they had oversight of staff compliance and could address any areas of non-compliance when needed. This was an improvement from our last inspection of the former provider, where we found the training tracker was not fully up-to-date and did not include dates for when training was due.

Staff received and kept up-to-date with their mandatory training. As of July 2020, 98% of staff were up-to-date with mandatory training (Source: Data Request (DR) DR2).

There was an up-to-date policy for sepsis management which staff were aware of. Staff had received annual training on sepsis management, which included the use of sepsis screening tools. As of July 2020, completion rates for sepsis management were 100% (Source: Data Request (DR) DR2).

Medical staff who worked at the service also worked for NHS trusts, other independent healthcare providers or locum agencies and completed their mandatory training with their substantive employer. Managers monitored their compliance with mandatory training annually.

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.

There were clear systems, processes and practices to safeguard adults, children and young people from avoidable harm, abuse and neglect that reflected legislation and local requirements. The safeguarding policy was in-date and accessible to staff. The policy included links to external resources, and the contact details of the local safeguarding board.

Staff received training specific for their roles on how to recognise and report abuse. Staff completed safeguarding adults and children training at level two. This level of training was proportionate to the type of service provided. As of July 2020, the completion rate for safeguarding adults and children training was 100% (Source: DR3). Staff we spoke with understood their responsibility to safeguard patients from abuse.

The registered manager was the designated lead for safeguarding adults and children. They were available during working hours to provide safeguarding support and advice to staff when needed. They would contact the local safeguarding team if they needed advice or support. This meant they had access to higher level trained safeguarding professionals. Staff confirmed they could contact the registered manager if they needed advice or support with any safeguarding concern.

Staff we spoke with had not made any safeguarding referrals. However, they were able to describe what action

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they would take if they identified a safeguarding concern. This included informing the registered manager. This was an improvement from our last inspection of the former provider, when we found not all staff understood how to protect patients from abuse. From when the service was taken over by a new provider in April 2020, the service had not reported any safeguarding concerns to the local authority and the Care Quality Commission (CQC) had not received any safeguarding notifications.

The service did not treat patients under the age of 18 years. Patients were required to provide proof of identity to ensure they were over the age of 18 before they underwent any treatment.

The service had an up-to-date chaperone policy. Staff had completed chaperone training and could describe how to carry out this role. The service displayed posters advising patients to ask if they wanted a chaperone.

Safety was promoted in recruitment procedures and employment checks. Staff had Disclosure and Barring Service (DBS) checks carried out at the level appropriate to their role. We saw staff had up-to-date DBS certificates and had submitted a DBS check before they were employed by the service.

Cleanliness, infection control and hygiene

The service controlled infection risk well. The service used systems to identify and prevent surgical site infections. Staff used equipment and control measures to protect patients, themselves and others from infection. They kept equipment and the premises visibly clean. However, the audit checklist for cleanliness of the physical environment lacked sufficient detail.

All areas of the service were clean and had suitable furnishings which were clean and well-maintained. There were systems to ensure standards of hygiene and cleanliness were regularly monitored, and results were used to improve infection prevention and control (IPC) practices when needed. There was a weekly and monthly programme of IPC audits to ensure good practice was embedded. The monthly IPC audit assessed compliance against national and local guidelines, use of personal protective equipment (PPE), the physical environment, hand hygiene, special equipment and instruments, dress code and barrier protection and routine precautions.

However, the checklist for the physical environment lacked sufficient detail, such as evidence that the area had been checked for spillages, stains and dust. We raised this with the senior management team who assured us all aspects of the environment were checked for cleanliness, but the audit checklist did not reflect this. We were told the IPC audit checklist had been amended following our feedback, but we were not provided with evidence of this. From April to July 2020, the IPC audit results for the service showed compliance was 100%.

Cleaning records were up-to-date and demonstrated that all areas were cleaned regularly. Staff cleaned equipment after patient contact. All the equipment we saw appeared visibly clean and well-maintained.

Staff followed infection control principles including the use of personal protective equipment. Clinical and non-clinical staff adhered to social distancing measures wherever possible and/or wore appropriate PPE in line with national recommendations to prevent the risk of Covid-19 transmission. The service had adequate supplies of PPE and was able to source it as needed. Staff confirmed they had received training on 'donning' (putting on) and 'doffing' (taking off) PPE. There was access to hand washing facilities and/or alcohol-based hand rub and PPE, such as surgical masks and gloves, throughout the service including the waiting area. We saw staff clean their hands with alcohol gel when they entered/exited different areas of the service. Monthly audits were carried out to monitor staff compliance with hand hygiene. From April to June, audit results showed hand hygiene compliance was 100%. Clinical staff were 'arms bare below the elbows' and hands and wrists were free from jewellery. This enabled effective handwashing in order to reduce the risk of spreading infections.

Staff worked effectively to prevent, identify and treat surgical site infections. Patients were given verbal and written information about preoperative skin preparation before their surgery. This was in line with national standards (National Institute for Health and Care Excellence (NICE), Surgical site infections: prevention and treatment [NG125] (April 2019)). Clinical staff cleaned the theatre between and after each case. The theatre air flow ventilation system was compliant with national recommendations (Department of Health, Heating and ventilation systems, Health Technical Memorandum 03-01: Specialised ventilation for healthcare premises, Part A:

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Design and validation (November 2007)). The ventilation system facilitated an adequate number of air changes in the theatre per hour, which reduced patient risk of surgical site infection (SSI). Patients were followed up daily, or as requested, for seven to 14 days following surgery, and again by the surgeon at around one week, two months and six months post-surgery, during which staff asked questions in line with national guidance (Public Health England, Protocol for the Surveillance of Surgical Site Infection: Surgical Site Infection Surveillance Service (June 2013)). If a patient raised any infection concerns, they were reviewed by the medical and/or nursing staff, or were advised to attend their GP or local A&E.

Surgical instruments used at the service were single patient use only where possible. This eliminated the risk of cross patient contamination from re-used medical equipment. All reusable equipment was decontaminated off site. There was a service level agreement in place with an accredited decontamination service. Clean and dirty equipment was managed well within the theatre and there was no cross contamination of equipment.

Staff wore appropriate theatre clothing. The service used disposable clinical wear (commonly referred to as 'scrubs') for all intraoperative procedures. Dedicated theatre shoes were available for staff to wear in the theatre. This was in line with national standards (NICE, Surgical site infection [QS49]: quality statement 4 (October 2013)).

Patients were not routinely screened for MRSA (an infection resistant to treatment) unless they had previously been colonised with MRSA. This was in line with national guidance (Department of Health Implementation of modified admission MRSA screening guidance for NHS (2014). The preoperative risk assessment form included patient history for MRSA.

From 1 April to 27 July 2020, the service reported zero incidences of hospital acquired MRSA, MSSA (an infection sensitive to treatment), E-Coli (an infection) and C. diff (an infection) (Source: DR1).

Staff completed IPC training during their induction and then annually at the level appropriate to their role. As of July 2020, 100% of staff had completed IPC training (Source: DR2).

The service had an up-to-date IPC policy which staff could easily access. Posters were displayed in the service about correct hand washing technique, appropriate PPE use and

preventing surgical site infections. The service had included the national guidance on Covid-19 in relevant policies and was keeping up-to-date with the latest guidance.

A risk assessment for Legionnaires' disease had been completed by an external provider in August 2019. Control measures were in place to minimise this risk. Legionnaires' disease is a serious pneumonia caused by the legionella bacteria. People become infected when they inhale water droplets from a contaminated water source.

Environment and equipment

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

The design of the environment followed national guidance (DH, Surgery, Health Building Note 10-02: Day surgery facilities (May 2007)). The premises were well maintained and had suitable facilities for the cosmetic surgeries and consultations provided. Toilet and shower facilities were available for patients, with a call bell system in case of emergency, such as a patient requiring urgent assistance. These were easily reachable. This was an improvement from our last inspection of the former provider, when we found there was no call bell system in the toilet and shower facilities.

Staff carried out daily checks of specialist equipment. Surgical, anaesthetic and resuscitation equipment was available, fit for purpose and checked in line with professional guidance. Emergency equipment was checked weekly and prior to any surgical list to ensure it was in working order. We reviewed the checklist for July 2020 which was fully completed. The resuscitation trolley had tamper-evident tags in place to minimise the risk of items being removed and not replaced. This was an improvement from our last inspection of the former provider, when we found the service did not use tamper-evident tags. We checked the contents of the resuscitation trolley and all items were in-date and fit for purpose.

The service had enough suitable equipment to help them to safely care for patients. A service level agreement was in place with an external provider who safety tested and serviced all electrical equipment annually, or as needed. We looked at 11 items of electrical equipment, all of which had been safety tested within the last 12 months.

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We checked a sample of consumable items for expiration dates and all were in-date. Store rooms were tidy and well organised.

Staff disposed of clinical waste safely. Waste management was handled appropriately with separate colour coded arrangements for general waste, clinical waste and sharps. Sharps bins were clean, dated and were not overfilled. Clinical waste and sharps containers were labelled with the clinic's details for traceability purposes. This was in line with clinic policy (Source: P11 Infection prevention and control policy) and national guidance (Health and Safety Executive Health and Safety (Sharp Instruments in Healthcare) Regulations 2013: Guidance for employers and employees (March 2013)).

The service stored potentially hazardous chemicals in locked cabinets. This was in line with legislation (Health and Safety Executive, Guidance on the Control of Substances Hazardous to Health (COSHH) Regulations 2002). This was an improvement from our last inspection of the former provider, when we found some flammable items were not stored in line with COSHH guidance.

There were processes in place for providing feedback on product failure to the Medicines and Healthcare Products Regulatory Agency (MHRA). Details of products used on each patient such as the lot number (an identification number assigned to a particular quantity or lot of material from a single manufacturer), was documented in the patient's medical record.

A back-up generator was in place which activated in the event of a power failure. This was tested monthly to ensure it was in working order.

Fire safety equipment was available throughout the service and was fit for purpose. The alarm system, heat and smoke detectors and emergency lighting were serviced annually. Fire extinguishers were accessible, stored correctly and had been serviced. Fire doors were closed and free from obstruction.

Assessing and responding to patient risk

Staff completed and updated risk assessments for each patient and took action to remove or minimise risks. Staff identified and quickly acted upon patients at risk of deterioration.

The service had an admission policy which set out safe and agreed criteria for the selection and admission of patients.

These considered social, medical and surgical factors. The service excluded patients who were not suitable for day surgery, such as those with active cancer or who were undergoing radiotherapy/chemotherapy and patients with a history of organ transplant. Patients with co-morbidities and/or a body mass index (BMI) over 30 (obese) required medical and/or anaesthetic review before being accepted for cosmetic surgery. Patients who were deemed unsuitable for day case surgery could be referred to an independent hospital which the service was affiliated with. Patients who had cosmetic surgery under deep sedation had to be escorted home in a car or taxi by a responsible adult who was available to provide support for the first 24 hours. All patients had to have access to a telephone in case they needed to contact the service for follow up advice or treatment.

There were arrangements in place to assess patients' suitability for surgery. All patients completed a medical questionnaire prior to their first consultation. This included questions relating to the patient's state of mind, relevant medical history, concerns and expectations. The bookings team completed an electronic form which included questions about the patient's medical history, medicines, conditions, concerns, expectations, height, weight and social factors when booking a patient for an initial consultation. This provided the surgeon with relevant information about the patient prior to their initial consultation. At the initial consultation, the surgeon completed an electronic consultation form with the necessary information for the surgeon to assess the patient's suitability for the planned surgery. This included an explanation of treatment options, the risks and expected outcome of the planned surgery. Once the planned surgery was confirmed, the patient was sent a preoperative health assessment form to complete. This included a risk assessment of the patient's suitability for the procedure, such as their medical history, general health, age, existing diseases or disorders, medicines and other planned procedures. We reviewed eight sets of patient records, all of which evidenced that preoperative assessments were carried out in line with national standards (Royal College of Surgeons Professional Standards for Cosmetic Surgery (2016)). The medical director and/or lead nurse had signed each preoperative

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assessment to evidence they had been reviewed. This was an improvement from our last inspection of the former provider, when it was not evident that staff had checked them and acted on any concerns.

Staff assessed patients for their risk of Covid-19. Staff routinely asked all patients if they, or any member of their family, had any symptoms of Covid-19 and checked their temperature when they attended the service. All patients undergoing treatment under deep sedation were required to have a test for Covid-19.

The service carried out cosmetic procedures under local anaesthesia or deep sedation. During procedures carried out under deep sedation, four staff were present in the operating theatre. These included the surgeon, anaesthetist and two registered nurses, or a nurse and the medical director.

There were arrangements in place to ensure patient safety checks were made prior to, during and after surgical procedures were completed. This was in line with national recommendations (National Patient Safety Agency (NPSA) Patient Safety Alert: WHO Surgical Safety Checklist (January 2009)). The service used a surgical safety checklist based on recommendations from the World Health Organisation (WHO). The WHO surgical safety checklist is a simple tool designed to improve the safety of surgical procedures by bringing together the whole operating team to perform key safety checks during vital phases of perioperative care. We reviewed eight surgical safety checklists which staff had fully completed. From April to June 2020, the records management audit showed staff compliance with completing the WHO surgical safety checklist was 100%.

Swab and needle counts were recorded on a white board in the theatre. This meant it was clear to both the surgeon and scrub nurse the number of swabs and needles that had been used. These were counted for completeness by the surgeon and scrub nurse at the end of each procedure.

All patients seen at the clinic had consultant-led care. There was access to consultant medical input the whole time a patient was in the clinic. The surgeon remained in the clinic until all patients had been discharged.

The service had up-to-date policies for the management of the deteriorating patient, emergency transfer, sepsis and resuscitation. There was a service level agreement in place with the local acute NHS trust for the transfer of patients who required a higher level of care. Staff could describe

what they would do if a patient required immediate transfer. In an emergency, staff would use the standard '999' system to transfer the patient by ambulance to the local acute NHS hospital. No patients had required transfer to the local acute NHS hospital. The theatre and recovery room were situated on the ground floor of the premises. The service had a roller shutter door which could be raised when needed to enable easy transfer from the premises to an ambulance. Locum anaesthetists employed by the service had up-to-date advanced life support (ALS) training, as did the medical director and two surgeons. The nursing staff had up-to-date intermediate life support (ILS) training.

Staff used a nationally recognised tool to identify deteriorating patients and knew how to escalate appropriately. The service had implemented the National Early Warning System (NEWS2) to help identify deteriorating patients who had cosmetic surgery under deep sedation. NEWS2 was designed to aid early recognition of acutely unwell patients by monitoring physical parameters such as respiration rate, oxygen saturations, level of consciousness and new confusion, and temperature. We reviewed five NEWS2 charts and found they were fully completed and scored correctly. None of the patient observations we reviewed warranted escalation. This was an improvement from our last inspection of the former provider, when we found the service was not using the most up-to-date version of NEWS nor were patient observations always fully completed.

Staff completed risk assessments for each patient, updated them when necessary and used recognised tools. Venous thromboembolism (VTE) (a deep vein blood clot) assessment was undertaken on all patients undergoing cosmetic surgery with deep sedation. The patient records we reviewed confirmed this.

Staff arranged psychological assessments for patients with mental health concerns. The surgeon requested a medical summary from the patient's GP if they had a history of mental health concerns. This was to help the surgeon make an informed decision about the patient's suitability for surgery. If the surgeon had any doubts about the patient's suitability, they referred them for appropriate psychological assessment. This was in line with national standards (Royal College of Surgeons Professional Standards for Cosmetic Surgery (2016)).

Patients were discharged once they had recovered appropriately from their procedure and anaesthesia. This

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included ensuring their vital signs were within normal limits, they were alert and orientated, they were not suffering from nausea or vomiting and were comfortable. The surgeon reviewed each patient prior to discharge. Patients were given verbal and written postoperative advice, a prescription for medicines (if indicated), contact telephone numbers and a follow-up appointment. The contact telephone numbers included their surgeon's personal mobile number, who they could contact directly for up to 48 hours after their surgery. The service was especially committed to providing patients with a comprehensive aftercare programme. A member of staff contacted each patient daily for seven to 14 days after their surgery to ensure they were recovering well and to answer any questions or concerns they may have. This was evident from the patient records we reviewed. Follow up appointments were arranged with the nurse and the surgeon and patients could continue to have complimentary follow ups up to a year after their surgery, and/or until the surgeon was happy to discharge them. Staff we spoke to were particularly proud of the aftercare they provided. Recent on-line patient reviews also spoke highly of the aftercare they had received. For example, one patient who posted a review in July 2020 said, "Amazing surgeon and amazing aftercare", another wrote, "Over two months now since op, but all going really smooth and the [service] have been calling me regularly to see how I'm doing". In August 2020, another patient posted, "From my first consultation with the surgeon right through to my aftercare, the experience was flawless. [The service] seemed to have a strong focus on patient care especially with the regular follow-up calls I was receiving..." A member of staff was also available via telephone 24 hours a day, seven days a week to answer any patient questions or concerns.

Staff asked patients about any signs of infection and sepsis daily, or as requested, for seven to 14 days post-surgery. If a patient raised any infection concerns, they were reviewed by medical and/or nursing staff or were advised to attend their GP or local A&E. Staff we spoke with were familiar with the signs of sepsis and had received sepsis training.

Nursing and support staffing

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

The service had enough nursing and support staff to keep patients safe. The service employed one whole-time equivalent (WTE) registered nurse (two part-time nursing staff) and one WTE support staff. Staffing levels followed the Association for Perioperative Practice (AfPP) guidance. All procedures carried out under deep sedation were staffed by two nurses, or one nurse and the medical director, as well as the surgeon and anaesthetist. Procedures carried out under local anaesthetic were staffed by the surgeon and one nurse. Staff we spoke with felt staffing levels were sufficient to provide safe and effective care.

Nurses were trained to monitor patients for signs and symptoms of toxicity when liposuction was performed under tumescent local anaesthesia. This is a technique commonly used in cosmetic procedures which involves injecting a very dilute solution of local anaesthesia into tissue until it becomes firm and tense (tumescent). This technique can aid certain procedures, such as liposuction.

From when the new provider took over the service in April 2020 to 27 July 2020, the service did not report any nurse and support staff sickness or turnover (Source: DR14-15). During this period, 20% of shifts were filled with agency staff (Source: DR12). The service was recruiting for one WTE nurse due to an increase in demand and workload (Source: DR11). The provider had another location in London and could flex staff between the two locations when necessary to ensure there were sufficient 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 patient's safe from avoidable harm and to provide the right care and treatment.

The service had enough medical staff to keep patients safe. Patient care was consultant-led. All consultants who worked at the service did so under practising privileges. This is a well-established process within independent healthcare, whereby a medical practitioner is granted permission to work in a private hospital or clinic. As of July 2020, four consultants had been granted practising privileges to work at the service.

The service ensured surgeons were contactable 24 hours a day, seven days a week and were available to attend a patient within a 30 to 40-minute time frame if required. This

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was also true for locum anaesthetists employed by the service. Each patient was given their surgeon's personal mobile number and they could call them directly for up to 48 hours following their surgery.

All surgery was planned which ensured the availability of the required surgeon.

There were no handovers or shift changes because all patients attended the service as a day-case or outpatient. The surgeon and anaesthetist, when used for patients requiring deep sedation, remained on the premises until all patients were discharged.

Records

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

Patient notes were comprehensive, and all staff could access them easily. This was an improvement from our last inspection of the former provider, where we found records were not always clear and there were some omissions. The service mostly used paper-based records, with some information recorded electronically. Electronic records were printed and added to the patients' paper medical file to ensure a complete record was available. The service reported that no patients were seen without all relevant medical records being available. Records were contemporaneous, legible, dated and signed. We reviewed eight sets of patient records and found these were completed in line with General Medical Council (GMC) and Nursing and Midwifery Council (NMC) standards for record keeping. The patient records were well organised and clearly filed under the appropriate subject-divider such as admissions checklist, discharge summary and consent, which made it easy for staff to find the information they needed.

The service ensured appropriate preoperative assessment was recorded. The patient records we reviewed included evidence of discussions with patients about the planned procedure and its implications, the likely outcome, follow-up treatment required, aftercare and an explanation of the fees. Surgeons used the RCS Cosmetic Surgery: Pre-surgery information checklist to ensure patients had received and understood important information before they consented to cosmetic surgery. The checklist was signed and dated by the patient and surgeon to confirm they had received enough information to allow them to

make an informed decision about their planned procedure. This was in line with best practice standards (RCS Professional Standards for Cosmetic Surgery (April 2016)). All the patient records we reviewed included completed and signed pre-surgery information checklists.

The registered manager audited the standard of patient records against best practice and identified areas for improvement, where indicated. The registered manager audited five sets of patient records monthly for legibility and completeness. The audit tool was detailed and checked the storage, completeness and accuracy of patient records, including the preoperative assessment and review by the nurse and/or medical director, tracking labels for implants and reusable instruments used, where applicable, and copy of the discharge summary and prescription given to the patient. The registered manager acted to address any record keeping issues with staff to ensure records were comprehensive, clear and complete. Minutes of meetings we reviewed showed the audit results were shared with staff. From April to July 2020, the records management audit showed staff compliance with record keeping standards was 100%. This was an improvement from our last inspection of the former provider, where we found record keeping audits were limited and did not contain details of the numbers of records audited, and if omissions were found, how many records this affected. Furthermore, in addition to the records management audit, a member of staff checked each patient file for completeness, including evidence of consent, aftercare information and if all queries had been resolved, such as blood tests and psychological assessment. We saw completed, signed and dated checklists attached to the front of each patient file.

Records were stored securely. Patient records were stored in a locked cabinet. When necessary, patient records were transferred to the provider's other location in a concealed bag by an authorised person, such as the medical director or registered manager. Access to the electronic records system was password protected. The service gave all staff individual log-ins and passwords to access computers and electronic records. Staff locked computer terminals when not in use. This reduced the risk of unauthorised people accessing patient records.

Records were organised in a way that allowed identification of patients who had been treated with a particular device or medicine in the event of product safety concerns or regulatory enquiries. This was in line with national

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guidance (RCS Professional Standards for Cosmetic Surgery (April 2016)). The service maintained a register of cosmetic implants used. At the time of the inspection (July 2020), the service was unable to upload these details to the national breast and cosmetic implant register because of delays in being given access to the national system, following the change of provider. Managers told us they planned to upload the data to the national system when they had access.

Patients were given a discharge summary and information, which included details of the surgery performed including any implants or injectables used, postoperative advice, medicines prescribed, contact numbers and follow-up appointments. Patients were asked for their consent to share information with their GP. All patients who consented had GP letters sent with a copy of the patients discharge summary. This ensured continuity of care within the community in the event of any need for additional care and/or treatment. If the patient refused consent for their GP to be contacted, this was clearly documented in the patient's record.

Medicines

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

At our last inspection of the former provider, we found the service did not use clear systems and processes to safely prescribe, administer, record and store medicines. At this inspection, we found the service had made significant improvements.

Staff followed systems and processes when safely prescribing, administering, recording and storing medicines. The service purchased medicines through a service level agreement. Nursing staff checked medicine stocks monthly to ensure stock was rotated, expiry dates were checked, out of date items were disposed of and stock levels were appropriately maintained. The registered manager carried out monthly medicines management audits to ensure staff safely prescribed, administered, recorded and stored medicines. The audit tool was based on guidance published by the Association of Perioperative Practice. The audit checked compliance against the medicines policy, the storage and administration of medicines, controlled drugs and incidents relating to medicines management. From April to July 2020, the medicines management audit showed compliance was

100%. Minutes of meetings we reviewed showed the audit results and any areas requiring improvement were shared with staff. Nursing staff were required to undertake annual medicines management e-learning training and practical competency assessment to demonstrate their knowledge and understanding of medicines. As of July 2020, the completion rate for eligible staff was 100% (Source: DR2). Surgeons had also completed refresher training on prescribing.

Staff stored and managed all medicines and prescribing documents in line with the provider's policy. Medicines and intravenous fluids (fluid given through a vein) were stored securely in locked cupboards. The keys for medicine cupboards and fridges were stored in a safe which only qualified members of staff (i.e. doctor or nurse) had access to. This prevented unauthorised personnel from accessing medicines. We found medicine storage areas were well organised and tidy, with effective processes in place to ensure stock was regularly rotated. All medicines we checked were within the use by date, including intravenous fluids. Checks were in place to ensure emergency medicines were available and safe for patient use. Controlled drugs (CDs) (medicines subject to additional security measures) were stored securely within wall mounted cupboards. Two members of qualified staff checked the physical stock against the stock level recorded in the CD register every time a CD was administered. Two members of qualified staff also completed a weekly check of all CDs. We reviewed the CD register and saw stock was reconciled when used and weekly. Medicines that needed to be kept below a certain temperature to maintain their efficacy were stored in a locked fridge. The treatment room where medicines were stored was air-conditioned. This meant the temperature was maintained within the recommended range (below 25°C). We saw storage temperatures were checked daily on the days the service was open, to ensure medicines were effective and safe for patient use. Temperatures recorded for all days seen were within the recommended range. The temperature checklist included the action staff should take if the temperature was found to have exceeded the recommended range.

Staff completed prescription charts in line with professional standards. The service had introduced a printed prescription chart which detailed the name, dose

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and route of medicines commonly used. We reviewed eight prescription charts and found they were signed, dated, timed and legible. Patient allergy status was documented, and medicines were given as prescribed.

Surgeons issued patients with private prescriptions for any medicines they needed to take postoperatively. We saw copies of these filed in the patient records we reviewed. Managers told us they had an arrangement with some local pharmacies who would dispense their private prescriptions.

The service had an up-to-date antibiotics prophylaxis (treatment given to prevent disease) policy which was designed to ensure staff adhered to the safe prescribing of antimicrobials. The policy identified the indications for prophylactic antibiotics, such as before surgery involving the placement of an implant. This was in line with national guidance (NICE, Surgical site infections: prevention and treatment [NG125] (April 2019)).

The service had systems to ensure staff knew about safety alerts and incidents, so patients received their medicines safely. Staff knew how to report medicine errors or incidents. Managers told us incidents involving medicines would be investigated and any learning would be shared with staff. From when the service was taken over by the new provider in April 2020, the service had not reported any medicine incidents.

Incidents

Although staff had not reported any incidents since the new provider took over the service in April 2020, staff knew how to manage patient safety incidents. Staff followed the policy for reporting incidents and near misses. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support. Managers ensured that actions from patient safety alerts were implemented and monitored.

However, staff did not report complications of treatment as an incident unless it was a 'significant or unexpected complication of a clinical procedure/

treatment'. This meant there was potentially a missed opportunity to identify trends and/or themes relating to complications. Managers took action to address this following our inspection.

Staff knew what kind of incidents and near misses they should report and how to report them. The service had an up-to-date managing incidents policy which included the types of incidents or near misses that should be reported. Staff recorded incidents on paper-based forms. However, staff did not report complications of treatment unless, according to the managing incidents policy, it was a 'significant or unexpected complication of a clinical procedure/treatment'. This meant there was potentially a missed opportunity to identify trends and/or themes relating to complications. We were assured that managers investigated complications of treatment and shared learning from these. This was evident from conversations we had with staff and meeting minutes we reviewed. Following our inspection, the senior management team reviewed the managing incidents policy and added post-operative complications to the adverse event reporting form. From when the service was taken over by the new provider in April 2020, there had been no incidents reported.

The service had no never events or serious incidents. Never events are serious patient safety incidents that should not happen if healthcare providers follow national guidance on how to prevent them. Each never event type has the potential to cause serious patient harm or death but neither need have happened for an incident to be a never event.

There were processes for investigating incidents. Incidents which resulted in no and/or low harm were investigated by the appropriate manager. Incidents which resulted in moderate harm or above were investigated by the senior management team. All incidents were reported to the medical director. Staff told us that managers shared any learning and feedback from incidents. The meeting minutes we reviewed confirmed this.

Managers debriefed and supported staff after any serious incident. While the service had not had any serious incidents occur, managers confirmed they would debrief and support staff after any serious incident.

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Managers shared learning with their staff about incidents that happened elsewhere. Staff told us they received feedback about incidents reported at the provider's other location. Meeting minutes we reviewed confirmed this.

Staff understood the duty of candour. They were open and transparent and gave patients a full explanation if and when things went wrong. The service's managing incidents policy referred to the duty of candour and when it should be instigated. The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain notifiable safety incidents and provide reasonable support to that person, under Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. A notifiable safety incident includes any incident that could result in, or appears to have resulted in, the death of a person using the service or severe, moderate or prolonged psychological harm. Staff we spoke with were aware of the importance of being open and honest with patients when something went wrong, and of the need to offer an appropriate remedy or support to put matters right and explain the effects of what had happened. From when the service was taken over by a new provider in April 2020, there had been no incidents which met the threshold for the duty of candour to be instigated.

Safety Thermometer (or equivalent)

The service collected safety information and shared it with staff.

The service was not required to use the NHS Safety Thermometer because it was an independent healthcare provider. The safety thermometer is a measurement tool for improvement in health care, which focuses on the most common harms to patients; falls, VTE, pressure ulcers and urinary tract infections in patients with a catheter.

The service did however, monitor safety information which was relevant to the service. From when the service was taken over by the new provider in April to 27 July 2020, the service reported zero incidents of VTE, pulmonary embolism (PE) (a blood clot in the lungs) or pressure ulcers (Source: DR1). Patients who attended the service underwent day case procedures. This meant there was a

very low risk of patients acquiring a VTE, PE or pressure ulcer while having treatment. Following our inspection, the provider informed us of one incident of VTE which was being investigated.

Are surgery services effective?

We have not rated this service.

Evidence-based care and treatment

The service provided care and treatment based on national guidance and best practice. Managers checked to make sure staff followed guidance.

At our last inspection of the former provider in June 2019, we found the service did not always provide care and treatment based on national guidance and evidence-based practice. Policies were not consistent and did not contain relevant up-to-date information and managers did not check to make sure staff followed guidance. At this inspection we found the service had addressed our concerns and made improvements.

Managers made sure policies reflected current evidence-based guidance and professional standards. We reviewed 13 policies, all of which were in line with and referenced current national guidance. The service had a document tracker to maintain oversight of when policies were due for review. The tracker included the issue date, version number, review date and document owner. Managers reviewed policies at least every five years or when national guidance was updated. We saw all policies were up-to-date. Staff were informed when policies were updated at team meetings and by email.

Staff followed up-to-date policies to plan and deliver high quality care according to best practice and national guidance. This was evident from our review of policies and patient records, and discussions with staff. For example, the eight patient records we reviewed showed people's suitability for proposed treatment was holistically assessed. Surgeons considered each patient's medical history, general health, mental health history, history of previous cosmetic surgery and discussion about their body image before any surgery was performed. The expected outcome was identified and discussed with each patient before

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treatment and was reviewed postoperatively. This was in line with professional standards (Royal College of Surgeons (RCS) Professional Standards for Cosmetic Surgery (April 2016)).

Care was managed in accordance with national guidelines for the prevention of surgical site infection. For example, patients were advised to shower with an antimicrobial preparation prior to surgery (National Institute for Health and Care Excellence (NICE) Surgical site infection: QS49, Quality statement 1 (October 2013)) and patient temperature was checked regularly during surgery to ensure normal body temperature was maintained (NICE Surgical site infection: QS49, Quality statement 3 (October 2013)).

Women of childbearing potential were asked if there was any possibility they could be pregnant on the day of surgery. Pregnancy tests were carried out with the patient's consent when indicated. This was in line with national guidance (NICE Routine preoperative tests for elective surgery [NG45] (April 2016)).

Patients were told when they needed to seek further help and were advised what to do if their condition deteriorated.

Patients were supported to be as fit as possible prior to surgery. For example, patients were advised to stop, or at least reduce, smoking before and following surgery. Research has shown quitting smoking can significantly lower the risk of complications like poor wound healing (Institute for Quality and Efficiency in Health Care (IQWiG)).

Managers checked to make sure staff followed guidance and used the results to improve. The service had an audit programme which included medicines management, infection prevention and control and records management. Audits were undertaken daily, weekly or monthly. We saw the results of audits were discussed at the monthly clinical governance meeting, with any agreed actions shared with staff by email and team meetings.

Technology and equipment was used to enhance the delivery of effective care and treatment. For example, the service offered video consultations to reduce the risk of spreading Covid-19 by limiting face-to-face contacts.

Nutrition and hydration

This sub-heading was not reviewed as part of the focused inspection.

Pain relief

This sub-heading was not reviewed as part of the focused inspection.

Patient outcomes

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

The service participated in the national Patient Reported Outcome Measures (PROMs) programme. PROMs are questionnaires patients complete on their health and quality of life before and after surgery in order to measure the health gain in patients following surgery. The service collected PROMs data in line with the Royal College of Surgeons standards. At the time of our inspection, the service had not yet received any PROMs data because this is collected from patients three to six months after their procedure. Managers were exploring ways to improve the collection of PROMs data and patient feedback, as many patients did not engage with the service's surveys. They had recently recruited a head of customer services to improve patient response rates. They were due to commence employment in August 2020, which the provider confirmed they had.

The service did however, monitor safety information which was relevant to the service, such as unplanned transfers, complications, surgical site infection (SSI) rates and readmission rates within 30 days of the original procedure. From when the service was taken over by a new provider in April to 27 July 2020, the service reported zero unplanned transfers, zero surgical site infections, zero readmissions within 28 days of discharge and one complication (Source: DR1).

Managers carried out a programme of regular audits to monitor the effectiveness of care and treatment and made improvements when indicated. Meeting minutes showed staff reviewed complex cases and complications relating to surgery.

Managers were engaged with the Private Healthcare Information Network (PHIN) and collected and submitted data in accordance with legal requirements regulated by the Competition Markets Authority (CMA). Managers used the PHIN website to compare outcomes with similar service providers. PHIN publishes data for 11 performance

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measures at both hospital and consultant level. These measures include the volume of procedures undertaken, infection rates, readmission rates and revision surgery rates.

Competent staff

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

Staff were experienced, qualified and had the right skills and knowledge to meet the needs of patients. We reviewed six staff files and found they all contained appropriate information, such as Disclosure and Barring Service (DBS) check, references, curriculum vitae and evidence of registration with the Nursing and Midwifery Council (NMC) or General Medical Council (GMC), where appropriate. Eligible medical and nursing staff had completed revalidation with their professional body. Staff completed a variety of mandatory and role specific training through e-learning and some face-to-face modules.

Managers arranged for all new staff to have a full induction tailored to their role before they started work. Staff told us they had received a good induction. Since our last inspection of the former provider, managers had introduced a comprehensive core competency framework and training programme for nursing staff. This was developed by drawing from the European Operating Room Nurses Association (EORNA) Common Core Curriculum for Perioperative Nursing (2019), the Perioperative Care Collaborative National Core Curriculum (2017) and the Association for Perioperative Practice (AfPP) Standards and Recommendations for Safe Perioperative Practice (2016). The programme consisted of over 40 modules designed to ensure nursing staff met the five core competencies, which were:

- Professional, ethical and legal practice
- Perioperative care and practice
- Interpersonal relationships and communications
- Organisational, managerial and leadership skills
- Educational and professional development

Nursing staff completed the competency framework by participating in observation, e-learning, one-to-one and external training sessions, over a four to six-week period.

Nursing staff then completed self-assessments by means of a recognised model for assessing competence. The medical director evaluated the practical assessments and carried out a final one-to-one review meeting with nursing staff before signing them off as competent. Nursing staff undertook update training and competency assessments every two years to ensure their skills and knowledge were up-to-date. Nursing staff we spoke with told us they felt well supported throughout the competency and training programme and described the medical director as a "mine of information". This was an improvement from our last inspection of the former provider, when we found managers did not consistently ensure staff were competent for their roles and there was no assessment framework in place to demonstrate and ensure that learning had taken place. Healthcare assistants completed a training and competency programme appropriate to their role. The registered manager or lead nurse assessed their competency upon completion of the programme.

Managers made sure consultants working under practising privileges were experienced, qualified and had the right skills and knowledge to meet the needs of patients. Practising privileges only applied to procedures or techniques that were part of the consultants' normal practice or where the consultant could provide evidence of adequate training, competency and experience. In order to maintain their practising privileges, every year the consultants had to provide the medical director with evidence of adequate indemnity insurance, GMC registration and current licence to practise, evidence of appraisal and personal development plan, immunisation status and participation in relevant mandatory training. We reviewed one consultant's personnel file and found it contained all required information. The consultant surgeons who worked under a practising privileges agreement were on the General Medical Council (GMC) Specialist Register. The Specialist Register was introduced on 1 January 1997. Since then doctors must be on the Specialist Register to take up any appointment as a consultant in the NHS. Of the four consultants, three were on the specialist register for plastic surgery and the fourth, who specialised in aesthetic gynaecology, was on the specialist register for obstetrics and gynaecology. Anaesthetists used by the service were provided by an agency and employed on a locum (temporary) basis. While the agency was responsible for ensuring the anaesthetists had the required experience and skills, the service also

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maintained oversight of this. We reviewed one anaesthetist's personnel file and found it contained references, photographic ID, DBS check, curriculum vitae, professional registration, immunisation status, indemnity insurance and evidence of relevant qualifications and competencies including up-to-date advanced life support training.

Staff had the opportunity to discuss training needs with their line manager and were supported to develop their skills and knowledge. Staff we spoke with confirmed this. Staff were required to complete an annual appraisal and personal development plan. This included demonstrating how they met the service's values, how they could improve, and their objectives for the next 12 months, including training needs.

Managers supported staff to develop through yearly, constructive appraisals of their work. As of July 2020, 100% of eligible staff had received an annual appraisal (Source: DR8). Staff told us they found the appraisal process useful. The appraisal process included feedback about the appraisee from a colleague.

Managers made sure staff attended team meetings or had access to full notes when they could not attend. Staff we spoke with confirmed this.

Managers identified poor staff performance promptly and supported staff to improve. Poor or variable staff performance was identified through complaints, incidents, feedback and appraisal. Staff were supported to reflect, improve and develop their practice through training and meetings with their managers.

Multidisciplinary working

This sub-heading was not reviewed as part of the focused inspection.

Seven-day services

This sub-heading was not reviewed as part of the focused inspection.

Health promotion

This sub-heading was not reviewed as part of the focused inspection.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

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

Staff understood the relevant consent and decision-making requirements of legislation and guidance, including the Mental Capacity Act 2005. As of July 2020, 100% of staff had completed training relating to the Mental Capacity Act 2005. The service did not treat any patients who lacked capacity. Consultants told us if they had any concerns about a patient's capacity to consent, they would seek further information from the patient's GP and/or psychology service before proceeding with any cosmetic surgery.

Staff gained consent from patients for their care and treatment in line with legislation and guidance (RCS Professional Standards for Cosmetic Surgery (April 2016)). Consent was obtained in a two-stage process, with a cooling-off period of at least two weeks between the consultation and surgery to allow the patient time to reflect on the decision. Managers told us patients could be treated within this period if they felt this was appropriate, such as to revise previous surgery. Patients who requested surgery within the cooling-off period were asked to sign a disclaimer. Information on the procedure was provided at a different time to the signing of the consent form. Patients were told they could change their mind up to the point of the procedure being started. Consent was obtained in writing by the operating surgeon. We reviewed eight patient records and found there was a time interval of at least two weeks between the consultation and surgery. The consent forms were fully completed, signed and dated by the patient and operating surgeon. Separate consent was sought for the use of medical photography and/or videography. From April to June 2020, 100% of patient records audited showed appropriate consent to treatment was obtained and documented.

Staff made sure patients consented to treatment based on all the information available. The patient records we reviewed included comprehensive details of the planned surgery, the intended benefits, potential risks and complications.

The service had also introduced an additional consent process regarding Covid-19 in response to the pandemic. The consent included confirmation that the patient nor

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anyone else in their household had any symptoms of Covid-19 within the last 14 days and that they understood there were no guarantees that the measures taken at the service would prevent the patient contracting Covid-19.

Are surgery services caring?

We did not review this key question as part of this inspection.

Compassionate care

This sub-heading was not reviewed as part of the focused inspection.

Emotional support

This sub-heading was not reviewed as part of the focused inspection.

Understanding and involvement of patients and those close to them

This sub-heading was not reviewed as part of the focused inspection.

Are surgery services responsive?

We have not rated this service.

Service delivery to meet the needs of local people

This sub-heading was not reviewed as part of the focused inspection.

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.

Patients with complex health and social care needs were not routinely treated at the service. Staff told us that no patients with mobility, sight and/or hearing difficulties had made enquiries about any of the procedures and treatments offered by the service and that these difficulties would not necessarily prevent them from receiving treatment, following individual assessment of their needs, preferences and health.

Staff made sure patients received psychiatric support where necessary. Staff referred patients to a psychology service if they had any concerns about their mental health and wellbeing.

Managers made sure staff and patients could get help from interpreters or signers when needed. A service level agreement was in place with an interpreting provider. They offered face-to-face, telephone and video remote interpreting services. This was an improvement from our last inspection of the former provider, where we found family members or friends were sometimes used as interpreters.

Staff could provide patients with information leaflets in other languages when needed.

Access and flow

This sub-heading was not reviewed as part of the focused inspection.

Learning from complaints and concerns

It was easy for people to give feedback and raise concerns about care received. The service treated concerns and complaints seriously, investigated them and shared lessons learned with all staff.

The service clearly displayed information about how to raise a concern in patient areas. We saw information on how to make a complaint displayed in the waiting area.

The service had an up-to-date complaints policy which detailed the process for managing informal and formal complaints, including staff responsibilities.

Staff understood the policy on complaints and knew how to handle them. Emphasis was placed on giving the patient, or their representative, time to discuss their concerns, apologising for any distress caused and to resolving them immediately, where possible. If concerns could not be resolved informally, patients were supported to make a formal complaint.

Managers investigated complaints and identified themes. The medical director had responsibility for dealing with complaints. They aimed to find out what happened and what went wrong, make it possible for the complainant to discuss the problem with those concerned, make sure an apology was given and to identify what could be done to make sure the problem does not happen again. Staff told

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us the service received very few formal complaints, which was validated by the number received within the inspection reporting period. From when the service was taken over by a new provider in April to 27 July 2020, the service received zero formal complaints (Source: DR1).

Staff knew how to acknowledge complaints and patients received feedback from managers after the investigation into their complaint. Complaints were responded to within three working days of receipt or five days, if the complaint could be investigated and responded to fully within this timeframe. Otherwise, the medical director aimed to investigate and provide a full written response to the complaint within 20 working days. Where this was not possible, the complainant was informed why there was a delay and when they could expect a full response.

Managers shared feedback from complaints with staff and learning was used to improve the service. Learning from complaints and feedback was shared with staff through a variety of means, such as team meetings and email. Staff confirmed they received feedback on complaints. Action was taken in response to complaints to improve patient experience and care provision, where indicated. Where individual members of staff were named in the complaint, managers discussed the concerns raised with them, so they could reflect and make changes to their practice accordingly.

There were processes for patients to appeal if they were unhappy with the outcome of their complaint. Patients could request an internal appeal. The director of operations managed this process. If the complainant remained dissatisfied with the outcome, they were advised to contact an independent advocate, such as Citizens Advice. The service did not subscribe to the Independent Sector Complaints Adjudication Service (ISCAS). This is a voluntary subscriber scheme which provides independent adjudication of complaints for independent healthcare providers.

Are surgery services well-led?

We have not rated this service.

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.

At our last inspection of the former provider, we found leaders did not have all the skills and abilities to run the service. They did not always understand and manage the priorities, nor did they understand the issues the service faced. At this inspection, we found significant improvements had been made.

The senior management team comprised of the registered manager, the operations director (also the nominated individual) and the medical director, who co-owned the service. Since our last inspection of the former provider, the registered manager and operations director had been recruited to the service. The registered manager, for example, had been a senior nurse at an acute NHS trust and demonstrated they had the right skills, knowledge and experience to run the service and provide high-quality care.

The senior management team understood the issues, challenges and priorities in the service and proactively sought to address them. They took action to address all the concerns we identified at our last inspection of the former provider. This included a new clinical governance structure with clear lines of responsibility and accountability, as well as a comprehensive training and competency programme, regular audit programme, standardised and up-to-date policies and risk management processes.

Leaders were visible, accessible and supportive, which we observed during our inspection. Staff told us they found the senior management team to be friendly and approachable. As a small team, staff worked closely together and were able to seek guidance and speak openly with one another.

Vision and strategy

The service had a vision for what it wanted to achieve and was developing a strategy to turn it into action.

There was a clear vision, mission and set of values, with quality and patient safety as the top priorities. The service's vision was, "to create a multi-disciplinary clinic offering the full range of aesthetic treatments all under one roof, with patient safety at the heart of everything we do". This vision was underpinned by the service's mission and values. The mission was:

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- Deliver an outstanding patient experience
- Offer unparalleled medical care and treatments
- Responsibility comes first

The service had an established set of values which were:

- Transparency
- Individuality
- Passion

The appraisal process incorporated the service's values, whereby staff had to evidence how they demonstrated the values at work and where they could improve.

Staff were familiar with the vision, mission and values and understood their role in achieving them.

The vision, mission and values were publicly displayed in the waiting room and the service's website.

At the time of our inspection (July 2020), the senior management team were developing a strategy for the service. This was an improvement from our last inspection of the former provider, where we found the service did not have a clear strategy or plans to turn it into action. The draft strategy was aligned to the service's vision and mission which it aimed to deliver, "with the right people, the right services and the right care". This overarching aim had been developed into three strategic aims; a recruitment and retention strategy, a clinical services strategy and a care strategy. The draft strategy was scheduled to be discussed and agreed by the senior leadership team at the clinical governance meeting (Source: DR20).

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.

All staff we spoke with felt supported, respected and valued. They told us there was an open and honest culture which was centred on improving services for all patients and the working environment for staff. The senior management team promoted an 'open door' culture and staff felt confident to voice any concerns or issues they had. None of the staff we spoke with raised any concerns about bullying or inappropriate behaviours from colleagues.

Arrangements were in place to ensure staff could raise concerns safely and without fear of reprisal, including an up-to-date whistleblowing policy which staff could easily access.

The culture encouraged openness and honesty. The service had processes to ensure the duty of candour was met, when indicated. Staff understood the duty of candour and confirmed they were encouraged to be open and honest with patients.

All staff we met were welcoming, friendly and helpful. It was evident that staff were passionate about the range of aesthetic treatments they offered and were proud to work at the service.

Staff worked collaboratively and were focused on providing patients with the best care and attention throughout their patient journey.

Leaders spoke with pride about the work and care their staff delivered. They celebrated staff success by sharing positive feedback received with staff. We saw evidence of this during our inspection. For example, the registered manager emailed one staff member to thank and praise them for their work.

There were mechanisms for providing staff with development needs, including appraisals. Staff spoke positively about learning and training opportunities.

There was a system in place to ensure patients were provided with a statement that included the terms and conditions of the services being provided to the person and the amount and method of payment of fees. Patients were provided with details of the terms and conditions and fees following their initial consultation with the surgeon.

The service ensured marketing was honest and responsible and complied with guidance from the Committee on Advertising Practice (CAP) and industry standards (Royal College of Surgeons (RCS) Professional Standards for Cosmetic Surgery (April 2016)). There were no financial incentives offered that might influence the patient's decision, such as time-limited discounts or two-for-one offers.

Governance

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

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organisations. Staff at all levels were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service.

At our last inspection of the former provider, we found leaders did not operate effective governance processes. Furthermore, staff were not clear about their roles and accountabilities. At this inspection, we found significant improvements had been made.

There were effective governance structures, processes and systems of accountability to support the delivery of good quality services and safeguard high standards of care. Following consultation with a third-party consultancy firm with expertise in clinical governance and risk management, the senior management team introduced a new clinical governance framework which combined clinical, organisational and financial accountabilities. The framework was built on eight key domains, namely; regulatory compliance, information governance, risk management, workforce, patient safety, patient experience, quality assurance, and clinical effectiveness. Each domain included specific areas of responsibility and had a clear objective(s). A senior manager had responsibility for each domain. Monthly clinical governance meetings were held, which were attended by the senior management team. The meetings followed a standing agenda which was aligned to the eight key domains. We reviewed four sets of meeting minutes which confirmed governance matters such as surgical site infections, complications, incidents, risks, complaints, patient feedback, audits and staffing were discussed. Any actions arising from the meeting were documented and allocated a lead and expected date for completion. We saw progress was monitored at the clinical governance and other staff meetings, until each action had been completed. Governance matters were shared with staff at team meetings. The service had separate bi-monthly/quarterly meetings for surgeons, nursing staff and non-clinical staff, which members of the senior management team also attended. Minutes of meetings we reviewed showed these were well attended and governance matters were discussed, such as incidents, complaints and patient feedback.

There were processes to ensure incidents and complaints were investigated in a timely manner, with lessons learned and improvements made to service provision when indicated. Staff we spoke with were familiar with incidents

and complaints that had occurred at both of the provider's locations. Furthermore, meeting minutes showed that staff discussed incidents relating to cosmetic surgery that occurred elsewhere. For example, meeting minutes showed that staff discussed a newspaper article regarding the inquest of a woman who had died as a result of blood clots following breast enlargement and tummy tuck surgery. In response, staff reviewed their risk assessment for venous thromboembolism (VTE) and agreed to add the question regarding family history of VTE to the preoperative questionnaire, as well as the initial medical questionnaire. However, staff did not report complications of treatment unless it was a 'significant or unexpected complication of a clinical procedure/treatment'. This meant there was potentially a missed opportunity to identify trends and/or themes as staff did not report complications of treatment as an incident. We were assured that managers investigated complications of treatment and shared learning from these. This was evident from conversations we had with staff and meeting minutes we reviewed. Following our inspection, the senior management team reviewed the managing incidents policy and added post-operative complications to the adverse event reporting form.

The service had effective governance processes in place to ensure equipment and medicines were checked regularly and were safe and fit for patient use. The checklists and audits we reviewed confirmed this.

Staff underwent appropriate recruitment checks prior to employment to ensure they had the skills, competence and experience needed for their roles. There were effective governance systems to grant and review practising privileges, which the medical director had responsibility for. In order to maintain their practising privileges, every year the consultants had to provide the medical director with evidence of adequate indemnity insurance, GMC registration and current licence to practise, evidence of appraisal and personal development plan, immunisation status and participation in relevant mandatory training. In addition to the annual review, the medical director formally reviewed practising privileges every three years. Staff working under practising privileges had an appropriate level of indemnity insurance in accordance with The Health Care and Associated Professions (Indemnity Arrangements) Order 2014 and their professional body. Staff personnel records we reviewed confirmed this.

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Staff were clear about their roles and had a clear understanding of their accountabilities and who they reported to. They knew how to report incidents and were encouraged to do so.

Arrangements were in place to manage and monitor contracts and service level agreements with partners and third-party providers. We saw contracts were in place which detailed the scope of work to be provided. Managers reviewed contracts on an annual basis, including a review of quality indicators and feedback, where appropriate.

Managing risks, issues and performance

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

At our last inspection of the former provider, we found leaders did not use effective systems to manage performance effectively, nor did they identify and escalate relevant risks and issues or identify actions to reduce their impact. Furthermore, it was not clear how often risks were reviewed and completed audits lacked detail. At this inspection, we found significant improvements had been made.

There were clear and effective processes for identifying, recording and managing risks. The service had an up-to-date risk management policy and related policies in place, such as managing incidents, clinical governance and feedback, concerns and complaints policies. The risk management policy detailed the service's framework for identifying, assessing, managing and tolerating risk throughout the service, including staff accountabilities and responsibilities for reporting and managing risks. When a risk was identified, staff were required to complete a risk assessment describing the risk, who was at risk, likely adverse effects of the risk and the control measures in place to minimise the risk. The senior management team reviewed each risk assessment and added them to the risk register. We reviewed eight risk assessments and the service's risk register, which were sufficiently detailed and reflected the risks within the service, such as low response rates to patient questionnaires and Covid-19. The risk register also included all the improvement actions

identified at the last CQC inspection, with evidence of action taken to address these risks. Minutes of meetings showed risks were reviewed and updated at the monthly clinical governance meeting.

Staff confirmed they received feedback on risks, incidents, complaints and performance at team meetings and through email. Staff also told us the senior management team would feedback any concerns informally, as and when they occurred. They were able to do this because there were few staff working at the clinic and they worked closely together.

There was an audit programme which was used to monitor quality and operational processes. Audits were completed daily, weekly and/or monthly. Audit results were shared with staff at team meetings and were used to identify where improvement action should be taken. Staff confirmed they received feedback from audits.

Managers made staff aware of any new or updated policies at team meetings and by email. We saw policies were regularly discussed at team meetings and staff were required to confirm they had received and read them.

Evacuation plans in the event of a fire were available throughout the service and staff were aware of them. There was a business continuity plan, which detailed what actions staff should take in the event of an emergency. A tested back-up generator was in place in case of power failure.

Managing information

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

There was a holistic understanding of performance which sufficiently covered and integrated patient experience with information on quality, operations and finances. Staff had access to quality and performance information through attendance at meetings and access to meeting minutes. The registered manager produced a monthly report with data on a range of performance and quality indicators, such as activity, complaints, patient feedback and incidents. Areas of good and poor performance were highlighted and used to drive forward improvements, where indicated.

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Staff had access to up-to-date and comprehensive information regarding patients' care and treatment. There were arrangements to ensure the confidentiality of patient information held electronically and staff were aware of how to use and store confidential information. Computers and laptops were encrypted, and password protected to prevent unauthorised persons from accessing confidential patient information. All staff had completed information governance and General Data Protection Regulation (GDPR) training. Patients' signed a consent form regarding why and how their personal and medical data would be collected, and when and with whom it would be shared. This was in line with the GDPR.

There were effective arrangements to ensure data was submitted to external bodies such as the Private Healthcare Information Network (PHIN). This enabled the service to benchmark performance against other cosmetic surgery providers. Managers ensured statutory notifications were submitted to the Care Quality Commission (CQC) as required.

Engagement

Leaders and staff had some engagement with patients to plan and manage services. However, response rates to patient surveys was low. The service was taking action to address this.

People's views and experiences were gathered and acted on to shape and improve the service. Patient feedback was sought pre- and post-operatively through the questionnaires for Patient Related Outcome Measures (Q-PROMs) and patient feedback survey. However, response rates were low. Managers recognised this was a risk and had recently recruited a head of customer services to help improve patient engagement. The first change they were implementing was to create a web form which patients could complete and submit online.

The service used social media to engage with people and promote their service. Staff told us that most feedback was received through social media platforms. In July 2020, 25 reviews were posted on-line about the service, most of which were overwhelmingly positive, rating the service '5-star'. There were however, two negative reviews which rated the service '1-star'. The on-line reviews were about both the provider's locations, and not solely MS Watford.

People considering or deciding to undergo cosmetic surgery were provided with the right information and

considerations to help them make the best decision about their choice of procedure and surgeon. We saw patients received comprehensive information about the surgery they were considering. This included how the procedure was performed, costs, and the risks and complications associated with the procedure. The service's website also contained information about the surgeons and range of procedures and treatments offered, such as suitability for surgery, recovery and frequently asked questions.

Staff were engaged in the service. This was evident from conversations we had with staff and observations we made during the inspection. Staff told us that information was shared regularly on an informal basis, as the team was small, and they worked so closely together. They also held regular team meetings. Staff felt well informed and were encouraged to make improvements and develop their skills. The minutes of meetings we reviewed showed good staff engagement from managers, clinical and support staff.

Learning, continuous improvement and innovation

Staff were committed to continually learning and improving services.

Leaders and staff strived for continuous learning, improvement and innovation. We found the service had addressed the concerns we reported at the June 2019 inspection of the former provider and significant improvements had been made. These included:

- The registered manager maintained an up-to-date training tracker and alerted staff when they needed to update their training.
- Staff understood how to protect patients from abuse and were able to describe what action they would take if they identified a safeguarding concern.
- Toilet and shower facilities were available for patients, with a call bell system in case of emergency, such as a patient requiring urgent assistance.
- The resuscitation trolley had tamper-evident tags in place to minimise the risk of items being removed and not replaced.
- Potentially hazardous chemicals were appropriately stored in locked cabinets.
- The medical director and/or lead nurse reviewed preoperative assessments and acted on any concerns to minimise any risks to patients.

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- Staff fully completed patient observation charts and scored them correctly.
- Patient notes were comprehensive, and all staff could access them easily.
- The records management audit was comprehensive, and the results were shared with staff.
- The service had introduced clear systems and processes to safely prescribe, administer, record and store medicines. All nursing staff had completed medicines management training and were competency assessed.
- Policies were up-to-date, standardised and reflected current evidence-based guidance and professional standards. Managers had introduced a document tracker to maintain oversight of when policies were due for review.
- Managers had introduced a comprehensive core competency framework and training programme for nursing and support staff.
- Managers made sure staff and patients could help from interpreters and signers when needed.
- The leadership team had the skills, knowledge and experience to run the service and provide high-quality care. They understood the issues, challenges and priorities in the service and proactively sought to address them.

- The senior management team were developing a strategy.
- A new clinical governance framework had been introduced which was effective. Regular governance meetings were held, and governance matters were shared with all staff.
- The service risk register was sufficiently detailed and reflected the risks within the service.

Managers encouraged staff to make suggestions for improvements to the service, although staff had not been formally trained in quality improvement methodologies.

The service was committed to training and staff development. Since our last inspection of the former provider, managers had introduced a comprehensive bespoke core competency framework and training programme for nursing staff. This was based on national guidance and consisted of 47 modules relating to professional, ethical and legal practice, perioperative care and practice, interpersonal relationships and communication, managerial and leadership skills, and education and professional development.

Outstanding practice and areas for improvement

Outstanding practice

- The service was especially committed to providing patients with a comprehensive aftercare programme. A member of staff contacted each patient daily for seven to 14 days after their surgery to ensure they were recovering well and to answer any questions or concerns they may have. This was evident from the patient records we reviewed. Follow up appointments were arranged with the nurse and the surgeon and patients could continue to have complimentary follow ups up to a year after their surgery, and/or until the surgeon was happy to discharge them. Staff we spoke to were particularly proud of the aftercare they provided. Recent on-line patient reviews also spoke highly of the aftercare

they had received. For example, one patient who posted a review in July 2020 said, “Amazing surgeon and amazing aftercare”, another wrote, “Over two months now since op, but all going really smooth and the [service] have been calling me regularly to see how I’m doing”. In August 2020, another patient posted, “From my first consultation with the surgeon right through to my aftercare, the experience was flawless. [The service] seemed to have a strong focus on patient care especially with the regular follow-up calls I was receiving...” A member of staff was also available via telephone 24 hours a day, seven days a week to answer any patient questions or concerns.

Areas for improvement

Action the provider **SHOULD** take to improve

- The provider should consider how it can improve response rates to patient questionnaires.
- The provider should consider how it reports complications of treatment to ensure any trends/themes can be easily identified and investigated, where needed.
- The provider should consider adding details of the environmental cleanliness checks undertaken as part of the infection prevention and control audit, as a means of evidencing that these have been done.