Cosmesurge Ltd

Quality Report

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

Ratings

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

Summary of findings

Letter from the Chief Inspector of Hospitals

Cosmesurge Ltd is operated by Cosmesurge Ltd. The service has three recovery beds, two operating theatres, and an outpatient facility.

The service provides cosmetic surgery and outpatient appointments for adults only. We inspected the cosmetic surgery service.

We inspected this service using our comprehensive inspection methodology. We carried out the unannounced part of the inspection on the 08 and 09 May 2019.

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

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

Services we rate

We rated it as **Requires improvement** overall.

We found areas of practice that require improvement in cosmetic surgery:

- At the time of the inspection staff at the service had expired mandatory training.
- At the time of the inspection there was no management oversight for sepsis, the hospital did not have a sepsis policy, sepsis training or a sepsis lead.
- We found some guidance being used was out-of-date and polices were not localised to the environment or hospital in which they were in use for.
- The hospital had not yet started to submit data to the Private Healthcare Information Network (PHIN) as per the legal requirements regulated by the Competition Market Authority.
- We were told on inspection that there were no arrangements in place for those patients requiring a hearing loop or for those patients who were visual impaired. However, post inspection we were told that there was a hearing loop in place and a sign has been put up in reception to notify patients of this facility.
- Cosmetic procedure Information leaflets were not readily available for patients.
- Staff at the hospital could not recall the hospital's vision and this was not displayed in the hospital.

We found the following areas of good practice:

- There were effective control measures to prevent the spread of infection.
- Records were secure and kept on an electronic record system.
- Pain relief was appropriately monitored and recorded.
- Medicines including controlled drugs were securely stored and the hospital adhered to good record keeping for controlled drugs
- Patients could arrange an appointment by phone or make an enquiry via the clinic's website. The on-line enquiry form was easy to use.

Summary of findings

- All staff we spoke with were positive about the senior management team. They told us they were very visible, and they felt well supported, valued and respected.

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

Professor Edward Baker
Chief Inspector of Hospitals

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Surgery	**Requires improvement** 	Surgery was the main activity of the hospital. We rated this service as requires improvement overall. Safe and well-led was rated as requires improvement because we were not assured that staff had adequate training in key areas, to keep patients safe, such as sepsis awareness. We rated effective, caring and responsive as good.

Summary of findings

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Requires improvement

Location name here

Services we looked at
Cosmetic surgery.

Summary of this inspection

Background to Cosmesurge Ltd

Cosmesurge Ltd is operated by Cosmesurge Ltd. The service opened in 2018. It is a private hospital in Marylebone, London. The hospital primarily serves the communities of London. It also accepts patient referrals from outside this area.

The hospital has had a registered manager in post since 30 November 2017.

The hospital also offers cosmetic procedures such as dermal fillers in the outpatient facility. We did not inspect these services as they are out of scope of CQC regulation.

Our inspection team

The team that inspected the service comprised a CQC lead inspector, two specialist advisors with an expertise in surgery. The inspection team was overseen by Teri Salt, Interim Head of Hospital Inspection.

Information about Cosmesurge Ltd

The hospital has two theatres and is registered to provide the following regulated activities:

- Surgical procedures.
- Treatment of disease, disorder or injury.

During the inspection, we visited the theatres, the recovery areas and the consultation rooms. We spoke with nine staff including registered nurses, health care assistants, reception staff, medical staff, operating department practitioners, and senior managers. We spoke with one patient and one relative. During our inspection, we reviewed five sets of patient records.

There were no special reviews or investigations of the hospital ongoing by the CQC at any time during the 12 months before this inspection. This was the hospital's first inspection since registration with CQC.

Activity (April 2018 to March 2019).

- In the reporting period April 2018 to March 2019 there were 166 inpatient and day case episodes of care recorded at the hospital, all patients were self-funded.
- All patients were day case patients, and there were no facilities to accommodate overnight patients.

18 Surgeons and 17 anaesthetists worked at the hospital under practising privileges. The hospital employed one theatre operating department practitioner, two registered nurses, one health care assistant, two administrative assistants, and a domestic staff member, as well as having its own bank staff.

The accountable officer for controlled drugs (CDs) was the registered manager.

Track record on safety

- There were no never events.
- There was eight clinical incidents.
- There were no serious injuries.
- There were no incidences of hospital acquired Meticillin-resistant Staphylococcus aureus (MRSA).
- There were no incidences of hospital acquired Meticillin-sensitive staphylococcus aureus (MSSA).
- There were no incidences of hospital acquired Clostridium difficile (c.diff).
- There were no incidences of hospital acquired E-Coli.
- There were two complaints.

Services accredited by a national body:

Summary of this inspection

- National Implant Register for Breast Implants.

Services provided for the hospital under service level agreement by outside contractors:

- Pathology services.
- Histopathology services.
- Sterilisation services.
- Health and Safety services.
- HR advisory services.
- Clinical waste services.
- Planned preventative maintenance (air-handling, air-conditioning).
- UPS/ back up power maintenance.
- Medical gas maintenance.
- Portable Appliance Testing, Legionella, testing fire assessments.
- Fire and security alarms.
- IT support.
- Staff training and development.
- Infection control.
- Building maintenance services.

Summary of this inspection

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?

Requires improvement

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

We found the following issues that the service provider needs to improve:

- The service did not ensure that all mandatory training was up to date and all staff had expired mandatory training.
- At the time of the inspection staff had no training in sepsis management, a sepsis policy has now been put in place.
- At the time of the inspection the safeguarding policy stated that training occurred only at induction and failed to include all types of abuse. The safeguarding policy has now been rectified to include all types of abuse and the training matrix we looked at ensured that training was in line with best practice.
- Care plans we looked at indicated that patient temperatures were not recorded perioperatively or during surgery.
- We found some incomplete patient pathways in patient records.
- We found incidents were under reported.

However, we found the following areas of good practice:

- There were effective control measures to prevent the spread of infection.
- Equipment was brand new, clean and in working order and was still under the two-year warrantee.
- Staff knew the correct procedures to follow for a deteriorating patient.
- The hospital had enough nursing and medical staffing.
- Records were secure and kept on an electronic record system.
- Medicines including controlled drugs were well stored and the hospital adhered to good record keeping for controlled drugs.
- The World Health Organisation check list for surgery was well audited and showed they were compliant.

Are services effective?

Requires improvement

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

- We found some guidance being used was out-of-date.
- Polices were not localised to the environment or hospital in which they were in use for.

Summary of this inspection

- The hospital had not yet started to submit data to the Private Healthcare Information Network (PHIN) as per the legal requirements regulated by the competition Markets Authority (CMA).
- The hospital did not collect Patient Reported Outcome Measures PROMs data for patients who underwent certain cosmetic surgeries
- Quality- Patient Reported Outcome Measures (Q-PROMS) data was not collected.
- At the time of the inspection the hospital did not measure competency of staff employed at the hospital.

However, we found the following areas of good practice:

- Patients nutrition and hydration needs were met.
- Pain relief was appropriately monitored and recorded.
- Consent forms on the whole were well completed.

Are services caring?

Good

We rated caring as **Good** because:

- Staff cared for patients with compassion. Feedback from patients confirmed that staff treated them well and with kindness.
- Staff provided emotional support to patients to minimise their distress.
- Staff ensured patients and those close to them were fully involved in decisions about their care and treatment.

Are services responsive?

Good

We rated it as **Good** because:

- The service planned and provided services in a way that met the needs of the service users.
- There were adequate facilities to aid those patients who required the use of a wheelchair.
- Waiting times from referral to treatment and arrangements to admit, treat and discharge patients were in line with good practice.
- Patients undergoing cosmetic surgery waited a minimum of two weeks between consultation and procedure. This 'cooling off' period was in line with national recommendations (Royal College of Surgeons (RCS) Professional Standards for Cosmetic Surgery April 2016).
- Patients could arrange an appointment by phone or make an enquiry via the hospital's website. The on-line enquiry form was easy to use.

However,

Summary of this inspection

- There were no arrangements on site for patients who required translations services.
- Information leaflets were not readily available about cosmetic procedures.
- There was no information available for the patient to inform them on how to make a complaint at the service or on the service's website.

Are services well-led?

Requires improvement

We rated well-led as **Requires improvement** because:

- Staff we spoke with including the CEO could not recall the vision of the hospital and the strategy of the hospital was unclear. The hospital did not have any values and the vision was not displayed anywhere.
- There was no sepsis lead to oversee the hospital sepsis management.
- The hospital risk register did not reflect the risks felt by staff working at the hospital.

However,

- Leaders had the right skills and qualifications required for the job.
- All staff we spoke with were positive about the senior management team. They told us they were very visible, and they felt well supported, valued and respected.
- We were assured that the hospital complied with the Competitions and Marketing Authority (CMA) Order that came into force in April 2015 about the prohibition of inducing a referring clinician to refer private patients to, or treat private patients at, the hospital.

Requires improvement

Surgery

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

Are surgery services safe?

Requires improvement

Mandatory training

- **The service provided mandatory training in key skills to all staff, however this training was out of date.**
- We observed that all staff employed at the service had out of date training for all mandatory training modules at the time of the inspection.
- All mandatory training via e-learning, class room learning, and assessments were booked in with a completion date post of the inspection in June 2019. This included moving and handling, health, safe and welfare and infection prevention and control.
- Required training such as equality and diversity, information governance and service delivery was scheduled up until January 2020. This training was also delivered in several ways such as e-learning, class room learning, and assessments.
- The hospital was in the process of revamping the provision of a more robust mandatory training programme. At the time of the inspection mandatory training was being booked in with a new provider on Saturdays for all staff.
- Clinical and non-clinical staff had the same mandatory training modules and we were not assured that the clinical staff members had enough suitable training for their roles. For example, there was no eLearning for sepsis recognition for clinical staff. This was raised with the manager at the hospital and sepsis training was introduced for May 2019.
- The service was in the process of developing an induction pack for all new staff.

Safeguarding

- **Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had out of date training on how to recognise and report abuse at the time of inspection, but they knew how to apply it.** Safeguarding training was completed by all staff by the end of May 2019.
- There were processes and practices in place to safeguard adults from avoidable harm, abuse and neglect that reflected relevant legislation and local requirements. The hospital's safeguarding policy was in-date and accessible to staff. There was a clear process to follow if a staff member suspected abuse.
- However, the policy stated that training was only given at induction level. The Intercollegiate document Adult Safeguarding: Roles and Competencies for Health Care Staff 2018 states that there should be a minimum of 4 hours refresher training every 3 years for level 2 safeguarding. The training matrix we looked at post inspection via a data request stated that level one and two safeguarding training was repeated annually, and level 3 safeguarding training was repeated every three years.
- The policy did not mention all types of abuse and failed to mention domestic abuse, female genital mutilation

(FGM), organisational abuse and modern slavery as outlined in the Intercollegiate document Adult Safeguarding: Roles and Competencies for Health Care Staff 2018. This was fed back to the manager in the hospital and FGM and modern slavery was now incorporated into the safeguarding policy.

- The registered manager was the hospital's safeguarding lead for vulnerable adults and had updated their level 2 safeguarding training on 23 May 2019.
- There had been no safeguarding concerns reported to CQC in the reporting period from April 2018 to March 2019.
- The hospital had an up-to-date chaperone policy in place, which staff knew how to access. Notices were displayed throughout the hospital advising patients that a chaperone was available on request. Refresher chaperone training was scheduled for the 14 June 2019.

Cleanliness, infection control and hygiene

- **The service controlled infection risk well. Staff kept their uniforms, equipment and the premises clean. They used control measures to prevent the spread of infection.**
- We found all areas of the service were visibly clean and tidy. We saw a checklist was in place, which confirmed the hospital was cleaned daily. Behind the wash room doors, we saw an hourly cleaning checklist which was ticked off throughout the day. There was a cleaning log in theatres which listed all the equipment that must be cleaned in preparation and ahead of the start of each operation list. There were signatures present to indicate cleaning had been done.
- Flooring throughout the hospital was well maintained and visibly clean. Flooring in the procedure rooms, consultation rooms and recovery rooms were in line with national requirements (Department of Health, Health Building Note 00-10 Part A: Flooring 2013).
- The computer keyboard and mouse were covered in a smart wipe down material which made cleaning effective and easy.
- We saw clinical staff adhere to the service's 'arms bare below the elbow' policy. This is an infection prevention and control (IPC) strategy to prevent the transmission of infection from contaminated clothing and enables clinicians to thoroughly wash their hands and wrists.
- There was access to hand washing facilities, hand sanitising gel, and personal protective equipment (PPE) such as gloves and gowns, in all areas. Gloves were available in all sizes and were latex and powder free.
- Automatic, no touch, hand sanitising gel dispensers were available throughout the hospital for staff, patients and visitors to use. Hand washing posters were displayed in the public toilet and clinical areas.
- Hand hygiene audits from 24 April 2019 to 13 May 2019 showed hand hygiene compliance of 90% for all clinical and non-clinical staff and 75% compliance from doctors and consultants. The audit listed recommendations on how to improve compliance.
- All patients were screened for MRSA prior to any procedure. The pre-operative risk assessment form included patient history for MRSA.
- From April 2018 to March 2019, the service reported zero surgical site infections resulting from surgeries.
- The hospital had entered into a service level agreement with an external specialist company who provided: a helpline, audits, training and an infection prevention and control manual.
- Designated theatre shoes were available for staff, patients and visitors to wear in the procedure room. This was in line with best practice (Association for Perioperative Practice Theatre Attire 2011).
- For anaesthesia delivery the laryngoscope handle and blade were single use equipment and discarded after use.

Environment and equipment

- **The service had suitable premises and equipment and looked after them well.**
- The premises were well designed, maintained and had adequate facilities for the minor cosmetic surgeries and consultations provided.
- Staff we spoke with told us that all theatre surgical equipment e.g. operating table and suction machine

were purchased brand new at the start of the opening of the hospital in December 2017. Therefore, all the equipment at present was still under the minimum two-year warranty period.

- We looked at various pieces of equipment in the recovery areas and theatre and found that all equipment we looked at had been portable appliance tested (PAT) within the last 12 months. This included the treatment couch and the blood pressure monitor.
- We looked at the resuscitation trolley located in theatres. Tamper evident seals were in place. The emergency equipment was checked prior to every surgical list. We examined five pieces of equipment in the trolley including fluids and medicines and found them all to be in date. We observed the daily checks of the defibrillator and did not identify any gaps.
- We looked at the anaesthetic machine and the daily log book which was only completed on the days where surgery was scheduled. The anaesthetic machine was fully maintained by the manufacture, an agreement was in place whereby the hospital could call the manufacture when required.
- We checked a range of consumable items in the procedure room, including curtains, swabs, needles, cannulas and syringes. We found all were in-date, except for the blood collection bottles.
- The hospital had a fully functional air handling unit that delivers air changes and had the ability to increase or lower air temperature. This adhered to best practice as per the Department of Health HTM guidelines.
- We found clinical waste and domestic waste suitably stored in separate foot operated bins with clear labels to distinguish the two. Sharps bins were clean, dated and were not overfilled.
- We were assured that fire safety equipment was fit for purpose. This included fire extinguishers, fire alarm system, heat and smoke detectors, and emergency lighting.

Assessing and responding to patient risk

- **Staff completed and updated risk assessments for each patient.** They kept clear records and asked for support when necessary.
- The American Society of Anaesthesiologists (ASA) classification of physical health was used to assess a patients' suitability for treatment at the clinic. Most patients had an ASA score of one. This meant they were completely healthy and fit for surgery. Occasionally, the surgeon would operate on a patient with an ASA score of two. This meant the patient had a mild systemic disease, which was well-controlled and had no functional limitations.
- All patients treated at the hospital had undergone a pre-operative consultation and assessment and had access to their consultants and the services telephone number, in case they needed to contact someone for follow up advice and/or treatment. However, pre-operative assessments were either carried out by the clinical services director or by the patients referring consultant. This meant that we were unassured of consistency in preoperative assessments.
- The surgeon requested, and the provider ensured that all pre-operative tests, and copies of the results of these tests were kept in the patient notes.
- We observed that the hospital had pressure relieving equipment including new mattresses and gel pads to minimise the risk of pressure sores.
- 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). We observed that staff adhered to the WHO safety checklist and checklists were completed in the patient records we reviewed. We looked at the most recent WHO audit which had 100% compliance, results were displayed in the staff room.
- We observed the breast prosthesis log book which contained patients' demographics and implant stickers to enable close reference and or any re-call. The operating department practitioner (OPD) uploaded this information to the national data base in the line with best practice Royal College of Surgeons Professional Standards for Cosmetic Surgery 2016.
- All surgeries were day case surgeries. Upon discharge, patients were handed printed guidance on do's and

don'ts and a helpline number which was specific to their surgery and surgeon. All patients were telephoned within 24 hours of their discharge as per British Association of Day Surgery guidelines.

- Venous thromboembolism (VTE) assessments were carried out pre-operatively, all VTE assessments we saw were documented well in patient's records.
- The hospital operated a senior management out of hours helpline, should patients or surgeons need contact for concerns or queries.
- There were no unplanned returns to theatre in the reporting period March 2018 to April 2019. Staff we spoke to were competent in the knowledge of what to do if there was an unplanned return to theatre.
- Care plans we reviewed showed that the patient temperature was not recorded perioperatively or during surgery as outlined in the National Institute for Health and Care Excellence (NICE) guidelines. NICE guidelines recommend that incident reporting should be considered for any patient arriving at the theatre suite with a temperature below 36 degrees Celsius and that the induction of anaesthesia should not begin unless the patient's temperature is 36 degrees Celsius or above. This is to avoid hypothermia, a medical emergency that occurs when the body loses heat faster than it can produce heat. This was relayed to the staff at the service during the inspection.
- There were no service level agreements or formal protocols in place to transfer a deteriorating patient to the NHS or other independent hospital, which was proving difficult to formalise. If a patient was deteriorating and in need of urgent care that could not be provided in the hospital staff would call 999. Telephone numbers of all surgeons and anaesthetists were held in the office for immediate contact should a patient's condition change post operatively.
- At the time of the inspection there was no reference made to sepsis management, however since the inspection the hospital devised a policy on sepsis which included the sepsis 6 bundle.

Nursing and support staffing

- **The service had staff with the right qualifications, and experience to keep people safe from avoidable harm and to provide the right care and treatment. However, training was not up to date and skills were not assessed.**
- The service followed NMC's safe staffing guidelines in relation to recruitment processes to ensure appropriate staffing in the healthcare setting.
- Staff recruited and deployed were subject to stringent background checks, interview process and credentialing.
- The services made minimal use of agency staff and maintained a regular bank of staff to ensure continuity of care for the consultant users and patient quality care. All agency staff went through an induction checklist.
- In stage 1 recovery the patient had one-to-one recovery care with a registered nurse.
- In the stage 2 recovery invariably one-to-one but on occasion one-to-two ratio of qualified nursing care.
- The service had a qualified theatre lead who was qualified as an operating department practitioner (OPD), who was responsible for the day to day running of the operating theatre. The OPD reported to the Clinical Services Director. The OPD ensured that there was a good skill mix on a day-to-day basis.
- There was a monthly rota and a daily theatre allocation rota for the operative period.
- Staff we spoke with were concerned with the low number of staffing available, to allow time of annual leave, but this was not reflected on the risk register.

Medical staffing

- **The service had enough medical staff, medical staff were not directly employed by the provider and worked under their practicing privileges.**
- Medical staff were not employed by the service. All consultants and anaesthetic clinicians were either introduced or were known to existing consultants and were recommended to the service.

- All medical staff worked under practising privileges. Practising privileges is a term used when doctors have been granted the right to practise in an independent service.
- The granting and retention of practicing privileges was at the discretion of the chairman and the members of the Medical Advisory Committee (MAC) with advice and support from the registered manager. Arrangements were in place to review practising privileges and to remove any consultants whose performance deteriorated or became unsuitable to work at the hospital. This was outlined in the practicing privileges policy and in the letter of agreement.
- Practising privileges were granted based on terms that were agreed, such as surgeons and anaesthetists should be readily available following surgery which was set out in the letter of agreement which the medical practitioner received.
  Consultants contact number (surgeon's personal/ emergency number) was readily available to clinical staff when required. A record of phone numbers were maintained and updated centrally within the hospital.
- Also noted in the letter of agreement, was that should a consultant not be available a suitable and of similar standing and of the same specialty alternative should be arranged with full details documented.

Records

- **Staff kept records of patients' care and treatment.** Records were clear, up-to-date and easily available to all staff providing care, however we found some gaps in the completion of patient records.
- All patients were seen with their relevant medical records, medical records were not taken off site at any time. The service reported that 0% of patients were seen without all relevant medical records being available.
- All consulting practioners using the service were asked to provide a full record of their patient's relevant history and notes.
- All patients' records were paper based until post-surgery; paper records were then scanned into the providers electronic record system and the paper copies were shredded. This process occurred almost immediately and there was no backlog of paper records.
- Access to the electronic records system was protected with individual log-ins and passwords, which all staff employed by the hospital or who had practising privileges were given. We saw computer terminals were locked when not in use. This reduced the risk of unauthorised people accessing patient records.
- We reviewed five patient records and found that all patients were screened for MRSA prior to surgery.
- We found some inconsistencies in the completion of the patient pathway, the recovery episode and the recording of the patient's temperature peri-operatively.
- Patients were asked for their consent to share information with their GP. All patients who consented had GP letters sent, detailing consultations and procedures performed. Patients who did not give consent were given a copy of their discharge summary.
- We asked to look at the latest record audit which included 7 sets of patient records from 22 May 2019. The audit found 84% compliance to record keeping and included areas of improvement such as, consultant entries in notes must be signed, dated and legible.

Medicines

- **The service followed best practice when prescribing, giving, recording and storing medicines. Patients received the right medication at the right dose at the right time.**
- Medicines requiring refrigeration were stored appropriately in a locked fridge. There was one fridge in theatres and one in the step down one recovery area. The fridge temperature was checked and recorded daily to ensure medicines were stored within the correct temperature range and were safe for patient use. An alarm would sound when the fridge temperature was out of the range and staff we spoke with understood the procedures to follow if this happened. We saw fridge temperatures were within the recommended range.
- We saw controlled drugs (CD) securely locked in a cupboard in the operating theatre and in the step down one recovery area. We inspected the CD log book and found that the register was completed in accordance to guidance. However, we found one occasion where the consulting anaesthetists had not signed for CD use. We raised this with staff at the service and was informed that this was not a regular attending anaesthetist and

the anaesthetist had been asked to return to the service to sign for this, this was in January 2019. This had not been recorded as an incident. A pharmacist from a local nearby independent hospital audits the CD register periodically.

- We observed in date medication stocked in the hospital used to treat patients with systemic toxicity from local anaesthetics.
- We saw that prescription records were completed correctly, and patient allergies were clearly documented.
- The service ordered medicines from a local external pharmacy provider as and when required.
- Over 88% of patients reported that if they had new medication prescribed the purpose and possible side effects were clearly explained, 13% of patients reported that it was explained to some extent.

Incidents

- **The service managed patient safety incidents.**
- 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.
- There was eight incident reported in the reporting period April 2018 to March 2019.
- Staff we spoke to were aware of the last reported incident.
- Incidents were reported on a paper-based form, which all staff had access to and were familiar with. The form included the date, time and description of the incident, consultant details, patient registration number, immediate action taken following the incident and time reported to registered manager.
- The form did not include whether a duty of candour was applied. 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. Staff we spoke to struggled to articulate what was meant by a duty of candour until prompted.
- There were no never events reported in the period March 2018 to April 2019. Never events are serious incidents that are entirely preventable because guidance or safety recommendation providing strong systemic protective barriers are available at a national level and should have been implemented by all healthcare providers.
- We were not assured that incidents were reported as often as they should, we found one incident in the CD book whilst on inspection. We asked the provider to complete an incident form for this incident which was done whilst we were on inspection.

Are surgery services effective?

Requires improvement

Evidence-based care and treatment

- **The service provided care and treatment based on national guidance and evidence of its effectiveness. However, we found some guidance being used was out-of-date.**
- We saw that the Association of Anaesthetists of Great Britain and Ireland (AABGI) were hanging on the side of the anaesthetic machine as required by the AABGI.
- We found some guidance being used was out-of-date, in the policy folder that we had been given to look at on inspection.
- All policies covered the National Safety Standards for Invasive Procedures (NatSSIPs). However, we found no Local Safety Standards for Invasive procedures (LocSSIPs). For example, the policy for the counting of items used during a surgical procedure and the policy for malignant hypothermia. This meant that polices were not localised to the service and the environment within the service.
- We also saw polices that were unfinished and polices referred to other polices that were not in existence. This meant that we were unassured that new staff, agency

staff and existing staff were following protocol, and we were unsure of what protocols were being followed. Adherence to protocol reduces error and allows for sufficient investigation when things go wrong.

- Many polices we looked at referred to another independent hospital that had no relation with this provider. We raised this with the provider for immediate action.

Nutrition and hydration

- **Staff gave patients enough food and drink to meet their needs and improve their health.**
- Patients nutrition and hydration needs were met.
- The service was able to make adjustments for patients' religious, cultural and other preferences.

Pain relief

- **Staff assessed and monitored patients regularly to see if they were in pain.** They supported those unable to communicate using suitable assessment tools and gave additional pain relief to ease pain.
- Patient pain was documented in the peri-operative care plan, and there was a pain scoring system which is in use for all surgical patients. The service also used the Modified Early Warning Score (MEWs).
- We observed an anaesthetist asking a patient about their pain using a pain score between 1 and 10.
- The service captured patient feedback on effective pain relief through patient satisfaction surveys and follow up telephone calls, 100% of patients answered yes when asked if their pain was managed effectively.

Patient outcomes

- **Patient outcomes were not monitored for the effectiveness of care and treatment.**
- At the time of our inspection, the service had not yet started to submit data to the Private Healthcare Information Network (PHIN) as per the legal requirements regulated by the competition Markets Authority (CMA). They also did not collect Patient Reported Outcome Measures PROMs data for patients who underwent certain cosmetic surgeries. This was not in line with the Royal College of Surgeons (RCS) standards.
- The provider did not make sure that routine collection of Q-PROMS took place for all patients following procedures for; abdominoplasty, augmentation mammoplasty, blepharoplasty, or rhinoplasty.
- The hospital did not benchmark themselves against other similar providers or participate in other relevant quality improvement initiatives to improve outcomes such as research trials or accreditation schemes.
- The service did not audit sepsis management or patient outcomes.

Competent staff

- **The service did not make sure staff were competent for their roles.**
- Staff employed by the hospital did not have a competency framework to complete in order to check and record new and ongoing skills. Senior staff we spoke with said that a competency framework was being developed. This was recorded on the risk register as a high risk and had an action target completion date for June 2019.
- Managers appraised staff's work performance and held supervision meetings with them to provide support and monitor the effectiveness of the service.
- The surgeons were skilled, competent and experienced to perform the treatments and procedures they provided. They performed plastic and cosmetic surgery procedures for NHS, privately funded and self-insured patients at a local independent hospital, and abroad, in addition to the minor cosmetic surgeries they performed at the hospital.

Multidisciplinary working

- **Staff of different kinds worked together as a team to benefit patients.** Doctors, nurses and other healthcare professionals supported each other to provide good care.
- The team worked well together, with care and treatment delivered to patients in a co-ordinated way. We observed positive working relationships between medical, nursing and administrative staff. Staff told us they worked closely together to ensure patients received person-centred care and support.

Requires improvement

Surgery

- Treatment provided was consultant-led. All team members were aware of who had overall responsibility for each patient's care.
- There was no formalised multidisciplinary team working but the teams were small and communicated well with each other regularly.

Seven-day services

- The hospital was open five days a week. From 8am to 6pm, Monday to Friday, staff we spoke to said that consultations were flexible, and patients could be booked in to see a consultant at 7pm.
- The hospital only undertook planned surgery, and minor procedures with operating lists organised in advance.
- The hospital's risk register recognised the risk of closing the hospital at the weekend reduces the availability of health care professionals for patients who had recently had surgery. This was recorded as a low risk as there was a well-established on-call management system with access to a wide range of health care professionals and consultants out of hours.

Health promotion

- Patients were supported to be as fit as possible for surgery. For example, patients were advised to stop, or at least reduce, smoking and alcohol intake before and following surgery.
- However, there was no information displayed to actively encourage healthy living

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- **Staff understood their roles and responsibilities under the Mental Health Act 1983 and the Mental Capacity Act 2005.** They knew how to support patients experiencing mental ill health and those who lacked the capacity to make decisions about their care.
- Staff understood how and when to assess whether a patient had the capacity to make decisions about their care. They followed the service policy and procedures when a patient could not give consent.
- Consent was obtained in line with national standards (Royal College of Surgeons (RCS) Professional Standards for Cosmetic Surgery April 2016). Consent was obtained in a two-stage process. Most patients undergoing cosmetic surgery waited a minimum of two weeks between consultation and surgery.
- Written consent was formally taken on the day of surgery. Consent was always taken by the operating surgeon.
- We reviewed five patient records and found consent forms were fully completed in four out of five records. The completed consent forms were signed and dated by the patient and the operating surgeon. The consent forms were comprehensive and included details of the planned surgery, intended benefits, potential risks and complications.
- Patients under the age of 18 were not treated at the clinic.

Are surgery services caring?

Good

Compassionate care

- **Staff cared for patients with compassion.** Feedback from patients confirmed that staff treated them well and with kindness
- There was a strong, visible patient-centred culture. Staff were motivated and inspired to provide care that was kind and promoted patient's dignity. We saw staff took the time to interact with people who used the service and those close to them in a polite, respectful and considerate way. Staff introduced themselves to patients and made them aware of their role and responsibilities.
- Patients' privacy and dignity needs were understood and always respected. Where care and treatment required a patient to undress, staff ensured this was done in complete privacy through the provision of a private room, curtains and/or screening. Appropriate clothing such as gowns were provided, where necessary. Female patients were examined in the presence of a chaperone. 100% of patients reported that they had enough privacy and dignity when discussing treatments or conditions and throughout their visit.

- Patients were kept warm once on the operating table using warmed blankets and a warming pad that was placed on the operating table.
- We saw thank you cards from patients displayed in the staff room on the staff pin board.
- The unit participated in patient satisfaction surveys. The question asked was 'how likely are you to recommend our hospital to friends and family if they need similar care or treatment?'. The hospital displayed data for February 2019 in the staff room which showed that 100% of patients were likely or extremely likely.

Emotional support

- Staff provided emotional support to patients to minimise their distress.
- Patients were given appropriate and timely support and information. All patients were given the surgeon's personal mobile number, who they could contact if they had any concerns or questions.
- There were no formal leaflets given to patients regarding psychological support. However, surgeons would carry out a psychological assessment on their patients to determine if a patient was suitable for surgery.

Understanding and involvement of patients and those close to them

- **Staff involved patients and those close to them in decisions about their care and treatment.**
- Staff communicated with patients so that they understood their care, treatment and any advice given.
- The service only performed minor surgeries. This meant patients were empowered to be independent and manage their own health very quickly after surgery.
- We saw a surgeon talking to their patient's relative post operatively to provide information on the outcome of the surgery and answer any questions.
- Patients were told who they should contact if they had any concerns following their surgery.
- All patients reported that if they had questions to ask about their treatments, answers were given in a way that could be easily understood.

Are surgery services responsive?

Good

Service delivery to meet the needs of local people

- The service planned and provided services in a way that met the needs of the service users.
- A range of cosmetic treatments and procedures were available at the clinic. The most common surgeries performed were breast augmentation and labia plasty.
- Procedures were available for men and women. The surgeon had the experience, skills and expertise to carry out the procedures and treatments provided at the clinic.
- The facilities and premises were appropriate for the services delivered. There was a large waiting area on the ground floor with three consultation rooms, one procedure room and one recovery room and one step down recovery room. This was sufficient for the number of patients who attended the clinic. There was adequate seating for patients and visitors. Toilets were available for patients on both floors.

Meeting people's individual needs

- **The service took account of patients' individual needs.**
- Reasonable adjustments had been made so that people with a disability could access and use the service. There was a portable ramp available for the steps leading into the building which made the hospital accessible to wheelchair users. There was a lift to the ground floor and suitable toilet facilities. However, there was no hearing loop available or information suitable for visually impaired patients. However, post inspection we were told that there was a hearing loop in place and a sign has been put up in reception to notify patients of this facility.
- Patients were given a choice of light meals post operatively, which took account of their individual preferences, respecting cultural and personal choice.
- A drinks machine was available to patients and their companions for complimentary hot drinks and water.

Requires improvement

Surgery

- Information leaflets were not readily available about cosmetic procedures, the waiting area consisted of advertisement leaflets for various procedures such as breast augmentation and skin rejuvenation. However, we were told that surgeons provided patients with information that covered all aspects of the surgical journey. This was not documented in patient records that we looked at and we could not be assured that all patients received the same information prior to surgery.
- There were no arrangements in place for patients who required translation services. However, we were subsequently told by the provider that translation services were available nearby that they could utilse and that embassy patients were accompanied by an interpreter arranged by their embassy.

Access and flow

- **People could access the service when they needed it.**
- Patients had timely access to consultations, treatment and after care. Most patients undergoing cosmetic surgery waited a minimum of two weeks between consultation and procedure. This 'cooling off' period was in line with national recommendations (Royal College of Surgeons (RCS) Professional Standards for Cosmetic Surgery April 2016). Staff we spoke with told us they would treat patients within this period if they felt this was appropriate, such as to revise previous surgery. Patients were required to sign a non-disclosure form if surgery took place within the cooling off period.
- The appointment system was easy to use and supported people to access appointments. Patients could arrange an appointment by phone or make an enquiry via the clinic's website. The on-line enquiry form was easy to use.
- Patients could normally access care and treatment between Monday and Friday 8am to 6pm. Sometimes clinics would run until 7pm to accommodate patients.

Learning from complaints and concerns

- **The service treated concerns and complaints seriously, investigated them and learned lessons from the results, and shared these with all staff.**
- Staff we spoke with said that all patients were asked to complete a patient satisfaction survey before leaving the service where patients had the opportunity to leave feedback on the treatment they received. We observed patients being asked to complete the survey on an electronic device when at the reception before leaving the service.
- There were two complaints received within the reporting period April 2018 to March 2019. Both complaints followed the complaints policy, an acknowledgment of the complaint was made within two working days and a full response was written within 14 days of the receipt of the complaint.
- There was no information available for the patient to inform them on how to make a complaint at the service or on the service's website.

Are surgery services well-led?

Requires improvement

Leadership

- **Managers at all levels in the service had the right skills and abilities to run a service providing high-quality sustainable care.**
- The overall manager in place was the CEO who was also the registered manager. There was a management structure in place with defining lines of responsibility and accountability.
- Leaders had the right skills and qualifications required for the job.
- All staff we spoke with were positive about the senior management team. They told us they were very visible, and they felt well supported, valued and respected.

Vision and strategy

- **The service had a vision for what it wanted to achieve but this was not embedded with the staff and was not visible in the hospital.**
- The service vision was 'To create the highest quality healthcare delivery ecosystem to improve the country's overall health and quality of life. Our promise to deliver such an ecosystem does not focus on simply providing good medical equipment and facilities, but also on staffing our hospital with internationally accredited,

highly skilled and qualified doctors, well-trained nurses, utilising and advance electronic method maintaining and storing medical records and implementing internationally practiced medical protocols, to name a few.'

- Staff we spoke with including the CEO could not recall the vision of the hospital and the strategy of the hospital was unclear.
- We could not see the vision embedded in the hospital, and we needed to ask staff to locate the vision document. The hospital did not have their own set of values.
- We were not assured that the hospital had a clear strategy in place when we questioned the registered manager.

Culture

- **The manager promoted a positive culture that supported and valued staff, creating a sense of common purpose based on shared values.**
- All staff we spoke with felt supported, respected and valued. They told us there was an open culture, which was centred on the needs and experience of people who used the service. Staff were positive and felt proud to work at the clinic.
- Staff we met were welcoming, friendly and helpful. It was evident that staff cared about the services they provided and told us they loved working at the service. We observed staff work collaboratively and shared responsibility in the delivery of good quality care. Staff were aware of their role in the patient experience and were committed to providing the best possible care for their patients.
- There were systems to ensure that patients were provided with information that included terms and conditions of the treatment being provided and the amount and method of payment and fees. However, patients could not see the costs of treatments prior to consultations as the costs were not displayed on the hospital's website or within the hospital. The provider subsequently told us that costings were usually given to the patients by their consultant at the time of consultation, and most consultants prefered to discuss this personally.
- We were assured that the hospital complied with the Competitions and Marketing Authority (CMA) Order that came into force in April 2015 about the prohibition of inducing a referring clinician to refer private patients to, or treat private patients at, the hospital. Staff we spoke with said that surgeons were not given incentives to provide a service here and all surgeons were charged the same fee per use of consultation rooms.
- Staff did not have up-to-date training for duty of candour and we observed that this had not been scheduled in on the training matrix we received post inspection.

Governance

- **The service systematically improved service quality and safeguarded high standards of care by creating an environment for excellent clinical care to flourish.**
- All staff at all levels were clear about their roles and they understood what they were accountable for and to whom.
- All Service Level Agreements (SLA's) with third party providers were governed and managed effectively to encourage appropriate interaction and promote coordinated, person centred care. We saw that the hospital kept copies of all their SLA contracts and had phone numbers to hand should they require their service immediately. The hospital picked local providers for their SLA's that could be at the hospital within an hour.
- We saw that the hospital manger was able to ensure that surgeons carrying out cosmetic surgery had an appropriate level of valid professional indemnity insurance in place. All surgeons were required to comply with the practicing privileges policy that stated that all surgeons must provide a copy of medical indemnity insurance, and every surgeon's privileges were subject to a two-yearly review. There were no surgeon's that had their practising privileges withdrawn in the last 12 months.
- The hospital did not encourage the use of external surgical first assistants and encouraged consultants to use the staff at the hospital. Surgical First assistants are medical professionals who assist both surgeons and nurses during surgical and other medical procedures.

First assistants that were used were required to go on a course and have the relevant competencies. Surgeons wanting to use first assistants must provide professional details of the first assistant to the clinical coordinator ahead of the surgery.

- Surgeons that performed surgeries at this hospital that also worked for the NHS would have their appraisals at their NHS hospital. Surgeons that did not work for the NHS belonged to an agency that performed appraisals. Minutes we reviewed from the Medical Advisory Committee (MAC) showed that all surgeons had their appraisals reviewed by the MAC chairman.
- There was no sepsis lead to oversee the hospital sepsis management, therefore management were unable to monitor patient outcomes or performance in regard to sepsis management. We told the CEO that the hospital should have a sepsis policy, training in sepsis and a sepsis lead. This was well received, and we were emailed a sepsis policy post inspection.

Managing risks, issues and performance

- **The service had identified their risks, but plans to eliminate or reduce them, and cope with both the expected and unexpected was poorly documented.**
- The hospital had a risk register in place; however, there was not an alignment between what was recorded as risks and what staff concerns were. For example, the risk register did not mention staffing numbers as a risk, but staff we spoke with said that staffing numbers was an issue and the lack of staffing hindered annual leave commitments.
- The hospitals risk register identified 17 risks, three of these risks were closed, two were in progress and 12 were ongoing. There were five risks identified for injury (physical and psychological) to patients, visitors or staff. There were four risks identified regarding patient experience. There were four risks identified for service or business interruption and four risks identified regarding staffing and competence. Each risk had their own action owner but not all risks had an action target completion date.
- We asked to look at the hospitals risk assessments. We were provided with a risk assessment report of the hospital of when it first opened. We were not assured that an action plan had been put in place to mitigate all the risks that had been identified in this report. This meant that we were not assured that staff were keeping track of their risk assessments. One of the risks identified was the lack of warning notices for low head room, but we did not see signs to reflect this in the relevant areas, nor did we see supporting documentation. Another risk identified was the lack of warning notices posted on the entrance to the oxygen storage room, we saw that this had been actioned but there was no documentation to support this.
- The hospital had a tested back up emergency generator in place in case of a failure of essential services.

Managing information

- **The service collected, analysed, managed and used information well to support all its activities, using secure electronic systems with security safeguards.**
- At the time of our inspection, the service had not yet started to submit data to the Private Healthcare Information Network (PHIN). They also did not collect PROMs data for patients who underwent certain cosmetic surgeries. This was not in line with the Royal College of Surgeons (RCS) standards.
- There were some arrangements in place to ensure surgical cosmetic procedures were coded in accordance with SNOMED_CT. This was not embedded with all procedures and all consultants. This is an electronic form of coding procedures and ensures that information is consistent across health settings.
- Staff had access to up-to-date, accurate and comprehensive information on patients' care and treatment. There were arrangements in place to ensure the confidentiality of patient information held electronically. Staff were aware of how to use and store confidential information. During our inspection, we found computer terminals were locked when not in use to prevent unauthorised persons from accessing confidential patient information.

Engagement

- **The service engaged well with patients, staff, the public and local organisations to plan and manage appropriate services and collaborated with partner organisations effectively.**

Requires improvement

Surgery

- From the conversations we had with staff and observations we made during our inspection, it was evident that staff were positively engaged in the service. The service only employed a small number of staff, most of which had been employed since the hospital was established. Staff told us that information was shared regularly on an informal basis, as they worked so closely together.
- All patients were required to complete a patient satisfaction survey before leaving the hospital after their appointment to provide feedback. The latest results of the survey were displayed in the staffroom and showed 100% satisfaction.

Learning, continuous improvement and innovation

- **The service was committed to improving services by learning from when things went well or wrong, promoting training, research and innovation.**
- During May 2019 the hospital implemented an electronic tracking on all document signing for consultants practicing privileges.
- The hospital was working on a project to expand their patient portal system to allow patients to have access to appointment information and patient care information within their own secure login.
- The hospital was investigating methods of improving their 'Green' credential in line with the NHS, whilst looking for ways to reduce plastic usage and conversion to greener energy consumption.

Outstanding practice and areas for improvement

Areas for improvement

Action the provider SHOULD take to improve

- The provider should ensure that all patient records are completed thoroughly before being scanned into their medical record system.
- The provider should review all polices to ensure that they are up to date with national guidelines and that LocSSIPs are in place.
- The provider should follow best practice when taking the patient's body temperature preoperatively, perioperatively and post operatively.
- The provider should have a sepsis lead, a sepsis policy, training in sepsis and a sepsis lead.
- The provider should ensure that mandatory training is kept up to date.
- The provider should ensure that staff have up-to-date training for duty of candour.