Medical Arts for Cosmetic Surgery

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

Overall summary

Medical Arts for Cosmetic Surgery Limited is operated by Medical Arts for Cosmetic Surgery Limited. Facilities include one operating theatre with a recovery facility and three consultation rooms.

The facility provides cosmetic surgery and a chronic pain management service. We inspected both the cosmetic surgery and the chronic pain management services. Day-case surgical procedures and outpatient appointments for preoperative and postoperative review, as well as pain management. In the reporting period of April 2016 to March 2017, there were 77 day-case episodes of care and 429 outpatient appointments. The outpatient appointments were a mixture of patients accessing the chronic pain management service, and cosmetic surgery outpatient consultations.

We inspected this service using our comprehensive inspection methodology. We carried out the announced part of the inspection on 25 July 2017, along with an unannounced visit to the hospital on 7 August 2017.

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.

We regulate cosmetic surgery services but we do not currently have a legal duty to **rate** them when they are provided as a single specialty service. We highlight good practice and issues that service providers need to improve and take regulatory action as necessary.

We found the following areas of good practice:

- All areas of the clinic were visibly clean and tidy.
- All staff had received mandatory training.
- Records were stored securely.
- The consent process was very robust.
- Patients received compassionate care and their dignity and confidentiality was respected.
- All areas of the service had wheelchair access.

Summary of findings

- There was an open culture and staff worked well together.
- The registered manager was visible and approachable.

However, we also found the following issues that the service provider needs to improve:

- The theatre did not meet the Department of Health Technical Memorandum 03-01 in relation to ventilation systems. However, following our inspection we saw evidence that the theatre did meet requirements.
- Venous thromboembolism assessments were not completed.
- The National Early Warning Score system to identify deteriorating patients had not been implemented. However, following our inspection we saw evidence that the service had begun to implement this.
- The World Health Organisation 'Five Steps to Safer Surgery' checklist was not used effectively. However, following our inspection we saw evidence that the checklist had been improved.
- There was no exclusion criteria to determine patients' eligibility for admission. However, following our inspection we saw evidence criteria was implemented.
- No data on patient outcomes was collected.
- Audits were not always thorough or identified the causes of areas of concern.
- There was a lack of action plans attached to audits.
- There were no arrangements in place for patients living with dementia or a learning disability.
- There were no translation services available.
- There was no governance framework in place.
- Not all risks identified had mitigating actions.

Following this inspection, we told the provider that it must take some actions to comply with the 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 provider with three requirement notices that affected cosmetic surgery. 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	Rating	Summary of each main service
Surgery		• The theatre did not meet the Department of Health Technical Memorandum 03-01 in relation to ventilation systems. However, following our inspection we saw evidence that the theatre did now meet requirements. • Venous thromboembolism assessments were not completed. • The National Early Warning Score system to identify deteriorating patients had not been implemented. However, following our inspection we saw evidence that the service had begun implementing this. • The World Health Organisation 'Five Steps to Safer Surgery' checklist was not used appropriately. However, following our inspection we saw evidence that the checklist had been improved. • There were no exclusion criteria to determine patients' eligibility for admission. However, following our inspection we saw evidence a criteria was implemented. • No data on patient outcomes was collected. • Audits were not always thorough or identified the causes of areas of concern. • There was a lack of action plans attached to audits. • There were no arrangements in place for patients living with dementia or a learning disability. • There were no translation services available. • There was no governance framework in place. • Not all risks identified had mitigating actions. However: • All areas of the clinic were visibly clean and tidy. • All staff had received mandatory training. • Records were stored securely. • The consent process was very robust. • Patients received compassionate care and their dignity and confidentiality was respected. • All areas of the service had wheelchair access.

Summary of findings

- There was an open culture and staff worked well together.
- The registered manager was visible and approachable.

Outpatients and diagnostic imaging

Cosmetic surgery was the main activity of the hospital. Where our findings on surgery also apply to other services, we do not repeat the information but cross-refer to the surgery section.

Summary of findings

Contents

Medical Arts for Cosmetic Surgery Limited

Services we looked at
Cosmetic surgery and outpatients and diagnostic imaging.

Summary of this inspection

Background to Medical Arts for Cosmetic Surgery

Medical Arts for Cosmetic Surgery Limited is operated by Medical Arts for Cosmetic Surgery Limited. The service opened in 2016. It is a private clinic in Watford, Hertfordshire. The service primarily serves the communities of the Greater London area. It also accepts patient referrals from outside this area.

The hospital has had a registered manager in post since September 2015.

The most common procedures were dimple creation, blepharoplasty (eye lid surgery), liposuction and gynaecomastia (male breast reduction).

The hospital also offers cosmetic procedures such as dermal fillers and Botulinum Toxin. We did not inspect these services, as these are not regulated by CQC.

We carried out an announced inspection on 25 July 2017 and an unannounced inspection on 7 August 2017.

Our inspection team

The team that inspected the service comprised a CQC lead inspector, a CQC inspection manager and a specialist advisor with expertise in surgical nursing. The inspection team was overseen by Bernadette Hanney, Head of Hospital Inspection.

Information about Medical Arts for Cosmetic Surgery

The main service at the clinic was cosmetic surgery. All surgery was performed under local anaesthetic. Pre-operative and post-operative consultations occurred at the clinic for cosmetic surgery that was performed by the registered manager at other local private hospitals. All patients were day case and there were no overnight stays. The other service provided was chronic pain management. This was provided by a consultant anaesthetist. Only patients aged over 18 were seen at the service.

The service has three consultation rooms and one operating room and is registered to provide the following regulated activities:

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

During the inspection, we visited all the consultation rooms and the operating room. We spoke with five staff including the registered manager and surgeon, the anaesthetist, the practice coordinator, a registered nurse and a receptionist.

We also received 29 'tell us about your care' comment cards which patients had completed prior to our inspection. During our inspection, we reviewed six 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 service's first inspection since registration with CQC.

Activity (April 2016 to March 2017)

- In the reporting period of April 2016 to March 2017, there were 77 day-case episodes of care.
- In the reporting period of April 2016 to March 2017, there were 429 outpatient appointments.
- All patients were privately funded.

Summary of this inspection

- The majority of patients attending the clinic (90%) were for cosmetic surgery, with 10% accessing the chronic pain management service.

One surgeon, one anaesthetist, and three registered nurses worked at the hospital under practising privileges. The service also employed one receptionist and one practice coordinator.

Track record on safety

- Zero never events
- Three clinical incidents which resulted in no harm
- Zero serious injuries
- Zero incidences of healthcare associated MRSA
- Zero incidences of healthcare associated Methicillin-sensitive staphylococcus aureus (MSSA)
- Zero incidences of healthcare associated Clostridium difficile (C.difficle)
- Zero incidences of healthcare associated Escherichia coli (E-Coli)
- Three complaints

Services provided at the hospital under service level agreement:

- Clinical and non-clinical waste removal
- Maintenance of medical equipment
- Pathology

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?

We do not currently have a legal duty to rate cosmetic surgery services where these services are provided as an independent healthcare single speciality service.

We found the following areas where the provider needs to improve:

- The theatre did not have sufficient air changes through their ventilation system, in line with Department of Health Technical Memorandum 03-01. However, following our inspection we saw evidence that the theatre did now meet requirements.
- Venous thromboembolism assessments were not completed prior to surgery.
- The service did not use the National Early Warning Score to identify deteriorating patients in line with National Institute for Health and Care Excellence guidance CG 50. However, following our inspection we saw evidence that the service had begun implementing this.
- The service did not use a complete version of the World Health Organisation's 'Five Steps to Safer Surgery' checklist. However, following our inspection we saw evidence that the checklist had been improved.
- The resuscitation pack did not have a contents checklist, so staff were unable to see if the pack was complete. However, following our inspection we saw evidence a checklist was implemented.
- There were no exclusion criteria to allow patients to be risk assessed as to whether they were suitable for admission. However, following our inspection we saw evidence criteria had been implemented.
- The times of patient observations and their vital signs were not recorded in recovery. As such, there was no evidence of how frequently they were completed. However, following our inspection we saw evidence that times were being recorded.
- Some equipment in the theatre and recovery were in an unusable condition.
- There was no service level agreement in place for deteriorating patients to be transferred to the local acute NHS hospital.
- There was no process in place for reporting product failures to the Medicines and Healthcare Products Regulatory Agency.

However, we also found the following areas of good practice:

- All areas of the clinic were visibly clean and tidy.
- All staff had completed mandatory training.

Summary of this inspection

Are services effective?

We found the following areas where the provider needs to improve:

- No data on patient outcomes was collected.
- The service's revision rate was above the national average of 5%.
- Audits were not always thorough or identified the causes of areas of concern.
- There was a lack of action plans attached to audits, to effect improvement.
- Not all staff had evidence of appraisals, professional registration or references.
- There were no equipment competencies for staff, to evidence their ability to use equipment safely.

However, we also found the following areas of good practice:

- The consent process was very robust, with all potential risks and benefits of procedures clearly explained to patients.
- Technology was used within the service to enhance patient care. Examples included positive use of video conferencing for consultations with patients who lived a distance from the clinic.

Are services caring?

We found the following areas of good practice:

- Patients received compassionate care from staff.
- All patient feedback was resoundingly positive, with many complimenting the caring attitudes of staff.
- Patients' dignity and respect was maintained.
- Patients' confidentiality was maintained.
- Processes were in place for patients to be referred for emotional support if necessary.

Are services responsive?

We found the following areas where the provider needs to improve:

- There were no arrangements in place for patients living with dementia or those with a learning disability.
- There were no translation services available.
- The clinic had not been adapted for patients with hearing loss.

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Summary of this inspection

Are services well-led?

We found the following areas where the provider needs to improve:

- There was no governance framework in place.
- Not all risks identified had mitigating actions.
- Not all national standards were adhered to. Prior to our inspection, the registered manager was not aware of all of the national standards.
- There was no formalised strategy to implement the vision and values.

However, we also found the following areas of good practice:

- There was an open culture and staff worked well together.
- The registered manager was visible and approachable.
- A vision and values were in place. Staff were familiar with these.

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
Outpatients and diagnostic imaging	N/A	N/A	N/A	N/A	N/A	N/A

Surgery

Safe	
Effective	
Caring	
Responsive	
Well-led	

Are surgery services safe?

The main service provided by this hospital was cosmetic surgery. Where our findings on cosmetic surgery also apply to other services, we do not repeat the information but cross-refer to the cosmetic surgery section.

Incidents

- Staff understood their responsibilities to raise concerns. Staff were able to provide examples of the types of incidents they would report, such as falls or needle stick injuries. During the reporting period of April 2016 to March 2017, there were three clinical incidents. These included a staff member falling ill, a patient going to the wrong address, and a cancelled appointment due to an IT failure.
- An incident reporting template was available electronically and staff were aware of this. An accident book was also kept by reception, for staff to report any accidents that had occurred. However, when we looked at this, there had been no entries.
- The incident reporting policy the service submitted was a National Institute for Health and Care Excellence (NICE) incident reporting procedure, which was out of date by five years. This was not applicable to the service as it was their policy for reporting internal incidents. It stated that the Business Planning and Resources Director and Governance Manager would investigate incidents, neither of which were positions within the clinic. We reviewed three incident files and saw that actions were taken to reduce the risk of reoccurrence. For example, for the incident involving the staff member falling ill, they introduced a blood glucose (sugar) measurement machine.
- The management team told us that there had been one never event. Never events are serious incidents that are entirely preventable as guidance, or safety recommendations providing strong systemic protective barriers, are available at a national level, and should have been implemented by all healthcare providers. Each never event type has the potential to cause serious patient harm or death. On review of the incident, it did not meet the NHS England criteria for never events, as the incident involved a staff member falling ill. Therefore, the clinic had not had a never event. However, this raised concerns with the registered manager's knowledge and understanding of never events and the grading of incidents.
- People who used the services were told when they were affected by something that went wrong, given an apology and informed of any actions taken as a result. Staff were aware of the duty of candour. Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations is the regulation that introduced the statutory duty of candour. For independent providers it came into effect in April 2015. Staff were able to explain the steps they would take in regards to apologising to the patient and being open and transparent about any failings in their care.
- Lessons were learned, both from incidents that had occurred at the clinic, and those that occurred elsewhere. Action was taken as a result of investigations when things went wrong. Staff were able to provide an example of an incident that had occurred at another private hospital whereby complications arose during local anaesthesia. As a result of this, the registered manager had reviewed their clinical pathways to ensure that a similar incident did not occur.
- Lessons were shared to make sure action was taken to improve safety beyond the affected team or service. Weekly team meetings were held where any learning from incidents was shared.

- The service had not set specific safety goals. This meant that performance against safety goals was not monitored.

Clinical Quality Dashboard or equivalent

- The service did not use a clinical quality dashboard. As all patients were undergoing outpatient or minor day-case procedures, and there were no inpatients, there was a very low risk of patients acquiring pressure ulcers whilst having treatment.
- The service did not risk assess patients for venous thromboembolism (VTE) on admission. VTEs are blood clots that can form in a vein and have the potential to cause severe harm to patients. This was not in line with National Institute for Health and Care Excellence (NICE) guideline CG92. We raised this as a concern and were told that a policy would be created to incorporate these assessments. By the time of our unannounced inspection, this had not yet been finalised but work was in progress. However, following our unannounced inspection, the management team submitted a thrombosis risk assessment form, which they said would be completed for every subsequent patient. The risk assessment form was from another healthcare company, however, we were told this would be adapted for the service's use.
- A VTE policy was also submitted. However, the policy had clearly been taken from another provider, as it contained information not relevant to this service. Examples included submitting guidelines to the trust's thrombosis committee, which the service did not have, reference to wards, which was not relevant as the service did not have wards and by contacting the on-call medical team, which the service did not have access to.
- Surgical site infection (SSI) rates were monitored for all cosmetic surgeries. This showed that no infections had occurred since the clinic opened.

Cleanliness, infection control and hygiene

- During the inspection, the management team were unable to provide evidence that the operating theatre had been commissioned and was compliant with Health Technical Memorandum (HTM) 03-01 Specialist ventilation for healthcare premises. This states that a day-case theatre needs to have a minimum of 15 air changes per hour. The certificate provided by the registered manager showed that the theatre had only been looked at in test conditions, the actual premises had not been tested and the number of likely air changes was 13, below the requirement. An adequate number of air changes per hour is required in order to reduce the risk of infection. We raised this with the registered manager during the unannounced inspection. Following this they sent evidence that the ventilation system had been looked at again, and that this was now compliant with HTM 03-01.
- All areas of the clinic were visibly clean and tidy. The clinic had a contract with an external company, who cleaned the premises every day. Audits of cleanliness were completed and we saw that mops and buckets were colour coded according to national guidelines. Deep cleans were undertaken every six months. We saw that an audit had taken place following a deep clean. This identified that there were spores (bacteria) present in the theatre. As a result, all surgical activity was suspended and further cleaning was conducted. Further testing was completed, which confirmed that the spores had been removed.
- An infection prevention and control policy was in place. This was in date and reflected best practice in regards to hand washing and use of personal protective equipment such as disposable gloves. However, during one post-operative review that we observed, the surgeon did not wash their hands or use gloves prior to a physical examination. This is not in line with national guidance. Staff should decontaminate their hands before and after every episode of care, in line with NICE guidance QS61 Statement 3.
- Hand sanitising gel dispensers were available throughout the clinic. However, we found two dispensers were empty and the soap dispenser in the main cosmetic surgery consultation room was also empty. The Royal College of Nursing guidance on adequate hand washing was displayed in the bathroom.
- Staff generally adhered to being 'arms bare below the elbow'. However, we did observe a nurse assist a surgeon with a wound dressing, whilst wearing jewellery. According to NICE CG139, healthcare workers should have 'arms bare below the elbow' and should remove wrist and hand jewellery to enable effective handwashing and reduce the risk of infection.

- The flooring in the consulting rooms were well maintained. However, they were carpeted and did not have smooth coving between the wall and the floor. This was not in line with Department of Health (DH) 2013 HBN0010 part A. The coving from the floor did not rise far enough up to the wall and was not smooth. This meant that cracks could appear where the floor met the wall and be a source for bacteria to collect. However, no procedures were carried out in the consulting room, which limited the risk of infection.
- As of June 2017, there had been no incidences of post-operative infections.
- Hazardous cleaning chemicals were not stored on site. Cleaning chemicals were brought in by the contracted cleaners, who were only in the clinic after closing hours. We saw a checklist was in place, which was completed every morning and night, to confirm the clinic was clean.
- All surgical instruments used within the service were single use. This meant that they were used for one patient and then disposed. Therefore, there was no need for on-site decontamination.
- Scrubs (theatre wear) were washed within the service at 60 degrees Celsius. Further to our inspection, a log was created to provide assurances that the scrubs had been washed. Some staff wore shoe covers when entering the theatre. This was not in accordance with best practice, as evidenced in research by the Hospital Infection Society 2002. In addition, we observed one staff member enter the theatre without shoe covers, and another staff member exited the theatre, walk around the clinic, and then re-enter the theatre, with the same shoe covers still on. Best practice is to have designated shoes solely for use in theatre to prevent contamination of the theatre and reduce the risk of infection.
- Patients were not routinely screened for MRSA and clostridium difficile. These are infections that have the capability of causing harm to patients. This was compliant with Department of Health 2014 guidance for day-case patients. The pre-anaesthetic assessment form asked patients if they had a history of MRSA. However, on review of six files, we saw three patients did not answer this question. From April 2016 to March 2017, the clinic had no incidences of hospital acquired MRSA, Methicillin-sensitive staphylococcus aureus (MSSA), Escherichia coli (E Coli) or Clostridium difficile (C. difficile).

Environment and equipment

- Maintenance of equipment was inconsistent. We saw equipment had been electrically safety tested, and equipment that required servicing was sent to an external contractor. All pieces of equipment were purchased at the same time, and therefore, their electrically safety testing dates were all at the same time. However, we did find one suction in the recovery room, which had a European two pronged plug. There was no adaptor in the recovery room to enable staff to use the suction if required. The tubing on the suction was also not connected appropriately and there was no suction tip available. When we returned on our unannounced inspection, we saw that the tubing and tip was attached appropriately. A UK adaptor was also attached.
- We also found a blood glucose machine (used to test patients' blood sugar levels) which had not had any control tests performed. This meant the readings from the machine could have been inaccurate. On our unannounced inspection, we looked to see if control tests had been completed. However, the machine had been removed from the theatre for testing by the registered manager. This meant in this interim period there was no blood glucose machine available. We also found a laryngoscope (used to guide a breathing tube to the larynx during cardiopulmonary resuscitation) which was not working as the batteries were the wrong way round. This could present a risk if a patient required urgent intubation. This was rectified immediately.
- The resuscitation pack in the theatre did not have a checklist of contents or expiry dates. The resuscitation pack was checked before each surgical list by the practice coordinator; however, they were unaware of what should be included, as it had been put together by the anaesthetist. As the practice coordinator was not aware of what should be included, and there was no contents checklist, there was a risk items could have been missing and this would not have been identified. Upon review of the resuscitation pack we found that this did not comply with the Resuscitation Council (UK) guidance. There was only one high concentration

oxygen mask and no nasal speculums. There was also only one size of supraglottic airway device (used to keep the upper airway open), and two 22g cannulas in order to deliver intravenous fluid. There should be a variety of sizes available, to ensure that all patients are catered for.

- On our unannounced inspection we rechecked the resuscitation pack. We saw that this had been updated to include a full contents checklist and expiry dates. This was checked daily by the practice coordinator and recorded on an electronic spreadsheet. The pack also had tamper tags, which meant that the resuscitation pack was secure.
- We found a sharps bin in a consulting room, which was not labelled or dated. Sharps bins should have dates of issue so that staff know when these need to be destroyed. They should also be labelled with the name of the clinic, to provide traceability. This was not compliant with section 4.3 of the service's own infection control policy, or section 5 of the Health and Safety (Sharp Instruments in Healthcare) Regulations 2013. The clinical waste bin outside of the service was also not locked on our inspection. This presented a risk to the public as it contained needles and soiled articles, such as patient gowns. A contract was in place with an external contractor to remove clinical waste once per month, and to remove sharps every three months.
- There were no processes in place for providing feedback on product failure to the Medicines and Healthcare Products Regulatory Agency (MHRA). We raised this as a concern and the registered manager took steps to start the registration process.
- The facilities and premises were well maintained. The premises was a new build and had adequate facilities, including a disabled access toilet and lift.

Medicines

- Arrangements were in place for managing medicines. Medicines were stored securely in locked cupboards. However, non-clinical staff had access to the medicines keys and cupboards. This was not compliant with the service's own medicines management policy, which stated at section 5.3, that the medical director or senior healthcare practitioner would be responsible for the keys.
- Medicines requiring refrigeration were stored appropriately, with fridge temperatures checked regularly. On our announced visit we reviewed the medicine policy and saw this stated that medicines should be kept between 20 and 80 degrees Celsius. We raised this with the team, who assured us this was a typographical error. The policy was corrected shortly after our inspection. All medicines reviewed were in date.
- The registered manager told us that no controlled drugs were kept on the premises. However, on inspection we found one controlled drug; buccal midazolam (used to stop seizures). This was kept within the resuscitation pack. There was no controlled drug register within the service and no controlled drug accountable officer. This is required by the Home Office. The service had no denaturing kits to ensure controlled drugs could be safely disposed of. Denaturing of controlled drugs typically involves physically mixing the medicines with a binding matrix to make the material physically irretrievable in the waste chain. The resultant material is classified, described and disposed of as a waste medicine. This is required by the Environment Agency. We were told that if they needed to dispose of a controlled drug they would call the pharmacy for advice.
- There were no service level agreements in place with a pharmacy to obtain medicines. Medicines were obtained as and when required from two pharmacies with whom the service had an account with. We raised concerns about the lack of service level agreements and the registered manager told us they had emailed the pharmacies requesting this be set up. We saw evidence of this at the unannounced inspection.
- All patients were prescribed antibiotics following their surgery, to reduce the risk of post-operative infections.
- We reviewed six medicine charts and saw that records regarding allergies and medications were completed correctly.

Records

- Patients' individual care records were not always complete. We reviewed six records and saw that on all records there were no times recorded for when

observations of vital signs had been done and no nausea scores recorded. However, following our inspection we saw evidence that times were now being recorded.

- All patient records were electronic. Access to the records system was through individual log-ins and passwords. During our inspection, we saw computers were locked when staff were away from their desks. This reduced the risk of unauthorised people gaining access to patient records. All staff employed by the clinic or who had practising privileges had log in details. The only paper records were patients' consent forms and their signed contracts. During our inspection, we saw that the cupboards where these were stored were not always locked.
- The registered manager told us that all patients seen within surgery had all their relevant medical records available.
- A limited record keeping audit had been conducted. This audit was not dated. This identified only 66% compliance with record keeping standards. No robust action plans were created following this. The only recommendations from the audit were to encourage nurses to complete documentation and to re-audit in six months' time. However, as the original audit was not dated, it was unclear when the next audit was due. The recommendations did not have any assigned owners or a deadline for completion.

Safeguarding

- We were told that the practice coordinator was the designated lead for adult safeguarding. However, this was not confirmed in the safeguarding policy and the practice coordinator named the registered manager as the safeguarding lead. There was a risk therefore, that if there had been a safeguarding concern, there could have been a lack of ownership, ensuring that the appropriate referrals were made.
- The clinic's safeguarding policy had contact details of the local safeguarding adults board, so staff could make referrals if necessary. The policy was in date and referenced Department of Health guidance.
- All staff had evidence of safeguarding adults training. Staff we spoke with were able to provide examples of the types of concerns they would refer to safeguarding. There was no evidence that staff had safeguarding children's training.
- From April 2016 to March 2017 there were no safeguarding concerns reported to CQC.

Mandatory training

- All administrative staff who were employed directly by the service, had received mandatory training. This covered topics including manual handling, fire safety, infection control, health and safety, first aid and data protection. Two non-clinical members of staff had received chaperone training.
- Clinical staff, who were employed on a bank basis, did not receive mandatory training from the service, but received this from their other places of employment.

Assessing and responding to patient risk (theatres, ward care and post-operative care)

- An admission policy was in place. However, this did not outline the eligibility or exclusion criteria for patients, to identify which patients were appropriate for admission. There was therefore, the potential for patients with high risk comorbidities to be admitted. We were told that only patients with an ASA1 score were admitted. The American Society of Anaesthesiologists (ASA) score is an assessment criteria to ascertain whether a patient is fit for surgery. Those with an ASA1 score are fit, healthy patients. This was not reflected in their policy. We raised the lack of exclusion criteria as a concern, and the registered manager told us this would be created. Following our unannounced inspection, the management team sent us a copy of their new exclusion criteria. This included a variety of contraindications, which included, but were not limited to: bleeding abnormalities, those with hearing difficulties or who did not understand the languages spoken by staff, stroke, obesity, pregnancy or postpartum, patients on blood thinning medication and those with difficult airways.
- In addition, the admission policy referenced Scottish government requirements, despite being based in Watford, Hertfordshire, and said that patient's social security numbers were required, despite UK residents not having social security numbers.

Surgery

- Preoperative risk assessments were conducted for all patients. All patients were asked about their previous medical history and had blood tests: full blood count, coagulation (clotting) profile, and liver function tests. Patients of African-Caribbean descent were also tested for sickle cell anaemia (a condition that affects the red blood cells).
- Patients were asked during their preoperative assessment whether they had a history of VTE. However, VTE risk assessments were not completed for patients.
- A sepsis policy was in place. This is required by NICE guidance NG51. However, the guidance had clearly not been created for the service, but had been taken from other documents at other services. The policy referenced directorate managers and clinical directors, which the service did not employ. It also referenced paediatric patients, which the service did not operate on and national early warning system guidance, which had not been introduced to the service by the announced inspection. It stated training on sepsis had been given to nursing staff through clinical nurse educators, who were not employed, that it had been discussed at the service's patient safety briefing, which the service did not hold and that information was kept in the staff lanyards, which they did not wear. Therefore, the policy was of no value, as it detailed a process, which had not been set up within the clinic and would not give staff helpful information they could use if they were concerned about a patient developing sepsis.
- The service did not provide staff with training on the screening and application of sepsis protocols. Staff told us that in the event of a suspected case of sepsis they would dial 999.
- The World Health Organisation (WHO) 'Five Steps to Safer Surgery' checklists are surgical safety checklists that should be completed before and after surgery occurs, to reduce the risk of errors. The clinic had incorporated a safety checklist into their care pathway; however, this did not reflect all aspects of the WHO checklist. For example, the following checks were not incorporated; the introduction of the team, anticipated critical events (including blood loss, ASA grade and equipment concerns), and use of VTE prophylaxis. We raised this as a concern and the registered manager told us they would ensure all the necessary steps were included.
- We reviewed two patient records on our unannounced inspection, to assess whether the WHO checklist had been adapted and used appropriately. We saw that both patients' files had the updated version of the checklist, but one chart was not completed fully. We saw that the VTE prophylaxis and SSI bundle (to prevent surgical site infections) boxes had not been completed and were left blank. We raised this concern with the registered manager and were told that this had not been recorded as the patient was young and healthy. We explained that all patients require the full checklist to be completed, in order to reduce the risk of safety incidents.
- We were told on our announced inspection that patients with a past medical history of psychological or psychiatric problems, including body dysmorphia, would be sent for psychological assessment prior to surgery. This was not stated in any policy. However, on our unannounced inspection the registered manager told us of a patient who had a severe personality disorder, who had requested surgery several times. We were told that on these occasions they had requested a view from the patient's mother and GP before going ahead. We asked if this patient had been sent for a formal psychological assessment and we were told that this had been declined by the patient, however their mother and their GP were involved and the surgery did not proceed.
- At the time of our announced inspection, the service had not, where appropriate, implemented a nationally recognised process for identifying a deteriorating patient, with appropriate escalation responses, such as the national early warning system (NEWS). The observation charts used in recovery covered observations such as blood pressure, pulse, oxygen saturation (the amount of oxygen in the blood) and pain score. However, there was no scoring to identify if a patient had deteriorated. This did not comply with NICE guidance CG50. We raised this as a concern and were told that the service would implement NEWS immediately.
- During our unannounced inspection, we reviewed the records of two patients who had been operated on since our last inspection. We saw both patients had NEWS charts incorporated into their records and these had been mainly completed. However, the area for recording temperature was blank on both files. We also noted that although the NEWS chart had been introduced, there

was no guidance underpinning the chart. Nurses may have recorded that a patient had a high NEWS score, but there was no guidance on what that meant for the patient, how it should be escalated or how frequent observations needed to be. We raised this as a concern during our unannounced inspection and were told that guidance would be written.

- The service ensured there was access to consultant medical input the whole time a patient was in the clinic. The surgeon remained in the clinic until the patient was discharged. There was only ever one patient in the service at a time. As all patients were day-case and had local anaesthetic, most patients were discharged within 20 minutes from recovery.
- On discharge, patients were given the office telephone number in case of any concerns following discharge. This number was used as a helpline during office hours. Out of office hours patients were given their surgeon's mobile number to call, as a 24 hour emergency hotline. This was in line with Association of Anaesthetists of Great Britain and Ireland guidance. The surgeon also had NHS commitments, and told patients that if their call was not answered and they had concerns postoperatively, that they should contact either their GP or the local Accident and Emergency department, depending on the severity of their concerns.
- All patients received a courtesy call the day after surgery from one of the administrative team. If any concerns were raised during this call, they would be escalated to the surgeon.
- An in date transfer policy was in place at the time of our announced inspection. This had the contact details of a local taxi firm and the emergency services. The policy stated that the consultant would accompany the patient during the transfer. However, there was no service level agreement in place with the local NHS provider to accept transfers. The policy stated that staff should call 999. This was not in line with the Independent Healthcare Advisory Services guidance on critical care transfer for patients (2015) which states formal agreements should be in place with local NHS trusts. We raised this as a concern and the registered manager told us they would speak to the trust to arrange this. On our unannounced inspection we looked to see if any progress had been made on this. We saw that emails had been sent, and that the registered manager was waiting for a response.
- The service did not have a haemorrhage pack. Saline (sodium chloride in water) and compound sodium lactate (a mixture of sodium chloride, sodium lactate, potassium chloride and calcium chloride in water which is used to replace fluids and electrolytes in those with low blood volume or low blood pressure) was available in the event of a patient requiring fluid replacement.
- Patients were discharged once they had recovered appropriately from their procedure and anaesthesia. Patients were encouraged to bring an escort with them, to collect them following their procedure. However, this was not mandatory.

Nursing and support staffing

- The service did not use any staffing tools to ensure that they had sufficient staffing levels to meet patient acuity and dependency. However, on inspection we saw that staffing levels were sufficient, with each patient being attended to by a surgeon and a registered nurse.
- Three bank nurses were employed. Agency staff were not used.
- Two non-clinical staff were employed. These were the practice coordinator and a receptionist, who also completed general administrative tasks.
- There were no vacancies at the time of our inspection.
- There had been no turnover of staff during the reporting period of April 2016 to March 2017.

Medical staffing

- Medical staffing levels were appropriate for the procedures performed at the clinic. The registered manager was the only surgeon who performed operations at the time of our inspection. We were told there were plans to grant practising privileges to other surgeons in the coming months.
- Although an anaesthetist worked under practising privileges at the clinic, to run a separate pain management service, they were not usually present during cosmetic procedures. As all procedures were performed under local anaesthetic, this did not require the services of an anaesthetist.

- As all patients were either out patients or had there procedure done as a day-case, there were no handovers or shift changes. The consultant surgeon remained with the patient until discharge.

Emergency awareness and training

- Potential risks were not always taken into account when planning services. There was no major incident policy in place, to cover events such as flooding or loss of power, and there were no emergency generators in case of electricity failure.
- A fire policy was in place and the practice coordinator had received fire marshal training. We were told one fire drill had occurred recent to our inspection. Prior to this, a drill had not occurred since July 2015. The fire policy stated that fire drills would occur on a six monthly basis.

Are surgery services effective?

Evidence-based care and treatment

- The registered manager attended several international conferences per year, and told us they used the learning from these to develop the service. However, on questioning, the registered manager was unable to reference any specific National Institute for Health and Care Excellence (NICE) guidance that was relevant to the services provided.
- Patients did not always have their care planned in line with evidence-based guidance or standards. Examples of this included the failure to conduct venous thromboembolism risk assessments or not having an agreement in place for patient transfers with the local NHS acute hospital, as discussed above.
- Audits to check compliance with national standards were not completed as the registered manager told us they were unnecessary. Some local audits were completed; however, these were not thorough and did not have associated action plans.
- As there was no admission or exclusions criteria in place at the time of the announced inspection, it was possible that the decision making process on whether to admit a patient could have been discriminatory. This was because it was based on the clinician's personal view of the patient, as opposed to clinical criteria.
- The service did not use the Royal College of Surgeons' audit tool, which covered key aspects of the preoperative consultation stage.
- Policies were not always clear or thorough. Many appeared to have been copied from an external source and did not have relevance to this clinic. The record keeping policy stated that records would be kept for 'relevant periods of time' but did not define how long this would be.
- Technology and equipment was used to enhance the delivery of effective care and treatment. For example, the service used video calls to conduct consultations if the patient lived far away from the clinic.
- Patients were supported to be as fit as possible for surgery. For example, patients were advised to limit alcohol intake and patients who smoked were not admitted.
- Due to the relative infancy of the service, they had not submitted to the NICE shared learning database at the time of our inspection. There were no formalised plans in place to start this.

Pain relief

- Pain was managed well. Patients had surgery under local anaesthetic. No patients were given general anaesthetic or conscious sedation within the service at the time of our inspection. This was a plan for the future.
- All patients were given Co-Dydramol (a type of pain relief) to take home with them following their surgery. They were advised they could take up to eight tablets per day.
- Thorough audits into pain relief provision were not routinely conducted at the time of our inspection. We saw one audit rom April 2017. The outcome of this audit was 'there were discrepancies in documentation'. The audit paperwork did not explain what the discrepancies were, how many discrepancies were found or whether there were any themes. Therefore, the audit was of very limited value. The recommendations of the audit were to raise awareness of documenting pain scores and re-audit in six months' time. There was no assigned owner to ensure that the recommendations were completed or information on how awareness would be raised.

- We were told that no patients had complained about their pain management as of June 2017.
- The service did not participate in the Anaesthesia Clinical Services Accreditation scheme. Anaesthesia Clinical Services Accreditation is a voluntary scheme for NHS and independent sector organisations that offers quality improvement through peer review.

Nutrition and hydration

- Patients' nutrition and hydration needs were assessed and met. Patients were offered sandwiches and beverages following their procedure.
- Prior to surgery patients were asked when they last consumed food and drinks. They were advised to withhold food for six hours before surgery and clear fluids four hours before surgery. This was contrary to Royal College of Anaesthetists guidance which stated clear fluids could be given up two hours prior to surgery.
- Vomit bowls were available if patients felt nauseas following surgery. However, there was no prevention of nausea and vomiting protocol in place. There were no medications available if patients felt nauseas after surgery. The registered manager told us this had never happened.

Patient outcomes

- Information about the outcomes of people's care and treatment was not routinely collected and monitored. The service did not collect Q-PROMS (patient reported outcome measures) at the time of our inspection. Completion of PROMs, pre- and post-operatively, allows for a patient's own measurement of their health and health-related quality of life, and how this has been changed by the surgical intervention. PROMs are distinct from more general measures of satisfaction and experience, being procedure-specific, validated, and constructed to reduce bias effects. We were told by the management team that this was due to the infancy of the service.
- Patient satisfaction surveys were completed following consultations and procedures. These showed positive feedback from patients.
- The revision rate for the service (when patients want their procedure to be done again, due to being unhappy with the outcome) was 7%. This was worse than the national average of 5%. The registered manager was unaware of the national revision rate, and thought that their revision rate was below the national average.
- The service did not benchmark their outcomes to other services. Therefore, we were unable to see how they compared to similar services.
- The registered manager submitted a list of documents, which were described as audits. However, the audit cycle, in every case, had not been completed. An audit cycle identifies areas of non-compliance with standards and associated action plans are set up to improve performance. For example, the postoperative pain recording audit did not identify whether patients' pain scores were recorded postoperatively, and whether their pain needs were met, but instead commented that there had been no complaints received any about pain. An audit entitled; 'a review of procedures where systems have failed,' identified two incidents where concerns were raised. The reasons for these were found to be that staff lacked training in the protocols. However, the action taken was to create a spreadsheet, which did not appear to address the issue of staff training.
- At the time of our inspection, the registered manager had not set up an account with the Private Healthcare Information Network (PHIN), so data could be submitted in accordance with the legal requirements set by the Competition and Markets Authority (CMA). PHIN became a legal requirement in September 2016. The registered manager told us that this was not necessary as PHIN was only for hospitals with overnight stays. However, this was incorrect and the CMA has specifically stated that 'operators providing inpatient and day-case services will be required to provide patient episode data'.
- The service reported that there had been no readmissions to theatre. This meant that there had been no occasions where a patient began to recover, faced complications, and then required the surgeons to operate again.
- There were no unplanned readmissions within the reporting period of April 2016 to March 2017.

Competent staff

Surgery

- Staff did not always have the right qualifications, skills, knowledge and experience to do their job. Evidence of their qualifications and skills was not always clear from their employment files. We looked at the files for all seven staff who worked at the clinic. There were items missing from all but one of the electronic files. We found other information in paper files, so all information could not be easily seen. Only one of the files we saw had two references.
- Staff had evidence of mandatory training and their clinical qualifications necessary for their role. However, there were no equipment competencies for staff, to check that they were competent to operate the equipment in the theatre. We were told this was going to be rolled out shortly.
- The registered manager, who was also the surgeon, had basic life support training. No one in the clinic had current intermediate life support or advanced life support training.
- Not all staff had two written employment references on file. We were told the nurses did not have references as the registered manager knew them from other places of employment. However, this did not assure us that there were sufficient governance processes in place for recruitment of staff. Following us raising these concerns, the registered manager contacted the nurses requesting their references.
- At the time of our announced inspection the registered manager did not have a process in place for regularly checking the Nursing and Midwifery Council's (NMC) website to ensure that the nurses employed were not subject to any interim conditions or suspensions on their practice.. For example, in two cases, confirmation that nurses had an up to date NMC PIN number was not in place. This was repeated for the doctors' General Medical Council (GMC) registration. We checked these were current on the NMC and GMC websites during the inspection. There were no up to date Medical Defence Union (MDU) certificates in the doctors' electronic files. MDU certificates provide evidence doctors have professional medical indemnity insurance. These had to be found from an email inbox. This meant that prior to the inspection; the registered manager could not be assured that the nurses were on the NMC register and that they had no restrictions placed on their practice. We raised this as a concern and were told this would be checked annually going forward.
- Upon review of the employment files, we saw one nurse had no evidence of NMC registration on file. A back page of an NMC certificate was on file but it contained no evidence of their current registration as a nurse. This had not been identified prior to us during the inspection. We raised this as a concern and were told that the nurse had been requested to provide evidence of valid NMC registration. When we returned on our unannounced visit, we saw that the same nurse had provided outdated evidence of registering with the General Nursing Council (GNC). The GNC was replaced in 1983. We again raised this as a concern, and the registered manager told us they would obtain current registration documents. However, this meant that we were not assured that the process for checking registration documents was robust, as the registered manager had not realised that the GNC document was not evidence of NMC registration or that the GNC was replaced over 30 years ago. A second nurse's file showed that the NMC registration on file expired in 2015. There was no evidence that this had been updated. We raised this as a concern and the registered manager told us they would either request a new updated copy or stop employing that nurse on the bank basis, due to the limited shifts the nurse undertook.
- All staff had valid disclosure and barring service certificates.
- The registered manager, who was the only surgeon employed at the time of our inspection, underwent revalidation with the GMC between April 2016 and March 2017. Revalidation is the process by which all licensed doctors are required to demonstrate on a regular basis that they are up to date and fit to practise in their chosen field and able to provide a good level of care.
- The surgeon who held practising privileges for cosmetic surgery was on the GMC specialist register. Entry on the GMC specialist register is a requirement for any doctor who wishes to undertake a consultant post within the NHS.
- At the time of the inspection, the registered manager had not applied for certification with the Royal College

of Surgeons (RCS). The RCS cosmetic surgery certification scheme was developed in response to the 2013 Keogh Review, which highlighted an urgent need for the robust regulation of cosmetic practice. Certification is voluntary, but the RCS expect all eligible surgeons who carry out cosmetic surgery in the private sector to certify to demonstrate high professional and clinical standards in their area of practice.

- We were told that the nurses employed on a bank basis had their appraisals completed at their substantive post. There was no copy of these on their employment files. All staff should have appraisals conducted at all places of employment, and not rely on appraisals from other organisations. During our announced inspection, there was no evidence of an appraisal for the registered manager on his employment file. We raised this as a concern and staff obtained a copy of an appraisal from another private hospital he worked at.
- Administrative staff were provided extra training where necessary. For example, we saw two staff members had received chaperoning training so that they could chaperone patients when required. However, we saw no evidence that clinical staff were given any extra training.
- At the time of our inspection, the registered manager was the only surgeon who operated on patients. The registered manager told us that all nursing staff were subject to continuous clinical supervision by them. However, this was not nursing supervision.
- External first assistants or advanced scrub practitioners were not used within the service. External first assistants or advanced scrub practitioners are registered practitioners who provide assistance under the supervision of the surgeon.
- At the time of our inspection only the registered manager performed surgical procedures. Plans were in place to expand, and include other surgeons on practising privilege arrangements. We were told the process for granting and reviewing practising privileges would include checking the GMC register, their health status, references, appraisal and curriculum vitae and that this would be done every two years. During our inspection, we were told that there was no policy in place as yet to underpin this process. However, as part of our pre-inspection request for information the registered manager sent us a policy. This appeared to have been copied from another service, as it referenced dental practitioners, despite not offering cosmetic dentistry, and stated that practising privileges would be checked yearly.

Multidisciplinary working

- All necessary staff were involved in assessing, planning and delivering people's care and treatment. Treatment was surgeon-led and involved discussions with the nursing staff and administrative staff where required.
- The team worked well together, providing cohesive care to patients. There were positive working relationships between the administrative team and the clinical team.
- Patients were discharged from the service at an appropriate time, once their observations had returned to baseline. This was determined in conjunction with the nursing staff and surgeon.
- Relevant information was shared between the service and the patients' GPs. If patients consented, details of the surgery were sent to the patient's GP, in order to maintain a full chain of records.
- As outlined above in 'assessing and responding to risk', there were no service level agreements in place with the local NHS acute trust to accept transfers of deteriorating patients.

Access to information

- All the information needed to deliver effective care and treatment was available to relevant staff in a timely and accessible way. All records were electronic, with the exception of consent forms and contracts. Staff were familiar with the electronic system and were able to navigate it. All records were integrated and kept in one place.
- The administrative staff asked all patients for their consent to share information with their GP regarding the procedure. All patients who gave consent had GP letters sent, outlining both consultations and procedures. If patients declined to consent for the service to contact their GP, their details were still kept on the system, in case they needed to be contacted in an emergency. Patients who did not consent were given a copy of their discharge summary and advised to show it to their GP.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- The consent to care and treatment policy referenced the Mental Capacity Act 2005, however, failed to incorporate all aspects of the test for mental capacity. The policy did not mention the requirement for an impairment or disturbance of the functioning of the mind or brain (section 2 of the Act), which is the first test which must be completed before going onto assessing mental capacity.
- Staff understood the need for consent. A three-stage consent process was in place. Written information including the risks and benefits of the proposed procedure was sent to patients.
- These were then discussed during the consultation. Written consent was formally taken on the day of surgery. Patients signed the consent form for surgery and also consented to photographs and videography, where relevant. Consent was always taken by the surgeon.
- On all patient records we reviewed, we saw completed consent forms. At the time of our inspection, completion of consent forms was not audited.
- Patients were supported to make decisions by being given realistic expectations about the outcome of their surgery. The letters, sent to patients following their consultation, which discussed the risks and benefits were very thorough, to ensure that patients gave fully informed consent.
- The RCS Professional Standards for Cosmetic Surgery sets out the requirement for a two-week cooling off period, between deciding to have cosmetic surgery and the procedure taking place. We were told the two-week cooling off period was usually maintained, but that on occasions surgery had occurred within this period. We were told this was when the patient had a clear maturity and understanding of the procedure, and that they would sign additional disclaimers. However, we reviewed six files and saw two cases of surgery occurring within the two-week period. There was no evidence of an additional disclaimer on their files.
- We were told that they would not allow young adults to have treatment within the cooling off period. However, this process was not documented in any policy. The registered manager did not audit compliance with the two-week cooling off period and as such, was unable to tell us how many patients had been operated on within this period.
- We were assured that young people under 18 years old, did not have treatment at the clinic.
- There was a lack of awareness of how to undertake mental capacity assessments, in accordance with the Mental Capacity Act 2005. The registered manager told us that if they had concerns about a patient's ability to consent, they would contact their GP. However, they were not aware of the two-stage test for assessing mental capacity, as per the 2005 Act.
- The rights of people subject to the Mental Health Act were protected. Staff were aware of what to do, in the event that a patient had mental health concerns.

Are surgery services caring?

Compassionate care

- Staff understood and respected people's personal, cultural, social and religious needs, and took these into account. Staff took the time to interact with patients and gave them the opportunity to ask questions. We observed three postoperative consultations and saw that the surgeon spoke in a respectful and considerate manner to the patients.
- Staff were encouraging, sensitive and supportive to patients and their relatives. We observed this during our inspection and on review of patients' comment cards, which told us, that staff were understanding and sympathetic towards them. This was in line with National Health and Care Excellence (NICE) guideline QS15 Statement 1.
- Patients' privacy and dignity was always respected. Patients got changed or undressed behind curtains. Female chaperones were used and the registered manager would leave the room whilst the patient was dressing and undressing, to provide privacy. Consent was taken for photographs or videos to be taken of the patients before and after surgery. These were used to show prospective patients a patient's perspective on the surgery.

- Confidentiality was maintained in the service. Patients who called the service were not given any information until they had confirmed their name, date of birth and email address. Staff ensured all correspondence was sent through email, so that letters could not be opened by anyone other than the named recipient.
- We reviewed copies of patient satisfaction surveys. These were very positive, with the vast majority of patients stating that their care was excellent or very good.
- We also received 29 comment cards from patients. These were overwhelmingly positive with comments such as 'all staff were very helpful', '[staff] were very caring, very understanding, very kind' and 'staff were friendly and professional, provided great support and realistic expectations'.

Understanding and involvement of patients and those close to them

- Staff communicated with patients so that they understood their care, treatment and condition. Information was given in easy to understand formats. Time was given at the end of the postoperative consultations if the patient wanted to ask any further questions.
- Staff recognised when patients needed additional support. They encouraged relatives to stay during consultations if patients wanted this and during the preoperative stage if patients were feeling anxious.
- Patients were advised at the booking stage of all possible costs that would be incurred. This was also sent by email, so that patients were fully aware of the cost implications. If patients wanted revisions (when patients want their procedure to be done again, due to being dissatisfied with the outcome) the surgeon's fee was waived. However, all other associated clinic and treatment costs would be incurred.
- Free consultations were offered. This is not approved by the British Association of Aesthetic Plastic Surgeons' consumer safety guidelines, which states 'a proper consultation with a qualified surgeon will not be free'.
- Patients were told of all possible risks and benefits of the procedure they were proposing to undertake. Realistic expectations were set, so that they understood what the outcome would be. This was in line with NICE guidance QS15 Statement 5.

Emotional support

- Staff understood the impact that a person's care and treatment could have on their wellbeing. Staff were empathetic to patients who were anxious about their surgery and reassured them.
- Procedures would be deferred if staff were concerned about the patient's emotional state. The registered manager had links with a psychologist who they could refer patients to, if they had concerns about a patient's emotional state.
- Due to the types of anaesthesia and short recovery times, patients were empowered to be independent and manage their own health very quickly after the operation.

Are surgery services responsive?

Service planning and delivery to meet the needs of local people

- Information about the needs of the local population was used to inform how services were planned and delivered. Patients had provided feedback that they would like free Wi-Fi within the clinic, and as a result, this was provided. The procedures offered were in line with the skill set of the surgeon.
- The registered manager had attended bodybuilding competitions to discuss the increased demand for gynaecomastia (male breast reduction).
- The services provided reflected the needs of the population. The most common procedures were dimple creation, gynaecomastia and liposuction (fat removal). Procedures were available for men and women.
- Evening and weekend consultation appointments were offered to patients to provide flexibility and choice. Appointments were available on Saturdays and until 7pm on weekdays. Postoperative checks were completed by the operating surgeon. This provided continuity of care.

- The facilities and premises were appropriate for the services that were planned and delivered. There was a waiting area, two consultation rooms for cosmetic surgery appointments, one theatre and one recovery room. This was sufficient for the number of patients seen.

Access and flow

- Patients had timely access from initial consultation to procedure, and after care. From records we reviewed, we saw that most patients were operated on within one month. All patients undergoing cosmetic surgery were advised to wait a minimum of two weeks between consultation and procedure, as a 'cooling off' period. However, this was not always complied with.
- Consultations were available via video calls if patients were unable to travel to the clinic.
- One theatre session was scheduled per week, dependent on activity levels.
- An appointments system was in use. We spoke with the administration team who told us this was easy to navigate. Patients did not wait long for consultations, due to the flexibility of having face to face consultations or video call consultations.

Meeting people's individual needs

- Services were not always planned and delivered to take account of the needs of different people. An equalities policy was in place, which stated that discrimination should be avoided. There were no arrangements in place for translation. The registered manager told us they would use relatives for translation if needed. This is not in line with best practice as staff cannot be sure that the translation is accurate or that the patient understands and agrees with the information. When asked how the registered manager would be able to tell if a person who did not speak English was happy with having cosmetic surgery, we were told they would determine this through their body language.
- As there was no exclusion criteria in place at the announced inspection, there was nothing in place to say that people living with dementia or a learning disability would not be eligible for admission. We were told they had not come across this scenario. There were no arrangements in place to help communicate with people living with dementia or those with a learning disability. The new exclusion criteria that was sent to us following our unannounced inspection did not include patients living with dementia or a learning disability as being ineligible for admission. Arrangements for these patients should have been in place.
- Some reasonable adjustments had been made so that disabled patients could access and use services on an equal basis to others. All areas of the service were wheelchair accessible, including a lift and the toilet facilities. However, there was no hearing loop in place for patients with hearing loss.
- Arrangements were in place for ensuring psychiatric support where necessary. The registered manager had links with a psychologist, who they had referred patients to when they identified areas of psychological concern. However, there was no service level agreement in place with the local NHS mental health trust and the registered manager did not have their contact details if a referral needed to be made.
- We were told that discrimination, including on grounds of age, disability, gender, gender reassignment, pregnancy and maternity status, race, religion or belief and sexual orientation was avoided when making care and treatment decisions. An equality policy was in place. The policy was out of date, as it was due for review in August 2016. Some of the information in the policy was also incorrect and contained typing errors. For example, it stated that 'equal opportunities relates to treating people the same, although they may belong to difference (sic) groups or cultures'. This is not the correct definition of equal opportunities. Equality of opportunity is to allow people from all groups and cultures to have the same access to opportunities. Some groups of people may need to be treated differently (known as reasonable adjustments), in order for them to have equal opportunities with other groups.
- A significant proportion of the service's patients were of Middle Eastern descent and sometimes requested that only female staff were present during consultations or procedures. This was taken into account where possible. Staff took into account the Islamic festival of Ramadan and how that could affect patients who were fasting.
- As all patients were treated under local anaesthetic, people were mobile and independent soon after surgery.

Surgery

Learning from complaints and concerns

- Patients knew how to make a complaint or raise concerns. Information on how to make a complaint was displayed in the reception waiting area. This included details of how to raise concerns with CQC.
- The service received three reported complaints during the reporting period of April 2016 to March 2017. These were all regarding difficulties finding the clinic. We saw that they had all been responded to in a timely and courteous manner, explaining what the clinic was doing to improve signage, in conjunction with the local council. None of these complaints had been referred onto the Independent Healthcare Sector Complaints Adjudication Service (ISCAS). We were told that this was an ongoing concern and that the registered manager had been in discussions with the local council and building manager to request better signage.
- The registered manager managed clinical complaints. The provider information return (information sent in by the provider prior to inspection) stated that the practice coordinator and receptionist managed non-clinical complaints. However, on inspection these staff members told us they did not manage any complaints. The complaints policy did not have any information on who was responsible for managing complaints. The registered manager stated that all complaints would be acknowledged within 24 hours and concluded within six weeks. However, the policy stated that all complaints would be acknowledged within two days resolved within 20 working days.
- The complaints policy did not include any details on appealing complaint outcomes. There were no details for the CQC or ISCAS.
- Complaints were a standing agenda item during the weekly staff meetings. For the three sets of notes from the staff meetings we reviewed, there were no complaints to discuss.

Are surgery services well-led?

Leadership / culture of service related to this core service

- The registered manager led the service. Their background was in plastic/cosmetic surgery. They had previously managed other cosmetic surgery clinics. The registered manager was very visible. They were the only surgeon who operated at the time of our inspection. All staff we spoke with said they were approachable and accessible.
- The management team had not taken reasonable practicable action to ensure that all national standards had been adhered to. Examples included not conducting venous thromboembolism risk assessments, not using an early warning score system and not having compliant theatre ventilation systems. We raised these concerns during our inspection; however, before this, the management team were unaware of their non-compliance with these standards. Therefore, we were not assured the management team had knowledge of relevant national standards or that they had taken appropriate action to ensure care and treatment was delivered in line with national standards.
- All staff we spoke with told us there was an open culture within the service and that they enjoyed working there. Staff felt valued and respected and worked well together.
- Staff worked collaboratively and shared responsibility in delivering good quality care. All staff were aware of their role in the patient experience and were committed to ensuring patients had a positive experience.
- The service ensured that all marketing was honest and responsible and complied with guidance from the Committee on Advertising Practice. They did not offer any two-for-one deals to entice patients or offer any seasonal discounts.
- A system was in place to ensure people using the service were provided with a statement that included the terms and conditions. This was sent by email to all patients before the procedure took place.
- Staff reported that lone working occurred on occasions. Administrative staff told us they sometimes were alone in the clinic when patients arrived early for their appointments. A lone working policy was in place, however, this had not been written for the service, but had been taken from another provider. It referenced the role of the director of estates, which the service did not

employ, and trust buildings. This inferred that the document was an NHS trust policy, which had been used by the service, but had not been adapted so that it was fit for use.

Vision and strategy for this core service

- A vision was in place to expand the service to include providing conscious sedation and conducting NHS work, including hand surgery, skin and subcutaneous lesions. Staff were aware of the vision and explained that it was discussed at staff meetings.
- The values of the service were numerous, and included beauty, wellness, safety, healing and care. Staff were familiar with the values as they were displayed on the windows of the clinic. The values had been developed by all the staff. All staff members submitted potential values to the registered manager, and together through team meetings, they decided which key values they wanted to set.
- All procedures were coded in accordance with the Clinical Coding and Schedule Development Group (CCSD). CCSD coding aims to standardise coding across the independent healthcare sector and is used for insurance purposes. The coding system used was also in accordance with SNOMED_CT. SNOMED_CT is an electronic form of coding procedures. It ensures that information is consistent across health settings.
- A business plan was in place. This showed that the expansion of the service would be through making contact with local GPs and clinical commissioning groups, in order to gain a wider patient base. The plan also stated that work would begin on creating a specific website for the clinic. At the time of our inspection the website was a general website for the registered manager, and covered multiple locations. There were no dates for when the aims of the business plan would be completed, or any way of assessing progress against the plan.

Governance, risk management and quality measurement

- There was no governance framework in place at the time of our inspection. No clinical governance meetings were held. However, incidents and complaints were discussed generally during the weekly team meetings.
- Staff were clear about their roles and understood what they were accountable for. All procedures were surgeon led and the surgeon took overall responsibility for the patient.
- A risk register was in place. However, this was not a thorough document. Potential risks included on the risk register were generic, for example, hygiene, falls, fire hazards and accidents. None of these related specifically to the service. Under the heading 'who might be harmed and how' for falls it stated 'flooring is clean'. This did not relate to who could fall or how they might fall. Similarly, for the risk titled accident, the same sub-heading stated 'first aid kit available'. This did not relate to who might have an accident or how the accident occurred.
- The controls in place which were supposed to mitigate the risks did not reduce the risk. For example, the risk of hygiene had a control of 'sanitisers kept in easily accessible places'. However, on inspection we found two hand sanitising dispensers were empty. In addition, one risk titled 'bleach strong detergents' was blank for 'who might be harmed' and the control measures. There were no assigned risk owners and no dates for when the risks should be mitigated and removed.
- We were told the risk register was reviewed during the weekly team meetings. However, there was no evidence of this in the three meeting notes we reviewed. The risk register was not a standing agenda item and was not discussed.
- There was no alignment between the recorded risks on the risk register and what the registered manager told us was on their 'worry list'. The registered manager told us that they worried about the fact cosmetic surgery was an 'exposed' field of surgery, where social media was influential. Other risks and concerns were succession planning for the business and the fact that it was a standalone service, without specialist critical care support if a patient deteriorated. None of these risks identified by the registered manager were on the risk register. Moreover, despite the lack of available specialist support being mentioned as a high risk, there was no service level agreement in place with the local NHS hospital to mitigate this risk.
- Staff meeting notes were not circulated to all staff. The nurse we spoke with told us they had never received any

notes from meetings that they had not attended. This did not assure us that any learning from incidents or complaints would be circulated across the whole team, if they were not all present during the meetings.

- There was not a comprehensive assurance system in place to monitor and improve performance. There was a limited audit schedule in place, with audits not being carried out on the completion of records or Q-PROMS (patient reported outcome measures). The audits that were conducted were not thorough and the actions did not correspond with the concerns identified. This meant the registered manager could not be assured of the service's performance in these areas.
- All staff given practising privileges had professional indemnity insurance in place. This was checked when practising privileges were granted and renewed.
- The registered manager carried out the same types of procedures in their other private hospital employment. These types of cosmetic procedures were included in their annual appraisal.
- The registered manager performed all cosmetic surgery; this meant they had oversight of all the operations that were undertaken.

Public and staff engagement

- Patients' views and experiences were gathered through patient satisfaction questionnaires. Videos were also taken following their procedures, with patients giving their feedback on the procedure and their outcome. All patient feedback we saw was very positive.
- Staff feedback was obtained through the weekly team meetings. Staff had contributed ideas for the values of the service and felt pleased that their ideas had been taken on board.
- The registered manager and all staff understood the value of staff raising concerns. Administrative staff told us they could escalate any concerns to the registered manager. However, the opportunity for staff to raise concerns internally, for example about clinical practice were limited, as the clinic was so small. No staff raised any concerns to the inspection team.

Innovation, improvement and sustainability

- A diagram had been designed and was displayed in the consultation room, which helped patients to pose appropriately for preoperative and postoperative photographs. This ensured that they were in the right positions.
- There were no arrangements in place to encourage surgeons to apply for certification with the Royal College of Surgeons. Certification is voluntary, but the RCS expect all eligible surgeons who want to carry out cosmetic surgery in the private sector to certify so they can demonstrate high professional and clinical standards in their area of practice.

Outpatients and diagnostic imaging

Safe	
Effective	
Caring	
Responsive	
Well-led	

Are outpatients and diagnostic imaging services safe?

Incidents

- The recorded number of incidents was not broken down by the service into cosmetic surgery or outpatients, so we were unable to see if any incidents had occurred within outpatients.
- For our detailed findings on incidents, please see the safe section in the cosmetic surgery report.

Cleanliness, infection control and hygiene

- See information under this sub-heading in the cosmetic surgery section.

Environment and equipment

- The chronic pain management specialist used several pain relief techniques, including a low-level laser, in conjunction with acupuncture. At the time of our inspection, we were told the laser was out of use and was away from the clinic, being serviced.
- For our detailed findings on environment and equipment, please see the safe section in the cosmetic surgery report.

Medicines

- See information under this sub-heading in the cosmetic surgery section.

Records

- See information under this sub-heading in the cosmetic surgery section. When we returned on our unannounced visit, the registered manager did not have access to the chronic pain management outpatient notes.

Safeguarding

- See information under this sub-heading in the cosmetic surgery section.

Mandatory training

- See information under this sub-heading in the cosmetic surgery section.

Assessing and responding to patient risk

- Cosmetic surgery patients who had their surgery elsewhere and only had their preoperative and postoperative appointments at the clinic, had all risk assessments completed at the place of surgery.
- An adapted version of the World Health Organisation 'Five Steps to Safer Surgery' checklist was used within the chronic pain management service. We were unable to check the completion of this on the unannounced inspection as the anaesthetist was not present and the registered manager did not have access to the records.
- For our detailed findings on assessing and responding to patient risk, please see the safe section in the cosmetic surgery section.

Nursing staffing

- No nursing staff were used within the outpatient service.

Medical staffing

- A consultant anaesthetist led the chronic pain management service. There was no locum usage.
- As all patients were seen for outpatient consultations, there were no handovers or shift changes.

Emergency awareness and training

- See information under this sub-heading in the cosmetic surgery section.

Outpatients and diagnostic imaging

Are outpatients and diagnostic imaging services effective?

Evidence-based care and treatment

- The anaesthetist who led the chronic pain management service told us that they were aware of and worked within, National Institute for Health and Care Excellence (NICE) guidance.
- For our detailed findings on evidence-based care and treatment, please see the effective section in the cosmetic surgery report.

Pain relief

- A variety of pain relief strategies were employed within the chronic pain management service. These included steroid injections, laser acupuncture and plans were in place to expand to include yoga and meditation.

Nutrition and hydration

- Patients were offered drinks when waiting in reception for their appointment.

Patient outcomes

- Data was not officially collected on patient outcomes within the pain management service. However, the anaesthetist had observed that since the introduction of laser techniques, the number of injections that had been administered had decreased. This showed that the laser techniques were effective in reducing pain levels and therefore, the need for more interventional treatment.

Competent staff

- The consultant anaesthetist who led the chronic pain management service had undergone revalidation with the General Medical Council (GMC) between April 2016 and March 2017. Revalidation is the process by which all licensed doctors are required to demonstrate on a regular basis that they are up to date and fit to practise in their chosen field and able to provide a good level of care.
- The anaesthetist who led the chronic pain management service had extensive experience in advanced pain medicine. They worked as a consultant anaesthetist at a local NHS trust and for other private providers.
- For our detailed findings on competent staff, please see the effective section in the cosmetic surgery report.

Multidisciplinary working

- See information under this sub-heading in the cosmetic surgery report.

Access to information

- See information under this sub-heading in the cosmetic surgery report.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Consent was taken in a previous consultation for the pain management service, as opposed to on the day of treatment.
- For our detailed findings on consent, Mental Capacity Act and Deprivation of Liberty Safeguards, please see the effective section in the cosmetic surgery report.

Are outpatients and diagnostic imaging services caring?

Compassionate care

- During our inspection we were unable to meet with any patients from the pain management service. We did see some patients who were attending outpatient cosmetic surgery postoperative consultations. We also received 'share your experience' cards from patients who had attended outpatient appointments.
- See information under this sub-heading in the cosmetic surgery section.

Understanding and involvement of patients and those close to them

- See information under this sub-heading in the cosmetic surgery section.

Emotional support

- See information under this sub-heading in the cosmetic surgery section.

Outpatients and diagnostic imaging

Are outpatients and diagnostic imaging services responsive?

Service planning and delivery to meet the needs of local people

- The environment was appropriate for the services delivered. There was adequate seating, toilets and a water machine for patients waiting for their outpatient appointment.
- Car parking was available in a nearby payable car park.
- Information was provided to patients before appointments. This included details on how to get to the clinic, and where the nearest parking facilities were.
- The clinic was in the centre of Watford town centre. It was in close proximity to three train stations, one of which was the London Underground.

Access and flow

- Appointments were available on Wednesdays and Friday afternoons, due to the anaesthetist's other clinical commitments.
- For our detailed findings on access and flow, please see the responsive section in the cosmetic surgery report.

Meeting people's individual needs

- See information under this sub-heading in the cosmetic surgery section.

Learning from complaints and concerns

- See information under this sub-heading in the cosmetic surgery section.

Are outpatients and diagnostic imaging services well-led?

Leadership and culture of service

- The chronic pain management service was led by a consultant anaesthetist. The anaesthetist provided similar work in both NHS and other private facilities.
- For our detailed findings on leadership and culture, please see the well-led section in the cosmetic surgery report.

Vision and strategy

- There was a vision for the anaesthetist to work more closely with the registered manager in expanding the cosmetic surgery service, to include use of conscious sedation.
- There were also plans in place to start using alternative therapies within pain management, including yoga and meditation.
- For our detailed findings on vision on strategy, please see the responsive section in the cosmetic surgery report.

Governance, risk management and quality measurement

- See information under this sub-heading in the cosmetic surgery report.

Public and staff engagement

- See information under this sub-heading in the cosmetic surgery report.

Innovation, improvement and sustainability

- The anaesthetist was one of a limited number of providers who offered laser therapy. They noted that since the introduction of the laser therapy the number of steroid injections patients had required had decreased.

Outstanding practice and areas for improvement

Areas for improvement

Action the provider MUST take to improve

- The provider must ensure that all patients are risk assessed for venous thromboembolism.
- The provider must ensure that all sharps, including those disposed of, are stored securely.
- The provider must ensure that all staff adhere to infection prevention and control measures.
- The provider must ensure that a service level agreement is in place for the transfer of a deteriorating patient.
- The provider must ensure that all staff have the necessary equipment competencies.
- The provider must ensure that all equipment is safe and ready for use.
- The registered manager must ensure that data is submitted to the Private Healthcare Information Network.
- The provider must ensure that they have governance frameworks in place and adequate oversight of the service and their legal responsibilities for compliance.
- The provider must ensure that data on patient outcomes is collected.
- The provider must ensure that audits are completed appropriately, with robust action plans developed to mitigate any areas of non-compliance.
- The provider must ensure that all policies contain clear and relevant information on the processes staff should follow.
- The provider must ensure that all staff have evidence of appraisals, references and professional registration.

Action the provider SHOULD take to improve

- The provider should ensure that their observation charts and management of deteriorating patients is in line with NICE guidance CG50.
- The provider should ensure that all World Health Organisation 'Five Steps to Safer Surgery' checklists are completed appropriately.
- The provider should ensure that all incidents are identified and graded appropriately.
- The provider should ensure that there is a clear criteria of who is eligible for admission.
- The provider should ensure that processes are in place for reporting product failures to the Medicines and Healthcare Products Regulatory Agency.
- The provider should review their revision rate and assess how this can be improved upon.
- The provider should ensure arrangements are in place to care for patients living with dementia or a learning disability.
- The provider should ensure arrangements are in place for patients with hearing loss.
- The provider should ensure translation services are in place.
- The provider should ensure that a strategy is developed.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment How the regulation was not being met: Patients were not risk assessed for venous thromboembolism. There was no service level agreement in place for the transfer of a deteriorating patient. Sharps, which had been used of and disposed in outside clinical waste bins, were not stored securely. Staff were not adhering to infection prevention and control measures. Staff did not have the necessary equipment competencies. Not all equipment was safe and ready for use.

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance How the regulation was not being met: The registered manager did not have adequate oversight of the service and their legal responsibilities for compliance. There was no governance framework in place. Data on patient outcomes was not collected. Data was not submitted to the Private Healthcare Information Network. Audits were not completed appropriately. Action plans were not robust and did not mitigate areas of concern.

This section is primarily information for the provider

Requirement notices

Policies did not contain clear or relevant information on the processes staff should follow.

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 19 HSCA (RA) Regulations 2014 Fit and proper persons employed How the regulation was not being met: Not all staff had evidence of appraisals, employment references and professional registration.