

# London Medical Aesthetic Clinic - 1 Harley Street

## Quality Report

1 Harley Street

London

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

## Ratings

### Overall rating for this location

Are services safe?

Are services effective?

Are services caring?

Are services responsive?

Are services well-led?

# Summary of findings

## Letter from the Chief Inspector of Hospitals

London Medical Aesthetic Clinic - 1 Harley Street is operated by Medical And Aesthetic Clinic Limited. The service's main activity involves non-surgical cosmetic treatments which are not subject to regulation. We did not inspect these services. The clinic also provides pre and post-surgical care made up of pre and post-surgical consultations as well as post-operative follow up of patients. We inspected this part of the service as it is subject to regulation under the Health and Social Care Act 2008. Consultants do not perform surgery at this clinic. Consultants consulting with patients at London Medical Aesthetic Clinic - 1 Harley Street perform surgery at other clinics and hospitals which are not part of this service.

London Medical Aesthetic Clinic - 1 Harley Street offers outpatient services only and patients are self-paying. Patients access the service by contacting the clinic via its website, by telephoning the clinic to book appointments, or by walking into the clinic. The clinic does not provide services to patients under the age of 18. Between January 2016 and December 2016, there were 204 consultations for laser-assisted liposuction and for a cellulite reduction treatment by use of a laser. In the same period, there were 83 surgeries following consultation. There were 332 post-operative follow-up appointments.

We inspected this service using our comprehensive inspection methodology. We carried out the announced part of the inspection on 21 February 2017. We did not carry out an unannounced inspection.

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

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

### Services we do not rate

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

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

- Staff, excluding the consultants, had not had safeguarding training (adults or children). Following the inspection, staff were trained in adult safeguarding at level one. The minimum requirement is level two. Staff had still not been trained in children safeguarding.
- Furthermore, consultants were trained to level one in children safeguarding. The minimum requirement is level two. Following the inspection, the provider told us consultants were trained to level two in children safeguarding but did not provide evidence of this training.
- The safeguarding lead for the service was not trained to level four in line with good practice. Although following the inspection the provider told us the safeguarding lead was trained at level four, the provider did not provide evidence of this training.
- Staff had not had information governance training.
- Staff had not had training on the Mental Capacity Act 2005.
- Staff had limited understanding of the duty of candour.
- There were insufficient governance structures in relation to risk assessment, monitoring and mitigation.

# Summary of findings

- There were insufficient governance structures in relation to assessing, monitoring and improving the quality and safety of the services provided. For example, there were no regular audits within the service.
- The clinic's policies were out of date. All policies were dated 2008 to be reviewed in 2009 but there had been no reviews.
- There was no record of staff meetings.
- We did not find risk assessments in all four patient records we checked during the inspection.
- There was no evidence of patients having been given information about the two week cooling off period in two of the four records we checked during the inspection.
- The clinic did not have a risk register and relied on the risk register carried out by the landlord of the building who rented the premises to them.
- Patients who did not speak or understand English paid for the clinic's translation services. Staff also reported that patients attended with relatives to aid translation and this was not in line with good practice.

However, we found the following areas of good practice:

- Incident reporting was embedded in the culture of the service and there was evidence of learning from incidents.
- The environment was visibly clean and tidy.
- Patients could access care and treatment in a timely way and patients were given a choice regarding when to access treatment.
- Patients we spoke with during the inspection gave positive feedback about the service. Positive feedback was also reflected in the results of the patient survey of 2015.
- Patients were given information about how to complain.
- Staff said they were happy to work at the clinic and said they were respected and valued.

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. Details are at the end of the report.

Importantly, the service must take the following action to meet the regulations:

- The service must ensure that all staff are trained in safeguarding (adults and children) at a minimum of level two.
- The safeguarding lead must be trained to level four.
- The service must ensure that persons employed by the service in the provision of the regulated activity receive such appropriate training as is necessary to enable them to carry out the duties they are employed to perform including information governance and Mental Capacity Act 2005 training.
- The service must ensure effective governance arrangements including assessing, monitoring and mitigating any risks relating to the health, safety, and welfare of service users and others who may be at risk from the carrying out of the regulated activity.
- The service must ensure effective governance arrangements to enable the provider to assess, monitor, and improve the quality and safety of the services provided in the carrying out of the regulated activity. This must include but is not limited to a comprehensive audit programme to assess the quality of the service.

Additionally, the provider should take the following action to improve:

# Summary of findings

- The provider should ensure policies are reviewed regularly, are up to date, and reflect changes in national guidance and legislation.
- The service should keep a record of staff meetings including agenda items and matters discussed.
- The service should ensure risk assessments are carried out for all patients and findings documented in patients' records.
- The service should ensure that staff are trained on the duty of candour and that duty of candour is part of the clinic's serious incident policy.
- The service should have staff surveys as a way of engaging staff and obtaining their views on how services can be improved.
- The service should ensure there is access to disabled toilets and facilities for disabled patients.
- The service should include the reporting of near misses in their incident reporting policy.
- The service should ensure a range of personal protective equipment (PPE) is available in the clinic including protective aprons.
- The service should ensure all waste bins are labelled appropriately to reflect the nature of waste to be disposed of in individual bins.
- The service should conduct audits to measure the quality of the service. For example, audits related to infection prevention and control.

**Professor Edward Baker**  
**Deputy Chief Inspector of Hospitals**

# Summary of findings

## Our judgements about each of the main services

### Service

#### Surgery

### Rating Summary of each main service

Non-surgical cosmetic procedures were the main activity at the clinic. We do not regulate non-surgical cosmetic procedures and as such, we did not inspect that part of the service. We inspected the part of the service involving pre and post-operative consultations for surgical cosmetic procedures as well as medical advice given as this falls under our remit. No surgical procedures were carried out at this location. Following consultation, consultants performed surgery at other clinics and hospitals independent of this location. Therefore, we only inspected areas where consultations (including examinations) and post-operative follow up visits for surgical procedures took place and not the locations where consultants carried out surgery. Although we regulate surgical cosmetic procedures we do not currently have a legal duty to rate services providing this service.

# Summary of findings

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# Location name here

**Services we looked at:**

Surgery

# Summary of this inspection

## Background to London Medical Aesthetic Clinic - 1 Harley Street

London Medical Aesthetic Clinic - 1 Harley Street is operated by Medical And Aesthetic Clinic Limited. The clinic was opened in 2008 and is based in central London. London Medical Aesthetic Clinic - 1 Harley Street, provides non-surgical cosmetic treatments on a private basis to adults only. The clinic also provides pre and post-operative consultations for surgical cosmetic treatments and follow up care post-surgery. Surgery is carried out at other locations that are independent of this clinic. The Care Quality Commission (CQC) only regulates the surgical treatments provided (including pre and post-operative care), alongside any medical advice given.

The clinic offers services to patients living in the United Kingdom as well as internationally.

The clinic is located on the fourth floor. It consists of a waiting area, a reception area, a consultation room and an examination room. There are two clinical rooms in the clinic with one being used for the examination of patients coming in or consultations for cosmetic surgery.

The clinic has been inspected three times with the most recent inspection in December 2013. The service met all the standards inspected against at the time.

The registered manager has been in post since 2012.

## Our inspection team

The team that inspected the service was made up of a CQC lead inspector, one other CQC inspector, and a specialist consultant advisor with expertise in cosmetic surgery.

## How we carried out this inspection

We inspected this service using our comprehensive inspection methodology. We carried out the announced part of the inspection on 21 February 2017. We did not carry out an unannounced inspection.

We asked the service for some information prior to the inspection. We analysed that information in the planning stages of the inspection.

During the inspection we spoke with the registered manager for the service who is also the managing director of the service and the permanent consultant at the clinic, the practice manager, a clinical assistant, a laser therapist, and two patients who came in for consultations. We also reviewed four sets of patient records and eight employee files.

## Information about London Medical Aesthetic Clinic - 1 Harley Street

The clinic only provides outpatient appointments. It is registered to provide the following regulated activities:

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

The clinic's opening hours are 9am to 6pm Mondays to Fridays. The clinic is closed at the weekend.

During the inspection we spoke with the registered manager for the service who is the managing director of the service and the permanent consultant at the clinic, the practice manager, a clinical assistant, a laser therapist, and two patients who came in for consultations. We also reviewed four sets of patient records and eight employee files.



# Summary of this inspection

There were no ongoing special reviews or investigations of the clinic by the CQC at any time during the 12 months before this inspection. The service has been inspected three times, and the most recent inspection took place in December 2013, which found that the clinic met all standards of quality and safety it was inspected against.

## Activity (January 2016 - December 2016)

- There were 204 pre-operative consultations. Of the 204 consultations, 83 resulted in surgery. Surgeries carried out following consultation were laser-assisted liposuction and cellulite reduction by use of a laser, one breast augmentation procedure and one thigh lift procedure.
- There were 332-post operative follow-up appointments in the same period.
- In the reporting period January 2016 to December 2016, 20% of consultations carried out at the clinic were for surgical procedures. The other 80% were for non-surgical cosmetic surgery.
- All patients who attended the clinic for consultations were self-paying patients.

## Track record on safety

Between January 2016 and December 2016 there were:

- No never events.
- Two no harm incidents.
- No serious injuries.
- No incidences of hospital acquired Methicillin-resistant Staphylococcus aureus (MRSA).
- No incidences of hospital acquired Methicillin-sensitive staphylococcus aureus (MSSA).
- No incidences of hospital acquired Clostridium difficile (C.Diff).
- No incidences of hospital acquired Escherichia coli (E-Coli).
- One complaint.

## Services accredited by a national body

- None

## Services provided at the clinic under service level agreement

- Cleaning services.
- Building management.
- Maintenance of medical equipment.
- Collection of clinical waste.

# 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 but we highlight good practice and issues that service providers need to improve and take regulatory action as necessary.

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

- Staff, excluding consultants, had not had safeguarding training (adults or children). Following the inspection, staff were trained in adult safeguarding at level one. The minimum requirement is level two. Staff had still not been trained in children safeguarding.
- Consultants were trained to level one in children safeguarding. The minimum requirement is level two. Although following the inspection the provider told us consultants were trained to level two in children safeguarding the provider did not provide evidence of this training.
- The safeguarding lead was not trained to level four in line with best practice. Following the inspection the provider told us the safeguarding lead was trained to level four but did not provide evidence of this.
- Staff had not had information governance training.
- Staff had not had training on the Mental Capacity Act 2005.
- We looked at four patient records and there were no risk assessments documented within those records.

However, we found the following areas of good practice:

- Incident reporting was embedded in the culture of the service and there was evidence of learning from incidents.
- The environment was clean and tidy.

### Are services effective?

We do not currently have a legal duty to rate cosmetic surgery services but we highlight good practice and issues that service providers need to improve and take regulatory action as necessary.

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

- Policies were not comprehensive and were out of date.

# Summary of this inspection

- There was minimal reference to evidence based guidelines and legislation in the service's policies.
- There was also a lack of audits within the service. We saw one audit, which related to completion of patient records.

However, we found the following areas of good practice:

- There were effective working relationships between staff at the clinic and staff at the locations where surgeries took place.
- Consent had been sought and documented in all four patient records we looked at.

## Are services caring?

We do not currently have a legal duty to rate cosmetic surgery services but 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:

- Patients were treated with compassion, respect, kindness and dignity.
- Feedback from patients spoken with on the day was positive. There was further positive feedback seen in the results of the patient survey carried out in 2015.

## Are services responsive?

We do not currently have a legal duty to rate cosmetic surgery services but 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:

- Services were planned to meet the needs and choices of patients, and the arrangements for treatment were prompt.
- There were arrangements to ensure the individual needs of patients were fully assessed, considered, and were met wherever possible.
- The service responded to feedback from patients and made improvements to the service.

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

- Patient and information leaflets were only available in English.

## Are services well-led?

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

# Summary of this inspection

- Governance arrangements were not established or operated effectively to ensure that quality, performance and risks were understood and managed in this service. These were a lack of a risk register to formally and effectively manage risks within the service, a lack of a clear training programme for staff which went beyond reading policies, and a lack of comprehensive policies which referenced current best practice guidance and applicable legislation and a comprehensive audit programme to assess the quality of the service.
- We also found that risks we identified as a result of this inspection had not been identified by the service. For example, lack of safeguarding training for staff, lack of Mental Capacity Act training for staff and relatives interpreting for patients.

However, we found the following areas of good practice:

- The managing director of the service was a well-established leader, who had a good working relationship with staff.
- There was a clear vision for the service and a strategy to achieve this vision. We found that staff understood the vision and values of the service and what was expected of them.
- Staff felt valued and respected and patients and staff were encouraged to feedback on the quality of services.

# Surgery

Safe

Effective

Caring

Responsive

Well-led

## Summary of findings

We do not currently have a legal duty to rate cosmetic surgery services but we highlight good practice and issues that service providers need to improve.

Our key findings were:

- Staff, excluding the consultants, had not had safeguarding training (adults or children). Following the inspection, staff were trained in adult safeguarding at level one. The minimum requirement is level two. Staff had still not been trained in children safeguarding.
- Consultants were trained to level one in children safeguarding. The minimum requirement is level two. Although following the inspection the provider told us consultants were trained to level two in children safeguarding the provider did not provide evidence of this training.
- The safeguarding lead had not been trained to level four. Following the inspection the provider told us the safeguarding lead had been trained to level four but did not provide evidence of this.
- Staff had not had information governance training.
- Staff had not had training on the Mental Capacity Act 2005.
- There were insufficient governance structures in relation to risk assessment, monitoring and mitigation.
- There were insufficient governance structures in relation to assessing, monitoring and improving the quality and safety of the services provided. For example, there were no regular audits within the service.

- Staff had limited understanding of the duty of candour.
- The clinic's policies were out of date. All policies were dated 2008 to be reviewed in 2009 but there had been no reviews.
- There was no record of staff meetings.
- We did not find risk assessments in all four patient records we checked during the inspection.
- There was no evidence of patients having been given information about the two week cooling off period in two of the four records we checked during the inspection.
- The clinic did not have a risk register and relied on the risk register carried out by the landlord of the building who rented the premises to them.
- Patients who did not speak or understand English paid for the clinic's translation services. Staff also reported that patients attended with relatives to aid translation and this was not in line with good practice.

However, we found the following areas of good practice:

- Incident reporting was embedded in the culture of the service and there was evidence of learning from incidents.
- The environment was visibly clean and tidy.
- Patients could access care and treatment in a timely way and patients were given a choice regarding when to access treatment.

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- Patients we spoke with during the inspection gave positive feedback about the service. Positive feedback was also reflected in the results of the patient survey of 2015.
- Patients were given information about how to complain.
- Staff said they were happy to work at the clinic and said they were respected and valued.

## Are surgery services safe?

### Incidents

- Between January 2016 and December 2016 there were two incidents reported by the clinic. Both incidents were of no harm. One incident related to a patient who had been left at the building's main reception downstairs as the building's reception staff failed to notify the clinic upon the patient's arrival. The other incident related to the building's lift being out of order.
- Staff were aware of how to report incidents. Staff recorded incidents in an "accident book". The medical director investigated all incidents.
- There was evidence of learning from incidents. For example, following the incident where a patient waited downstairs, the clinic requested that staff for the main building reception make the clinic aware of any patients signing in to come to the clinic.
- The clinic had not reported any 'never events' between January 2016 and December 2016. Never events are serious patient safety incidents that are wholly preventable and should not happen if healthcare providers follow national guidance on how to prevent them. Each never event incident type has the potential to cause serious patient harm or death and must be reported to the Care Quality Commission as a serious incident even if it did not result in harm to the patient. Any never event indicates a failure in measures to keep people safe from harm.
- The clinic had a policy on incident reporting which set out how staff should record incidents and who they should report them to. However, the policy did not mention whether staff should be recording near misses. We also found that the policy was out of date.
- The duty of candour is a regulatory duty that relates to openness and transparency, and requires providers of health and social care services to notify patients (or other relevant persons) of certain 'notifiable safety incidents' and provide reasonable support to that person. This means providers must be open and honest with service users and other 'relevant persons' (people acting lawfully on behalf of service users) when things go wrong with care and treatment, giving them reasonable support, truthful information and a written

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apology. Staff we spoke with had minimal knowledge of this duty and were not able to explain what it was. Staff had not had training on duty of candour and the service did not have a serious incident policy.

## Cleanliness, infection control and hygiene

- Surgical procedures are not carried out at this location. We therefore only inspected the waiting room, the main reception, the consulting room, and the examination room. We found all areas were visibly clean, tidy, and free from dust.
- Cleaning was outsourced to the company who owned the building. This company cleaned the clinic every day. Deep cleaning of the carpets in the clinic was carried out once a week.
- The clinic had a hygiene policy, which covered general cleaning, hygiene and waste handling and disposal. There was a separate hand hygiene policy, which covered the use of alcohol gel and hand hygiene before and after patient contact.
- An external company collected the clinic's clinical waste once a month under a service level agreement. Staff told us they could request collection more frequently if required. Staff told us they had minimal waste at the clinic because no surgery took place there. Clinical waste tended to be swabs and needles used for non-surgical procedures which we do not regulate. No dressings were placed or removed at the clinic and hence clinical waste was minimal.
- Sharps bins were signed and dated and were not overfull. An external company collected sharps bins for disposal once a month or more than once upon request.
- There was appropriate storage of cleaning materials such as mops within the clinic. Hand gel and paper towels were available in the toilet and consulting room. Personal protective equipment (PPE) such as gloves was available in the clinic. However, we did not see any protective aprons.
- The large consulting room had no clinical waste bin. There was a yellow bin, which did not say what sort of waste would go in it.
- There had been no hand hygiene or any other infection control audits between January 2016 and December 2016.

## Environment and equipment

- The clinic occupies one floor and is situated on the fourth floor of the building. It is accessible by stairs and a lift.
- The clinic had a waiting room, a reception area with more waiting space, a consultation room and two examination rooms, and a toilet. Only one of the examination rooms is used for examinations arising from pre or post-surgical procedures.
- There are no theatres and no surgical procedures are carried out at the clinic. Equipment used for procedures such as the laser-assisted liposuction was not kept at this location. We did not inspect any equipment used in the actual surgical procedures because it was located at the clinics or hospitals where surgery took place.
- The environment in which patients received their consultations and examinations was suitably arranged for that purpose.
- The clinic had an emergency basic life support equipment box, a defibrillator, emergency resuscitation equipment and oxygen. Staff had been trained on the use of this equipment.
- A fire extinguisher was available in the clinic and there was evidence of servicing.
- Medical equipment was serviced by an external company and we saw evidence of this. An external company was responsible for repairs and electronics within the clinic. However, the clinic conducted its own portable appliance testing.

## Medicines

- The service did not administer medicines to patients attending the clinic pre or post operatively. No controlled drugs were kept at the clinic. The only medicines kept at the clinic were emergency medicines, which we found were stored appropriately and securely. The managing director who is a consultant was the only person allowed to routinely administer emergency medicines. The two consultants with practising privileges could also administer emergency medicines in the event of an emergency.
- Medicines required by patients immediately following surgery were prescribed and administered at the locations where surgery took place. If there was need for

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a patient to have medicines prescribed at the post-operative follow up, the consultant could prescribe medicines to be collected by the patient from pharmacy. The clinic had a policy on the prescribing of medicines. However, this policy was out of date. It was dated 2008 to be reviewed in 2009 but had not been reviewed.

- Oxygen cylinders were secured and stored correctly within the clinic.
- All medicine storage units were lockable to prevent unauthorised access.

## Records

- Patient records were kept in paper form as well as electronically. Paper records were scanned onto the electronic system so that information was held centrally. Visiting consultants' consultation notes were scanned onto the electronic system.
- Information held electronically included patient details, appointment times and dates, brief description of appointment, and details of patient follow up.
- Staff at London Medical Aesthetic Clinic sent pre-operative assessments to the clinics or hospitals where surgery took place before the procedure. There was liaison between staff at the clinic and the booking managers at the locations where surgeries took place.
- We looked at four patient records for patients who had consultations for surgical procedures at the clinic. Records were legible, dated and signed. There was evidence staff gave patients detailed information about the procedures and about surgery. The records identified the location where the surgery would take place.
- Patient medical history was documented in the records. In two of the four records we saw, it was clear that patients had been given information about the cooling off period of two weeks but in the other two records, this information was not there.
- In all four records, patients' consent had been sought and recorded.
- In February 2017, the service carried out an audit of 15 clinical records. The files related to both surgical and non-surgical procedures. The result of the audit was 100% compliance in all the sections audited which

included legibility, dating, signing and completeness of records. There was also 100% compliance for obtaining consent, completing medical history and client involvement.

- Payment options were discussed with patients and documented in the patient records.

## Safeguarding

- The managing director was the safeguarding lead for the clinic. He was trained up to level one in children safeguarding and up to level two in adult safeguarding. The two consultants with practising privileges were also trained up to level one in children safeguarding and up to level two in adult safeguarding. Training had been completed by the three consultants as part of their training with the National Health Service (NHS). The Intercollegiate Document for Healthcare Staff (2014) states that all non-clinical and clinical staff who have any contact with children, young people and/or parents/carers should have children safeguarding at level two. The safeguarding provision for children safeguarding was not being met in relation to all consultants at this clinic. Furthermore, the safeguarding lead must be trained to level four safeguarding.
- Following the inspection, the managing director told us consultants were trained in children safeguarding at level two. The managing director also told us the safeguarding lead was trained at level four but this was not consistent with what we were told on inspection. The provider did not provide evidence of safeguarding training for consultants at level two for children safeguarding or for level four training for the safeguarding lead. Without evidence of consultants' training in safeguarding the provider cannot be assured that staff have the appropriate level of safeguarding training. Furthermore, as we did not see evidence to substantiate what we were told following the inspection we are not assured that consultants had safeguarding training at the appropriate level or that the safeguarding lead was trained to level four.
- Apart from the consultants referred to above, staff at the clinic had not been trained in adult or children safeguarding. Staff told us they had read the clinic's policies on protecting vulnerable adults and child protection procedures and signed that they had done so. They also told us the managing director had gone



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through the policies with them to check their understanding of the policies. However, it was not sufficient that they had merely read the service's safeguarding policies. Staff told us it was the clinic's policy not to allow children under the age of 18 into the clinic but they acknowledged that it was possible that adults attending appointments could bring children into the clinic. Staff should therefore have been trained in children safeguarding (at level two) in addition to adult safeguarding. Following the inspection the provider provided evidence that staff had been trained up to level one in adult safeguarding. The minimum requirement is level two. The safeguarding provision was therefore not being met in relation to three non-medical staff employed by the clinic at the time of the inspection and following the inspection.

- The clinic had policies on adult and children safeguarding. These were the Policy for Protection of Vulnerable Adults and Child Protection Procedures policy. The policies did not refer to any guidance or legislation relating to safeguarding. For example, the clinic's policy for child safeguarding did not refer to the Safeguarding Children and Young People: Roles and Competencies for Health Care Staff (March 2014) document or the HM working together to safeguard children: A guide to inter-agency working to safeguard and promote the welfare of children document of March 2015. In addition, none of the clinic's safeguarding policies included information on female genital mutilation or domestic violence as something staff should have been aware of.
- We found that the clinic's safeguarding policies were out of date. They had been produced in 2008 and were due to be reviewed in 2009 but there had been no review. There was therefore no assurance that policies upon which the clinic staff relied on had sufficient or up to date information to allow them to effectively protect patients from abuse and improper treatment.
- We found that staff had a limited understanding of safeguarding. For example, some staff thought it meant protecting patient confidentiality.
- During the inspection, staff told us that 98% of non-English speaking patients came with their relatives to translate for them. The use of relatives to interpret for patients was not in line with best practice and potentially put patients at risk. Following the inspection,

we asked the service for data relating to the numbers of patients who had relatives translate for them between November 2016 and February 2017. The consultant at the clinic told us there had been none. This was not consistent with information staff told us during the inspection.

- The service did not raise any safeguarding concerns in the 12 months prior to our inspection and there had not been any safeguarding matters reported to the commission during the year up to our inspection visit.

## **Mandatory training**

- The clinic did not have a formal programme of mandatory training. Staff told us they read the clinic's policies and signed to indicate they had read them. They also told us the managing director went through the policies with them and they could ask questions. The clinic's policies included health and safety, records management, recording of accidents, resuscitation, consent, dignity, care, and protection of patients and fire risk management.
- Staff had not received training in information governance. This meant that the clinic did not follow the requirements of the information governance toolkit for qualified providers. There had been no annual information governance training or assessment and monitoring of staff training needs for adequacy in line with the requirements of this toolkit. It was not sufficient that staff had read the clinic's policies on records and information management.

## **Assessing and responding to patient risk (pre and post-operative care)**

- The clinic offered routine pre and post-operative consultations and post-operative follow up appointments. During the consultation, consultants discussed the surgical procedure and assessed the patient's risk using the information completed by the patient on the form given to them prior to the consultation. The managing director told us there was a strict policy on which patients would receive surgery following consultations. He told us patients would not proceed to surgery if they were not fit and healthy, for example, some patients would be expected to reach a certain weight before surgery could be considered. Patients were required to complete a pre-operative questionnaire, used as part of a pre-operative screening

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tool detailing medical history, whether patients were on any medication, any information on allergies and whether they could be pregnant. The managing director told us staff at the locations where surgery took place further assessed patient risk as per their policies at those locations.

- We looked at four records during our inspection and did not see any risk assessments in all four records.
- The pre surgery cosmetic procedures screening tool required the patient to complete a list of questions about how they felt about their physical appearance. The consultant could then carry out a psychological assessment based on the patient's responses. In addition, pre surgical checklists and patient intake forms completed at the clinic asked for information about whether a patient was suffering from depression. This meant that the clinic could make attempts to identify psychologically vulnerable patients in line with the recommendations by the Royal College of Surgeons professional standards for cosmetic surgery, published in April 2016.
- There were formal arrangements with two private clinics and an NHS trust in case patients had complications following surgery. The managing director told us if a patient had complications requiring readmission, he could examine patients at the clinic where he performed surgery. There was an arrangement that the clinic could be opened until midnight to allow him to examine patients. After midnight, patients who had complications could be admitted to a local NHS trust. The managing director did not have practising privileges there but had an agreement with another consultant who had practising privileges at this NHS hospital. The managing director could visit and advise professionals there as the consultant who performed the surgery. While the clinic had agreements and arrangements in place for emergency transfers with a local acute NHS hospital and also non-emergency transfers with a local independent clinic there had been no emergency readmissions or transfers to an NHS hospital in the 12 months preceding our inspection and those arrangements had not been utilised.
- The clinic wrote to the patients' general practitioners if the patients consented to it. The letter would detail what procedure the patient had undergone done and the outcome.

- Consultants saw patients following surgery. The managing director told us they saw patients a day or two following surgery depending on how quickly they recovered. An appointment was booked at the London Medical Aesthetic following surgery then weekly, monthly, three monthly and in some cases six monthly. During these appointments, consultants took measurements in order to assess any risk and monitor results of the surgery.

## **Nursing and support staffing**

- The clinic did not have any nursing staff. The clinic had a practice manager, a clinic assistant and a laser therapist. The laser therapist was involved in non-surgical cosmetic treatments which we do not regulate but also assisted in pre and post-operative consultations and follow-ups for surgical procedures falling under our regulation. We interviewed the laser therapist only in relation to procedures we regulate.
- There was no use of bank or agency staff.
- Three staff members left the clinic between January 2016 and December 2016.

## **Medical staffing**

- The managing director who is also the registered manager was employed by the clinic as a part time but permanent consultant. He was an ear, nose, and throat (ENT) surgeon. He worked for the clinic four days a week, including the days he performed surgery for the clinic but at another location. The managing director had practising privileges at the clinic where he performed surgery.
- Two other consultants worked at London Medical and Aesthetic Clinic under practising privileges. Both consultants were plastic surgeons. They were required to maintain current practising privileges in line with the clinic's practising privileges policy to be eligible to work on site. We did not speak to them during this inspection, as they were unavailable.
- One of the two consultants had not completed an episode of care at the clinic between January 2016 and December 2016, which may mean they could be unfamiliar with the clinic practices when they next arrived. The managing director told us practising privileges were reviewed every two years and that

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consultants were kept updated about changes in practice at the clinic by email or in person. The other consultant carried out ten consultations for surgery and two surgeries during this period.

- Consultants who consulted with patients at the clinic were clinically responsible for these patients during and after surgery. They also reviewed their care following surgery. The number of follow up consultations would depend on the procedure. For laser assisted liposuction, a consultant told us they would arrange follow up consultations a day or two after the procedure and at one week, one month, three months, six months, nine months and sometimes one year. However, patients did not tend to come for follow-ups after six months.

## Emergency awareness and training

- The hospital had a fire risk management policy and procedures document, which set out staff responsibilities to minimise the risk of a fire and the required actions to minimise risk of injury to patients or staff in the event of a fire.
- All fire extinguishers we saw at the building had up to date service checks.

## Are surgery services effective?

### Evidence-based care and treatment

- The clinic's policies made minimal reference to current guidance and legislation. For example, the clinic's policy on consent did not reference the Mental Capacity Act 2005. The clinic's policies had not been reviewed since 2008, which meant that any relevant changes in the law or in guidance since 2008 were not reflected in these policies.
- There had been one audit carried out between January 2016 and December 2016, which related to record completion. There had been no other audits within the service.

### Pain relief

- The clinic did not routinely administer medicines to patients attending the clinic for pre and post-operative consultations. If patients required pain relief, consultants could prescribe pain relief medicines to be obtained by the patient from a pharmacy.

### Nutrition and hydration

- The clinic followed the Association of Anaesthetists of Great Britain and Ireland (AAGBI) guidelines for directing fasting periods prior to surgery.
- There was clean drinking water provided for patients in the clinic.

### Patient outcomes

- The clinic did not submit data to the Private Healthcare Information Network (PHIN). The managing director told us data was submitted by the clinics and hospitals where surgery was performed.
- The managing director reported that 85% of patients were happy with their treatment in the 12 months preceding the inspection. This number included patients satisfied with treatments that do not fall under our regulation.

### Competent Staff

- The managing director was appraised and supervised by the National Health Service (NHS) trust he worked for once a week. Two consultants working at London Medical and Aesthetic Clinic were required to maintain current practising privileges in line with the clinic's practising privileges policy. This policy ensured consultants took responsibility for maintaining their own clinical competence. The policy stated that consultants were responsible for their continued professional development. Consultants were also required to have adequate professional insurance to practice, show evidence of annual appraisal by their NHS trusts and General Medical Council (GMC) revalidation. To ensure this was the case the clinic reviewed practising privileges every two years and kept evidence of how they met the requirements in the staff files.
- The service kept appraisal folders for the two consultants with practising privileges. We saw folders containing their qualifications and expertise, completed appraisal forms, and continued professional development activity.
- Non-medical staff had their appraisal and supervision carried out by the managing director. Staff told us they

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had had their appraisal and supervision. Staff files contained evidence of supervision and appraisal as well as certificates showing the courses staff had undertaken to make sure they were competent in their roles.

- Staff told us they had training opportunities to aid career progression. Some staff reported that the managing director had paid for them to attend some courses. Staff also told us they were given opportunities to shadow the managing director as a way of developing learning.

## Multidisciplinary working

- Staff at the clinic liaised with staff at the clinics and hospitals where surgery took place.
- There were discussions about what time theatres were free to allow staff at the clinic to schedule surgery. This was only in relation to the consultant employed permanently by the clinic. The consultants with practising privileges arranged booking for theatres themselves but copied the practice manager at the clinic into the correspondence.
- There was joint working in relation to making sure that staff at the clinic or hospital where surgery was performed had all the documents needed for the surgery for example, the pre-operative questionnaire completed by patients and returned to the clinic.
- There were arrangements with other local NHS and private hospitals in case patients had complications following surgery. Patients could be readmitted there.
- The clinic wrote to patients' GPs if patients consented to it. The letter would detail what procedure the patient had undergone and the outcome.

## Access to information

- Patient records were a mixture of paper and electronic records. Paper records were scanned into the electronic record each week so that full information could be held.
- Staff at the clinic could access policies, which were kept in a folder located in the reception area.
- Consultants had access to patients' records during surgery. Pre-operative assessments completed by

patients and sent to the London Medical Aesthetic Clinic were sent to the booking manager at the hospital where surgery would take place by staff at the clinic prior to surgery.

- Records at the clinic were in paper and electronic forms. Information contained electronically included patient details, appointment times and dates, brief description of appointments, treatment or follow up.

## Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- At the initial consultation, consultants explained the surgical procedure to be undertaken and patients were given a copy of the consent form for this procedure. There was no requirement for it to be signed at the time of the consultation. Staff told us the consent form was given to patients at this stage for their information and to help them make the decision about whether to have the procedure. The patient's capacity to consent to care and treatment was assessed during the pre-operative consultation. The service's policy was to give patients a cooling off period (time given to the patient to consider whether they wanted to proceed with the surgery) of two weeks. After the cooling off period, the clinic sent patients a pre-operative questionnaire, directions to the clinic where surgery would take place, pre, and post procedure guidelines.
- There was an option for patients to waive this cooling off period and to do this they had to complete a patient waiver form that would need to be discussed and agreed with the surgeon.
- Staff told us the patient signed the consent form for the procedure on the morning of the procedure at the clinic where surgery was performed.
- The service carried out an audit of 15 patient records in February 2017 and it had included an audit of completion of consent paperwork. Consent had been recorded in 100% of records.
- We looked at four sets of patient records during our inspection and found that consent had been sought and fully completed in all of them.

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- The clinic had a consent policy but the policy was not up to date. It was dated 2008 to be reviewed in 2009. Patients' capacity was assessed in the pre assessment questionnaire and the pre surgery cosmetic procedures screening questionnaire.
- While the clinic had a policy on consent, there was no formal training on the Mental Capacity Act (2005) (MCA). Staff were knowledgeable about the consent process for obtaining the patient's consent for the surgical procedure however, knowledge of MCA principles such as lack of capacity and best interest decision was limited.
- Between January 2016 and December 2016, no patients lacking capacity had been seen in the clinic.

## Are surgery services caring?

### Compassionate care

- We spoke with two patients during the inspection. Both patients reported staff at the clinic treated them with dignity, compassion and respect.
- We observed interactions between staff and patients and observed staff being compassionate, empathetic and respectful.
- Staff told us they reassured patients at every stage of treatment at the clinic.
- Private rooms were used for consultations and examinations of patients and this meant that patient's privacy and dignity was maintained.
- The clinic had a Dignity, Care and Protection of Patients policy, which reminded staff to respect the privacy, and dignity of patients at all times. The clinic also had a chaperone policy, which described the role of the chaperone as including providing emotional comfort and reassurance to patients. All patients were made aware of their right to have a chaperone present during any consultations.
- We observed all staff introducing themselves to patients as they met them at each stage.

### Understanding and involvement of patients and those close to them

- Staff including the practice manager gave patients information on non-clinical matters such as appointments and costs. Payments for the consultation were taken on the day of the consultation. Staff told us no payments were taken prior to consultation. Staff gave prospective patients a price range for the procedure being sought if the patient enquired over the telephone. Further cost information was given on the day of the consultation.
- The managing director told us he spoke with patients during consultations and made them aware of what to expect from surgery. In the consultations, patients were given an opportunity to ask questions about procedures and about surgery.

### Emotional support

- Patients told us they were supported emotionally by staff at the clinic. The managing director told us any patient concerns and anxieties were addressed prior to surgery.

## Are surgery services responsive?

### Service planning and delivery to meet the needs of local people

- The clinic provided services to patients from across the United Kingdom as well as to international patients. Services were planned to cater for different patients groups.
- Services ensured flexibility. The clinic's appointment system was flexible and was able to offer an array of appointment times and days to suit the needs of the patient.
- Services were planned to ensure continuity of care. The same consultant who consulted with the patient performed surgery and followed the patient up post-surgery.

### Access and flow

- Patients accessed the clinic's services by contacting the clinic via their website, by making telephone enquiries and arranging an appointment or by walking into the clinic. A pre-operative consultation was arranged by

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staff. Following this appointment, subsequent consultations could be offered or the surgery was booked to take place at the different locations, as there were no theatres at the clinic.

- Patients were offered a choice of appointment time according to their needs and availability. However, the clinic did not open at weekends.
- Staff regularly updated patients if a consultant was running late and how long they may have to wait.
- Staff reported that the wait between consultation and surgery was two weeks and this was the two week cooling off period required by national guidance. Patients could waive the cooling off period and access surgery sooner than two weeks following consultation.
- All patients seen were seen on an outpatient day case basis.
- It was the responsibility of staff at the operating hospital to provide patients with discharge information which included phone numbers that they could use to contact the clinic after their operation. The consultations at London Medical and Aesthetic Clinic were responsible for their own patients and were contactable over the phone.
- All patients were contacted within 24 hours of their surgery to review how they were recovering. Patients would then be reviewed in a follow up appointment which was arranged as soon as possible following the procedure.
- Patients could contact the operating consultant outside of normal working hours. For example, the managing director told us he gave all his patients his contact card, which meant patients could contact him directly. He also told us he telephoned patients on the same day following the procedure to speak to them about how they felt.
- Staff told us the clinic had not cancelled any patient consultations or surgery between January 2016 and December 2016.

## Meeting people's individual needs

- The clinic offered pre and post-operative consultation to patients across the United Kingdom as well as international patients mainly from the Middle East. Patients from the Middle East made up 10% of the patients seen at the clinic.
- We found the clinic's information leaflets, consent forms and questionnaires were in English only even though they had Arabic speaking patients attending the clinic. Staff told us they advised them to attend with someone who could translate for them. A translation company was sometimes used to enable communication. Staff told us they used this company every other month and the patients covered the cost of the translation. Staff reported that 98% of patients who could not speak in English attended with their relatives to translate for them.
- Staff offered patients appointments at times that suited them. This included remaining open later than 6pm to allow patients to attend the clinic if they could not make it between the opening hours.
- Staff reported they improved the service by responding to all patients on the same day they made an enquiry. The clinic's phone was diverted to two mobile phones to minimise patients having to leave voicemail.
- The clinic had a waiting area and more chairs in reception where patients could wait. Magazines were available for those waiting.
- Facilities and premises were appropriate for the services planned and delivered. However, patients with mobility difficulties who could not use the lift or stairs could not access the clinic on the fourth floor of the building. To address this, consultations could be carried out in a room on the ground floor of the building.
- Patients could cancel and re-schedule any appointments at any time, without any penalty or administration fees (excluding the booking deposit), up to 72 hours before the procedure. Less than 48 hours' notice of cancellation (excluding weekends) incurred a 50% cancellation fee and failure to attend or cancel within 24 hours of the procedure incurred a 100% cancellation charge.

## Learning from complaints and concerns

- The clinic provided patients with information on how to make a complaint in the consultation. We saw the

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patient complaint form and a patient leaflet with information on how to make a complaint. Both were made available to patients wishing to make a complaint.

- Staff told us that the managing director handled, investigated and responded to complaints. Complaints were acknowledged within two days and a response provided within 20 days but this was not stated on the patient complaint form. There was no specific area about raising a complaint on the clinic's website but there was a general option to make an enquiry.
- Between January 2016 and December 2016, the clinic received one verbal complaint, which was to do with the lift being out of order. The lift has since been replaced by the landlord of the building.

## Are surgery services well-led?

### Leadership / culture of service

- The managing director who was also the registered manager for this location provided the leadership of the clinic. He had been the registered manager since 2012.
- The managing director was responsible for all the policies and governance documents within the clinic. He was also the safeguarding lead for the service.
- The practice manager was responsible for the day-to-day running of the clinic such as booking patient consultations, sending out letters and taking payments following consultations.
- All staff we spoke with reported that they enjoyed working at the clinic. They reported a good working relationship with their colleagues and with the managing director. Staff reported feeling respected and valued. Staff said things such as "it is a nice team", "there is always something new to learn", and "[the managing director] is understanding".
- We reviewed staff records and found staff had disclosure and barring (DBS) certificates held within their files.
- Staff reported the managing director was both very visible and easily accessible. Staff we spoke with said they could talk to them whenever they needed too. Staff also reported they felt supported and listened to.

### Vision and strategy for this core service

- The vision of the service was to provide high quality, medical and ethical care to patients, providing a safe environment for patients, and learning new and better technologies to give patients the best results.
- There were no plans to physically expand the clinic. Due to space and building planning arrangements there was no possibility of having a theatre as part of the clinic. However, the managing director told us there were plans to grant practising privileges to more consultants and to expand on the treatments offered at the clinic. Part of the strategy to achieve this vision was to increase treatments offered. The managing director told us the strategy would involve visiting developers of various treatments, speaking to them about their treatments and conducting his own research on the treatments prior to considering them as part of the clinic's treatment expansion strategy.
- Staff were aware of the values and vision of the service. They told us the vision was to maintain high standards in offering services and to adapt and learn about new technologies and this was consistent with what the managing director told us the vision for the service was.

### Governance, risk management and quality measurement (and service overall if this is the main service provided)

- There was a clear organisational structure, made up of the managing director, a clinic assistant, a laser therapist, a practice manager, and the two consultants working under practising privileges.
- Governance arrangements were not established or operated effectively to ensure that quality, performance and risks were understood and managed in this service. These were a lack of a risk register to formally and effectively manage risks within the service, a lack of a clear training programme for staff which went beyond reading policies, and a lack of comprehensive policies which referenced current best practice guidance and applicable legislation and a lack of regular audits to assess the quality of the service.
- During the inspection, we identified concerns that the provider had not identified. For example, lack of safeguarding and Mental Capacity Act 2005 training for staff as well as the risk around relatives interpreting for non-English speaking patients during consultations.

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- An external company (the company that owns the building and rents it to the clinic) completed a health, safety, and risk assessment document. The most recent assessment was in February 2017 to be reviewed in February 2018. This meant the service was not reviewing risks on a regular basis. Risks identified in the above mentioned risk document mostly related to the hazards in the building, for example, changing lightbulbs, using ladders and moving furniture. There had been no independent assessment of risk by the clinic to ascertain what clinical or non-clinical risks there were within the service to staff and patients.
- Staff told us they had weekly meetings at the clinic where they discussed areas of improvement and the strategy for the service. These meetings had not been recorded. It was therefore not possible to ascertain whether there was any risk assessment or measurement of the quality of the service in those meetings.
- Consultants with practising privileges were assessed for their suitability to work at the clinic in line with the clinic's practising privileges policy. They were subject to an interview, requirement for professional references, qualifications relevant to the post, suitable indemnity insurance, Disclosure and Barring Service checks (to check if a person has a criminal record) and evidence of continuing registration with professional bodies.

## Public and staff engagement

- The clinic used various ways to engage with the public. This included the clinic website and various social

media platforms. The clinic's website had a link to a blog where the managing director wrote about the various treatments and latest techniques in the cosmetic surgery industry.

- Staff told us staff meetings were held once a week and provided an opportunity for them to give feedback and raise concerns.
- The clinic did not carry out staff surveys. However, staff told us the managing director sought their views on new procedures and techniques in the industry.
- In order to assess the quality of the service provided, the clinic gave out patient satisfaction questionnaires to complete. The clinic carried out a patient satisfaction survey in 2015 involving ten patients. Results of the survey showed that 64.3% of questions scored the highest mark possible. For example, 'Were you given written information explaining the treatment?', 'Did you feel your privacy and dignity were a priority?', and 'Were you treated with respect?'

## Innovation, improvement and sustainability

- One of the procedures patients consulted on (laser-assisted liposuction) was a procedure developed by the managing director of the clinic. He told us he is always looking at improving existing procedures and coming up with new techniques in the industry. There was evidence of research and numerous publications related to cosmetic surgery by the managing director on the clinic's website.



# Outstanding practice and areas for improvement

## Areas for improvement

### Action the provider **MUST** take to improve

- The service must ensure that all staff are trained in safeguarding (adults and children) at a minimum of level two. The safeguarding lead must be trained to level four.
- The service must ensure that persons employed by the service in the provision of the regulated activity receive such appropriate training as is necessary to enable them to carry out the duties they are employed to perform including information governance and Mental Capacity Act 2005 training.
- The service must ensure effective governance arrangements including assessing, monitoring and mitigating any risks relating to the health, safety, and welfare of service users and others who may be at risk from the carrying out of the regulated activity.
- The service must ensure effective governance arrangements to enable the provider to assess, monitor, and improve the quality and safety of the services provided in the carrying out of the regulated activity. This must include but is not limited to a comprehensive audit programme to assess the quality of the service.

### Action the provider **SHOULD** take to improve

- The provider should ensure policies are reviewed regularly, are up to date, and reflect changes in national guidance and legislation.

- The service should keep a record of staff meetings including agenda items and matters discussed.
- The service should ensure risk assessments are carried out for all patients and findings documented in patients' records.
- The service should ensure that staff are trained on the duty of candour and that duty of candour is part of the clinic's serious incident policy.
- The service should have staff surveys as a way of engaging staff and obtaining their views on how services can be improved.
- The service should ensure there is access to disabled toilets and facilities for disabled patients.
- The service should include the reporting of near misses in their incident reporting policy.
- The service should ensure a range of personal protective equipment (PPE) is available in the clinic including protective aprons.
- The service should ensure all waste bins are labelled appropriately to reflect the nature of waste to be disposed of in individual bins.
- The service should conduct audits to measure the quality of the service. For example, audits related to infection prevention and control.

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
Surgical procedures	<p>Regulation 17 HSCA (RA) Regulations 2014 Good governance</p> <p><b>You failed to meet this regulation because :</b></p> <ul style="list-style-type: none"><li>• Systems and processes were not established and operated effectively to prevent abuse of service users. Staff, with the exception of consultants, were not trained in safeguarding (adults or children). Following the inspection, you provided evidence that staff had been trained to level one in adult safeguarding. The minimum requirement is level two.</li><li>• Furthermore, consultants were trained to level one in children safeguarding. The minimum requirement is level two.</li><li>• All staff therefore need to be trained to a minimum of level two for adult and children safeguarding.</li><li>• Although following the inspection the provider told us consultants were trained to level two in children safeguarding the provider did not provide evidence of this training.</li><li>• The safeguarding lead must be trained to level four. Although following the inspection the provider told us the safeguarding lead was trained at level four, the provider did not provide evidence of this training.</li><li>• We also found that safeguarding policies were out of date and did not refer to national guidance.</li><li>• You did not have a risk register for the service as evidence that there had been an assessment of risks by the provider or monitoring and mitigation of those risks. For example, the lack of safeguarding training had not been identified as a risk. Relatives interpreting for patients during consultations had not been identified as a risk.</li></ul>

This section is primarily information for the provider

## Requirement notices

- There were no governance structures around the reviewing of policies and all policies were out of date.
- There were no regular audits in the service to assess, monitor and improve the quality and safety of the service.

### Regulated activity

Surgical procedures

### Regulation

Regulation 18 HSCA (RA) Regulations 2014 Staffing

**You failed to meet this regulation because:**

- Persons employed by the service in the provision of the regulated activity must receive such appropriate training as is necessary to enable them to carry out the duties they are employed to perform.
- Staff had not been trained in information governance. It was not adequate that they had read the policies.
- Staff had not been trained in the Mental Capacity Act 2005 training. It was not adequate that they had read the policies.

This section is primarily information for the provider

## Enforcement actions

### Action we have told the provider to take

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