First Trust Hospital

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

Summary of findings

Letter from the Chief Inspector of Hospitals

The First Trust Hospital (FTH) provides surgical care, predominantly cosmetic procedures, for adults 18 years and over and is located North of Preston. It is owned by Anaster Limited and is registered for 22 beds.

The First Trust Hospital is registered to provide the following Regulated Activities:

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

The hospital's senior management team consists of two owners, the Registered Manager, the Deputy Manager and Clinical Matron. One of the owners acts as Responsible Medical Officer.

We inspected the hospital on 5 and 6 July 2016 and carried out an unannounced inspection on 12 July 2016.

We inspected the surgical core service at the First Trust Private Hospital as part of our ongoing programme of comprehensive independent healthcare inspections.

Are services safe at this hospital/service

- The hospital told us that all patients attending for surgical procedures had previously been identified, by their referring companies, as a low risk for anaesthesia. We saw evidence of a pre-operative assessment in all the patient records that we reviewed.There was a patient admission policy in operation at FTH which included an exclusion criteria. However the provider was not part of the process for applying the exclusion criteria and the hospital was dependent upon the robustness of the pre-operative assessment undertaken by another provider.
- There was a lack of clinical oversight in the recovery area, where we observed that patients were not being monitored in line with national guidelines. We raised these issues during the inspection and they were addressed immediately by managers. At our unannounced inspection we found that changes in clinical practice for monitoring patients had already been implemented.
- Managers were responsible for investigating incidents and we saw evidence of this taking place. However, the system to identify themes and trends of incidents was embryonic and required further development.
- Readmission rates and complaints for the service were lower than other comparable providers. We were not assured that all infections occurring from surgical procedures were being identified. A system for analysing the cause of infections was in place.However the hospital acknowledged the difficulty obtaining comprehensive infection information from the cosmetic surgery companies.
- The hospital undertook limited monitoring of compliance with the hand hygiene policy. We observed poor compliance with the hand hygiene policy and patient feedback had identified that ward staff were not always washing their hands before touching them.
- There was a system in place to monitor the safe keeping of drugs in fridges. This involved monitoring the maximum, minimum and actual temperature of the drug fridges and a member of staff signing to verify the temperature. We found that on 22 occasions, in March 2016, the required sheet was not signed to confirm the temperature had been checked. We also noted that another fridge had not been monitored since December 2015 and the hospital managers could not be assured as to the integrity of the medicines stored in the fridge. This was acted upon immediately by managers. We raised this with managers at the time of inspection. The drugs stored in the fridge which had not been monitored were safely disposed of and when we returned on the unannounced inspection fridge temperatures had been regularly monitored.

Summary of findings

- Three pieces of anaesthetic equipment, which included a monitor, anaesthetic gas machine and ventilator, appeared to be out of date for servicing according to the label attached to them. However, when this was raised with managers they provided evidence of a service log and we were assured that the equipment was fully functional.
- Staff were fully aware of their duties under the duty of candour.
- There was a service level agreement in place with the local acute hospital to provide emergency blood supplies to FTH. We found this agreement had not been reviewed at the time of the inspection, a matter which was immediately rectified. During the time between our announced and unannounced inspection, the policy and procedure had been clarified and emergency bloods would be delivered to FTH through an emergency ambulance. There were plans in place to test this procedure in practice.
- Surgical procedures were carried out by a team of consultant surgeons and anaesthetists registered with the General Medical Council (GMC). The consultants were employed by other organisations (usually in the NHS) in substantive posts and had practising privileges (the right to practice in a hospital) with First Trust Hospital.
- Staff were aware of their role and responsibilities with regards to safeguarding. Staff had attended mandatory training. The provider reported no never events and no venous thromboembolism (VTE) (a condition where blood clots form in a vein).
- There was a process for identifying and managing a deteriorating patient and transfer arrangements were in place with the local acute provider.
- The RMO provided out of hours and weekend cover. Consultant surgical and anaesthetic cover was provided by the medical practitioner who undertook the procedure. If there was a surgical problem out of hours the surgeon would attend to see the patient.

Are services effective at this hospital/service

- The majority of provider's policies, such as the appraisal policy and complaints policy, were out of date and referred to out of date material, such as the predecessor organisation of the Care Quality Commission and did not always reflect current best practice.
- Care did not always reflect best practice. We observed that, whilst patients were in the recovery area, they were not managed in line with the association of anaesthetists of Great Britain and Ireland (AABGI) guidelines. In particular we did not observe any carbon dioxide monitoring or heart monitoring being undertaken in recovery, which contravenes the AABGI guidelines for the immediate post-operative period.
- The provider had been in negotiation with its two main referring providers to obtain the relevant data for the submission to Private Healthcare Information Network (PHIN). It was also in the process of seeking to obtain the quality outcomes for its patients from the referring providers. At the time of our inspection the data was limited and, from the data provided, it was not possible to comment on the patient outcomes other than the patient feedback information, which was very positive. Providers were not expected to contribute to PHIN until September 2016. The hospital was beginning to make arrangements to ensure that surgical cosmetic procedures were coded in accordance with national coding guidance.
- The hospital reported one unplanned transfer of an inpatient to another hospital in the reporting period April 2015 to March 2016 which was better than the national average.
- Data provided by the hospital prior to the inspection showed an above average unplanned readmission rate. During our inspection we found that the data had included all readmissions and the readmission rate was lower than the national average.

Summary of findings

Are services caring at this hospital/service

- We observed that care was delivered with compassion and kindness at all stages of the surgical process.
- In the recovery area, we observed patients' privacy and dignity being compromised.
- We saw patients being treated with respect at all times, including throughout the surgical procedure.
- We spoke with patients and relatives who were extremely happy with the care they had received throughout the procedure.
- We looked at 20 comment cards which were all highly favourable and stated how well they had been treated. Patients were fully involved in their care and staff explained procedures to them, and provided emotional support.

Are services responsive at this hospital/service

- There was a patient admission policy in operation at FTH which included an exclusion criteria to identify those patients who would not be suitable for surgery. However the provider was not part of the process for applying the exclusion criteria and the hospital was dependent upon the robustness of the pre-operative assessment undertaken by another provider.
- Due to the unique nature of the provider, patients were only referred from other independent cosmetic surgery providers. Patients were admitted to the unit having all the pre-operative procedures completed by the referring cosmetic surgery company.
- Systems were in place for patients requiring emergency care. We saw evidence of when a patient had required emergency care and had been transferred appropriately to the local acute provider.
- The provider arranged admission to the hospital for patients' surgical procedures with consideration of the needs of the individual patient.There was a patient admission policy in operation at FTH which included an exclusion criteria.
- The trust had a complaints policy, although some information within it was out of date, such as no referral to the duty of candour regulation and referred to the previous name of the Care Quality Commission.
- Data provided by the hospital showed only one cancellation for a non-clinical reason in the twelve months period prior to our inspection. At the time of our inspection there was no waiting list for the service.

Are services well led at this hospital/service

- Staff spoke very positively about the leadership of the service. They felt engaged with and enjoyed working at the hospital.
- The provider sought feedback from all patients regarding the care they had received. Every patient was given a feedback card to fill in and all comments were taken weekly to a team briefing for follow up and appropriate action. Quarterly feedback was also presented to the Medical Advisory Committee (MAC) for review of any wider service issues.
- The service had a Medical Advisory Committee but minutes from these meetings showed the service did not always follow its own processes and terms of reference for the committee. For example, the minutes of the last three committee meetings showed the committee did not have the correct medical representation and the process for agreeing practising privileges had not been adhered to in line with the hospital's own policy.
- There was a clear vision and strategy for the hospital to develop the hospital to provide high quality cosmetic surgery.

Summary of findings

- A framework for governance of the service had been developed but arrangements were embryonic and not yet embedded in the service.
- We found documentation for two service level agreements were out of date although the actual agreements were still in place. This showed that the trust did not have clear assurance for the provision of services, such as emergency blood transfusion services.
- The service had produced a risk register with associated risk assessments and action plans. The hospital senior managers were aware that further work was required to make sure they had clear action plans in place and timescales for completion. The managers were clear they needed to give themselves greater assurance that policies and procedures were being followed.

Our key findings were as follows:

- The hospital told us that all patients attending for surgical procedures had previously been identified, by their referring companies, as a low risk for anaesthesia. We saw evidence of a pre-operative assessment in all the patient records that we reviewed. However, although there was there was a written patient exclusion policy in operation at FTH the hospital was dependent upon the robustness of the pre-operative assessment undertaken by another provider.
- The arrangement for managing medicines was not robust. There was a system in place to monitor the safe keeping of drugs in fridges. This involved monitoring the maximum, minimum and actual temperature of the drug fridges and a member of staff signing to verify the temperature. We found that on 22 occasions, in March 2016, the required sheet was not signed to confirm the temperature had been checked. We also noted that another fridge had not been monitored since December 2015 and the hospital managers could not be assured as to the integrity of the medicines stored in the fridge. This was acted upon immediately by managers and the drugs in the non-monitored fridge were disposed of. When we returned on our unannounced visit we saw evidence the temperature of the drugs fridge was monitored regularly.
- There was a lack of clinical oversight in the recovery area, where we observed patients not being monitored in line with national guidelines. We raised these issues during the inspection and they were addressed immediately by managers. At our unannounced inspection we found that changes in clinical practice for monitoring patients had already been implemented.
- Managers were responsible for investigating incidents and we saw evidence of this. Managers were responsible for investigating incidents and we saw evidence of this taking place. However, there were embryonic systems in place to identify themes and trends to prevent reoccurrence, which required further development.
- Readmission rates and complaints for the service were lower than other comparable providers. The system for identifying surgical site infections was not robust and we were not assured that all infections occurring from surgical procedures were being identified. A system for analysing the cause of infections was in place, however, the hospital acknowledged the difficulty obtaining comprehensive infection information from the cosmetic surgery companies.
- All areas of the hospital, that we observed, were visibly clean and tidy.
- There was limited monitoring of compliance with the hospital hand hygiene policy undertaken by the hospital. We observed poor compliance with the hand hygiene policy and patient feedback had identified that ward staff were not always washing their hands before touching them.
- Three pieces of anaesthetic equipment were out of date for servicing according to the label on them.
- Staff were fully aware of their duties under the duty of candour.

Summary of findings

- Surgical procedures were carried out by a team of consultant surgeons and anaesthetists registered with the General Medical Council (GMC). All the consultants were employed by other organisations (usually in the NHS) in substantive posts and had practising privileges (the right to practice in a hospital) with First Trust Hospital.
- There was a safeguarding policy in place for the hospital. Safeguarding training was provided as part of the mandatory training programme and we were told that all staff had received training this year. Staff were aware of their role and responsibilities with regards to safeguarding. Staff had attended mandatory training.
- The provider reported no never events and no venous thromboembolism (VTE) (a condition where blood clots form in a vein).
- We observed that, whilst patients were in the recovery area, they were not managed in line with Association of Anaesthetists of Great Britain and Ireland (AABGI) guidelines. In particular, we did not observe any carbon dioxide monitoring or heart monitoring being undertaken in recovery, which contravenes the AABGI guidelines for the immediate post-operative period.
- We observed the World Health Organisation (WHO) surgical safety checklist was used for every operation. We observed staff implementing the WHO checklist in the correct manner.
- The service had a Medical Advisory Committee but minutes from these meetings showed the service did not always follow its own processes and terms of reference for the committee.
- There was a clear vision and strategy for the hospital to develop the hospital to provide high quality cosmetic surgery.
- Governance structure for the service had been developed but arrangements were embryonic and not yet embedded in the service.

There were areas where the provider needs to make improvements.

Importantly, the provider must:

- Ensure there are robust governance arrangements in place that include ensuring risk assessments, quality monitoring and audits are in place and clear actions identified to ensure the provision of high quality care .
- Ensure that the documentation supporting service contracts is in place in order to provide assurance that equipment is safe and fit for purpose.
- Ensure formal written agreements are in place and up to date with external services for example the local NHS trust agreement for access to blood transfusion.
- Ensure there is a safe process for the monitoring of processes and procedures for the management of medicines.

In addition the provider should:

- Consider how they document the processes in place to meet the requirements of the duty of candour regulation.
- Should review its relationship with referring providers to ensure it has appropriate assurance for the full patient pathway.
- Continue to develop formal staff competences for all clinical nursing and medical roles.
- Develop more robust audit processes to ensure that staff are complying with trust policies.
- Ensure they are meeting the recommendations from the Review of the Regulation of Cosmetic Interventions, in particular the use of collecting appropriate data to monitor quality outcomes.
- Continue to review staffing to meet the changes in acuity and activity within the service.

Summary of findings

- Review clinical practice to make sure the service is following best practice, for example association of anaesthetists of Great Britain and Ireland (AABGI) guidelines.
- Consider the inclusion of female genital mutilation (FGM) training as part of the trust wide safeguarding training due to the nature of some of the surgical procedures.

Professor Sir Mike Richards

Chief Inspector of Hospitals

Overall summary

- Senior staff were aware of their responsibilities relating to duty of candour legislation and gave us examples of when it had been implemented. The trust had a duty of candour process in place to ensure people had been appropriately informed of an incident and the actions that had been taken to prevent recurrence. 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.
- The hospital told us that all the patients attending for surgical procedures had previously been identified, by their referring companies, as low risk for anaesthesia. We did see evidence in all of the records we reviewed of a pre-operative assessment, which included an assessment of risk of VTE and blood clotting factor. However, we were not sure who was assessing the patient pre-operatively, as there was no clear evidence of the profession or competencies of the professional undertaking the pre-operative assessment, included on the assessment sheet. However although there was there was a written patient exclusion policy in operation at FTH the hospital was dependent upon the robustness of the pre-operative assessment undertaken by another provider.
- There was a lack of clinical oversight in the recovery area, where we observed that patients were not being monitored in line with national guidelines, a blood-filled suction tube being used after it had been used in theatre and patients' privacy and dignity being compromised. We raised these issues during our inspection and they were addressed immediately by managers and clinical leadership.
- There was a system in place to analyse each incident as it occurred which included the cascading of the investigation to relevant staff. The process of identifying themes and trends was embryonic and required further development. We saw little evidence themes and trends were discussed regularly at team meetings.
- There was no monitoring of compliance with the hospital hand hygiene policy. We observed poor compliance with the hand hygiene policy and patient feedback had identified that ward staff were not always washing their hands before touching them.
- Three pieces of anaesthetic equipment were out of date for servicing according to the label on them.

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Surgery		• The hospital told us that all patients attending for surgical procedures had previously been identified, by their referring companies, as a low risk for anaesthesia. We did see evidence of a pre-operative assessment in all the patient records that we reviewed. • There was a lack of clinical oversight in the recovery area, where we observed patients not being monitored in line with national guidelines. • The arrangement for managing medicines was not robust. There was a system in place to monitor the safe keeping of drugs in fridges. However, we found the monitoring processes had not been clearly adhered to. Managers were responsible for investigating incidents and we saw evidence of this. Managers were responsible for investigating incidents and we saw evidence of this taking place. There was a system in place to analyse each incident as it occurred. The process of identifying themes and trends was embryonic and required further development. to prevent reoccurrence. • The system for identifying surgical site infections was not robust and we were not assured that all infections occurring from surgical procedures were being identified. • We identified that managers were unclear about the policy and procedure for securing large volumes of blood for patients requiring a transfusion. There was a service level agreement in place with the local acute hospital to provide emergency blood supplies to FTH. The documentation for the agreement was found to be out of date, a matter which was immediately rectified. • There was limited monitoring of compliance with the hospital hand hygiene policy undertaken by the hospital. We observed poor compliance with the hand hygiene policy.

Summary of findings

- The majority of provider's policies such as the appraisal policy and complaints policy were out of date.
- Three pieces of anaesthetic equipment were out of date for servicing according to the label on them.
- The provider had begun to develop its governance structure and developed both a vision and strategy for the service. Governance arrangements were embryonic and the service was not able to robustly assess, monitor and improve the quality and safety of the services they provided.

Summary of findings

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Surgery

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Background to First Trust Hospital

First Trust Hospital (FTH) is an independent cosmetic hospital based in Preston providing cosmetic surgery to self-funding patients. Patients are referred for surgery at FTH from two private cosmetic companies. The hospital has been running as a private hospital since 1987. The provider is owned by Ancaster Limited and is registered for 22 beds.

The First Trust Hospital is registered to provide the following Regulated Activities:

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

The hospital's senior management team consists of the owner, the Registered Manager, the Deputy Manager and Nurse Lead. The owner also acted as Responsible Medical Officer.

The hospital provides cosmetic surgery for self-funded patients. The hospital facilities include individual rooms located on the ground floor and two operating theatres. The hospital does not perform surgery every day; but provides staff and facilities out of hours and at weekend for inpatients.

First Trust Hospital was last inspected by the Care Quality Commission on 13 August 2013 when they were found to be complaint with five of the core standards being assessed during these inspections.

Our inspection team

Our inspection team was led by:

Inspection Lead: Elizabeth McMullin, Inspector Care Quality Commission.

The team included CQC inspectors, an inspection manager, a consultant surgeon specialist advisor, theatre specialist advisor and a governance specialist advisor.

Why we carried out this inspection

We inspected surgery at the First Trust Hospital. Our inspection was part of our on-going programme of comprehensive Independent Health Care inspections.

How we carried out this inspection

Prior to the inspection, we reviewed a range of information we held about the hospital and core service.

We inspected the hospital on 5 and 6 July 2016 on an announced visit. During this visit we met patients attending for surgery and their relatives. On 12 July 2016, we carried out an unannounced inspection of the hospital, as part of our inspection methodology.

We spoke with staff including; registered nurses, health care assistants, reception staff, medical staff, including consultants, who were not directly employed by the hospital), operating department practitioners, and senior managers. We spoke with eight patients and one relative. We also received six 'tell us about your care' comment cards which patients had completed prior to our inspection. During our inspection we reviewed ten sets of patient records.

On this inspection we visited all 14 patient rooms, theatres one and two, anaesthetic room for theatre one and recovery area. We spoke with eight patients, 20 staff which included surgeons, anaesthetists, a registered

Summary of this inspection

medical officer, matron, ward manager, registered nurses, health care assistants and operating department practitioners. We also reviewed 20 Care Quality Commission 'tell us about your experience' cards.

During our inspection we reviewed services provided by FTH in the ward and operating theatres.

We observed how people were being cared for and talked with patients and reviewed personal care or treatment records of patients.

To get to the heart of people who use services' experience of care, we always ask the following five questions of every service and provider:

? Is it safe?

? Is it effective?

? Is it caring?

? Is it responsive to people's needs?

? Is it well-led?

Information about First Trust Hospital

The hospital has 14 patient rooms on one floor and it has capacity to run two surgical lists a day, each list comprising of eight patients. Between the 1 April 2015 and 31 March 2016, FTH completed 1,939 episodes of care, of which 481 were completed as in-patient episodes and 1,458 were completed as day case episodes.

All patients are admitted and treated under the direct care of a consultant and medical care is supported 24 hours per day, seven days per week by an onsite resident medical officer (RMO). Patients are cared for and supported by registered nurses and health care assistants, who are employed by the hospital.

The hospital Accountable Officer for Controlled Drugs (CDs) is the clinical matron. The hospital has a contract with the local acute provider for both pharmacy and access to emergency blood products.

The five most common operations performed at the hospital are breast augmentation, rhinoplasty (plastic surgery to the nose), liposuction (surgery for removing excess fat from under the skin) and abdominoplasty (removal of excess flesh from the abdomen).

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 inspected but did not rate surgical services at First Trust Hospital. We found:

- There was a lack of clinical oversight in the recovery area, where we observed a blood-filled suction tube being used in recovery that had been used in theatre for the same patient.We raised this during inspection and it was addressed immediately by the manager and clinical lead.
- There was a system in place to analyse each incident as it occurred which included the cascading of the investigation to relevant staff.
- The process of identifying themes and trends was embryonic and required further development.
- Although staff did receive training in how to report an incident, they did not receive training on the classification of incidents.
- The system for identifying surgical site infections was not robust and we were not assured that all infections occurring from surgical procedures were being identified. A system for analysing the cause of infections was in place, However the hospital acknowledged the difficulty obtaining comprehensive infection information from the cosmetic surgery companies.
- There was limited monitoring of compliance with the hospital hand hygiene policy. We observed poor compliance with the hand hygiene policy and patient feedback had identified that ward staff were not always washing their hands before touching them.
- Three pieces of anaesthetic equipment were out of date for servicing according to the label on them.
- There was a service level agreement in place with the local acute hospital to provide emergency blood supplies to FTH. We found this agreement had no been reviewed at the time of our inspection, a matter which was immediately rectified. During the time between our announced and unannounced inspection, the policy and procedure had been clarified and confirmed that emergency bloods would be delivered to FTH through an emergency ambulance. There were plans in place to test this procedure in practice.

However:

Summary of this inspection

- All staff received training in duty of candour as part of the hospital's mandatory training programme. All staff we spoke with understood their duty to be open and honest with patients in the event of a mistake occurring.
- All areas of the hospital, that were inspected, were visibly clean and tidy.
- Personal protective equipment and handwashing facilities were in place within theatres, recovery and all ward areas. In theatres we observed that staff used appropriate gowning procedures and infection control procedures.
- There was a system in place to monitor resuscitation equipment. This involved a daily check of the contents of the resuscitation trolley and a member of staff to sign a document verifying that all equipment was present, in date and in working order. We found this system was adhered to on all occasions.

Are services effective?

We inspected but did not rate surgical services at First trust hospital. We found:

- We did not see evidence of a programme to measure the effectiveness of surgical procedures carried out at the hospital.
- We did not see evidence of the full implementation of a robust clinical audit programme.
- The hospital did not collect information on the outcomes of the surgical procedures it carried out.
- Not all key clinical roles were supported by a competency framework.
- The hospital was beginning to make arrangements to ensure that surgical cosmetic procedures were coded in accordance with national coding guidance but had no arrangements in place at the time of the inspection (SNOMED-CT). SNOMED-CT uses standardised codes to describe cosmetic surgical procedures, which can be used across electronic patient record systems.

However:

- Surgical procedures were carried out by a team of consultant surgeons and anaesthetists registered with the General Medical Council (GMC).All the consultants were employed by other organisations (usually in the NHS) in substantive posts and had practising privileges (the right to practice in a hospital) with First Trust Hospital. The hospital held practising privileges for eight surgeons and 24 anaesthetists.
- The hospital reported one unplanned transfer of an inpatient to another hospital, in the reporting period April 2015 to March 2016, which was better than the national average.

Summary of this inspection

- The readmission rate for the hospital was better than the national average.

Are services caring?

We inspected but did not rate surgical services at First trust hospital. We found:

- We observed that care was delivered with compassion and kindness at all stages of the surgical process.
- We saw patients being treated with great respect, at all times, including throughout the surgical procedure.
- We spoke with patients and relatives who were extremely happy with the care they had received throughout the procedure.
- We looked at 20 comment cards which were all highly favourable and stated how well they had been treated.

However:

- The recovery area was a very small room which held two patient trolleys. There was a mobile screen just outside of the recovery room and we were told this was brought into the recovery area in the event that there were two patients of mixed gender recovering in the room. On three occasions, we observed two patients being cared for in recovery and the screen was not used.

Are services responsive?

We inspected but did not rate surgical services at First Trust Hospital. We found:

- The service had a very regular patient flow through the system. Surgical lists were reviewed a week in advance by the management team and staffing and housekeeping decisions were subsequently made.
- The hospital provided surgery for patients who had been referred from three other cosmetic clinics, as well as accepting patients who self-referred directly to the hospital.
- Data provided by the hospital identified nine complaints were received in the reporting period April 2015 to March 2016.The level of complaints was significantly lower than the average of other independent hospitals. The hospital had a complaints procedure and we saw examples of appropriate complaint management.

Are services well-led?

We inspected but did not rate surgical services at First Trust Hospital. We found:

Summary of this inspection

- Policies were in place and were taken to the Medical Advisory Committee (MAC) for approval. However, during our inspection, we found that, out of 94 policies, 61 were noted to be out of date. Managers we spoke with told us there was a plan in place to review all the policies before the end of the year and this was confirmed by data provided by the hospital.
- The service had a Medical Advisory Committee chaired by the registered manager, which were held quarterly. Minutes from these meetings showed the service did not always follow its own processes and terms of reference for the committee. For example, the minutes of the last three committee meetings showed that the committee did not have the correct medical representation and the process for agreeing practising privileges had not been adhered to in line with the hospital's own policy.
- The hospital had introduced revised governance arrangements, in January 2016, but these changes were not yet embedded in the hospital. The hospital senior managers were aware further work was required to raise awareness and to give them greater assurance that policies and procedures were being followed. An audit programme had been developed and the hospital had held its first clinical governance meeting but no minutes were available at the time of our inspection.
- Service level agreements and contracts were in place with other providers, such as the provision of blood supplies. However, although it was confirmed on the first day of our inspection that contracts were still valid, we found the documentation was out of date and the hospital was not immediately able to confirm an agreement was still valid in the case of an emergency.

However

- The trust had produced a vision and emerging strategy for the service and staff were aware of this vision.
- The service received regular feedback from service users and was proactive in responding to comments made for improvement of service delivery.
- Staff were happy and confident in the trust leadership and felt it was an open and supportive culture.

Detailed findings from this inspection

Surgery

Safe	
Effective	
Caring	
Responsive	
Well-led	

Are surgery services safe?

Incidents

- The hospital reported no never events or serious incidents for the period, 1 April 2015 to 31 March 2016. Never events are serious, wholly preventable incidents that should not occur if the available preventative measures had been implemented.
- We were provided with a list of incidents dated from 1 July 2015 to 23 June 2016. There were 96 incidents contained in this list. The hospital only began grading incidents in January 2016 and had reported 61 incidents between January 2016 and 23 June 2016. Of these 61 incidents, 21 were identified as causing moderate harm, which is a comparatively high number. All the staff we spoke with knew how to report incidents, but we were informed that staff were not trained in how to grade an incident on severity.
- We looked at a root cause analysis (RCA) of a serious incident which had been investigated. The RCA was a thorough investigation into the event. Although there was a lessons learned conclusion on the RCA and remedial actions had been identified we found no clear evidence of dissemination of learning from the incident. However some of the actions were to be undertaken by the referring provider which at the time of inspection had not completed their own investigation limiting the provider's ability to close the RCA. Evidence provided after the inspection confirmed that this had now been completed.
- The process of identifying themes and trends was embryonic and required further development. We saw little evidence themes and trends were discussed regularly at team meetings.
- There were no incidents of mortality at the hospital over the past 12 months. However there was no system in place toof review for morbidity occurring at FTH.
- All staff received training in duty of candour as part of the hospital's mandatory training programme. All staff we spoke with understood their duty to be open and honest with patients in the event of a mistake occurring.

Safety thermometer or equivalent (how does the service monitor safety and use results)

- From the data we received, between April 2015 and March 2016, there were no incidents of venous thromboembolism (VTE), which is a blood clot in the vein, or pulmonary embolism (PE) reported as occurring at the hospital.
- The hospital had only started to monitor surgical site infections since January 2016. There was a problem with the data being reported due to a lack of clarity around whether the companies which referred patients were informing FTH of the details of all infections. The system for analysing the cause of infections was embryonic. From the data provided it was not possible to comment on the surgical infections occurring at the hospital.

Cleanliness, infection control and hygiene

- All areas of the hospital, that were inspected, were visibly clean and tidy.
- Suitable personal protective equipment and hand washing facilities were available within theatres, recovery and all ward areas. In theatres, we observed that staff used appropriate gowning procedures and infection control procedures.
- In recovery we observed a member of staff removed a laryngeal airway mask without wearing protective gloves. We also observed, following a rhinoplasty (a cosmetic, surgical procedure undertaken on the nose),

an anaesthetist entered the recovery area with a blood stained suction tube that had been used on the same patient in theatre. We identified this as an infection control issue and raised it at the time of the inspection. We were informed that there were clean suction tubes available in the recovery area and this was not accepted practice.

- There was a hand hygiene policy in operation at FTH. However, we observed five occasions over a period of 20 minutes where staff did not use the alcohol gel placed at the entrance to patient bedrooms. Hand hygiene audits were not carried out at the hospital because managers felt observation of staff would not provide a realistic picture of daily practice. Managers included patient observations about staff washing hands prior to and after touching them, in the hospital's customer feedback form. The customer feedback forms revealed there were a number of instances where patients reported that staff did not wash their hands prior to touching them. The matron and managers accepted that consistency in hand washing for ward staff required attention and were giving thought to how to ensure that the policy was fully implemented, embedded and regularly audited in a meaningful way.
- There were no instances of clostridium difficile (C.diff) or methicillin resistant staphylococcus aureus (MRSA) occurring at the hospital in the past 12 months.
- All storage areas were tidy and well-organised. The clean linen room was in good order with only appropriate items in the room.

Environment and equipment

- There was a system in place to monitor resuscitation equipment. This involved a daily check of the contents of the resuscitation trolley and a member of staff to sign a document verifying that all equipment was present, in date and in working order. We found this system was adhered to on all occasions.
- We noted that the resuscitation trolley in recovery was located in the corner of the room behind a patient recovery space. In the event that a second patient in the recovery room required the resuscitation trolley, the first patient had to be moved out of the recovery area and the trolley moved over to the second patient. This would create an unacceptable delay in providing the second patient with the treatment required. In addition the first patient would have to be detached from the monitoring equipment in order to be moved out of recovery, which created an unnecessary risk. This was raised with management at the time of inspection who in response to our concerns altered the organisation of recovery. On our unannounced inspection we observed that the recovery room was used for only one patient and the second patient was being recovered in theatre one. This was a temporary situation while a longer term solution was being sought.
- We found three of pieces of anaesthetic equipment were labelled as out of date in terms of portable electrical testing and required servicing. The monitoring and assessment of all anaesthetic equipment was provided by a third party provider under a service level agreement (SLA). We raised this with managers at the time of inspection and they contacted their service provider to remedy this issue. All equipment was reported to have been serviced earlier in the year, but this could not be verified from the labelling. Managers acted on this issue when we raised it with them, but we still found a piece of equipment not labelled as serviced on our unannounced visit.

Medicines

- Medicines were provided under a service level agreement with a local acute provider. There was a system in place for the safe storage of all medicines. When we were reviewing drugs in anaesthetic room one, we noted that there were two different drugs left on the work surface and not locked away. The room was empty, meaning that the drugs were left unsupervised and therefore open to tampering.
- There was a system in place to monitor the safe keeping of drugs in fridges. This involved monitoring the maximum, minimum and actual temperature of the drug fridges and a member of staff signing to verify the temperature. We found that, on 22 occasions in March 2016, the required sheet was not signed to say that the temperature had been checked. We also noted that another fridge had not been monitored since December 2015 and the hospital managers could not be assured as to the integrity of the medicines stored in the fridge. This was acted upon immediately by managers and the drugs were disposed of. When we returned on our unannounced saw evidence that the fridge temperatures were regularly monitored.

- Some medicines were stored in a room, locked with a key pad, at the end of the ward corridor. On one occasion we entered the room and it was unlocked and Intravenous fluids were laid out on a work surface. This was not safe practice and was raised immediately with the Ward Manager, who ensured that the door was immediately locked. When we returned on the unannounced inspection this door was locked.
- Controlled drugs were kept in a double-locked, metal cupboard and a controlled drug book was used to monitor usage. This book was up to date and appropriately signed.

Records

- We reviewed 10 patient records and found they were in good order, legible and signed. They were stored securely in a locked office.
- We found evidence of pre-operative assessments in all the records we reviewed. This included past medical history, as reported from the patient, as a checklist. All patients underwent a check for MRSA status and blood clotting levels.
- In every set of records we reviewed, all patients were assessed for venous thromboembolism (VTE).

Safeguarding

- There was a safeguarding policy in place for the hospital. Level one safeguarding training was provided as part of the mandatory training programme and we were told that all staff had received training within the past year. All staff who we spoke with confirmed they had received safeguarding training.
- Staff understood what type of incident would be regarded as a safeguarding incident and gave us an example of an incident where they considered a young person had come under undue influence to consent to the procedure for which they were admitted. Staff recognised that this was not valid consent. The procedure did not go ahead and the matter was reported as a safeguarding incident.
- First Trust Hospital did not provide training for staff in female genital mutilation (FGM) and two staff members that we spoke with were not familiar with the term. In October 2015, it became mandatory for regulated health and social care professionals to report known cases of FGM, in persons under the age of 18, to the police. First Trust Hospital did not provide surgical services to patients under the age of 18; however, healthcare staff have a professional duty to report any concerns where a parent has had FGM and may have female children.

Mandatory training

- All staff were required to undertake mandatory training, which included health and safety, moving and handling, infection prevention and control, basic life support and food safety. All staff we spoke with had received their mandatory training. First Trust Hospital did not have an organisational target for mandatory training.

Assessing and responding to patient risk

- The hospital told us that all patients attending for surgical procedures had previously been identified, by their referring companies, as low risk for anaesthesia. We did see evidence in all the records we reviewed of a pre-operative assessment, which included an assessment of risk of VTE and blood clotting factor. However, it was not clear from the records as to who was assessing the patient pre-operatively, as there was no clear evidence of the profession or competencies of the professional undertaking the pre-operative assessment, included on the assessment sheet. Although there was there was a written patient exclusion policy in operation at FTH the hospital was dependent upon the robustness of the pre-operative assessment undertaken by another provider.
- Once a patient was admitted, a further VTE assessment was undertaken and we saw evidence of this in the patient case notes. We observed measures being taken to reduce the risk of VTE during surgery and post-operatively.
- We saw evidence that the World Health Organisation (WHO) surgical safety checklist was used for every operation. We observed staff implementing this appropriately.
- The hospital used close observation and monitoring of vital signs to monitor any deterioration in the patient's medical condition. There was regular half hourly monitoring of patients when they were transferred to the ward from recovery. When vital signs indicated stability, patients then went on to regular but less

frequent monitoring. We saw close attention to the management of risk and deterioration when patients were on the ward. We also observed that all observations for each patient were recorded on a general observation sheet and staff reviewed this sheet at very regular intervals.

- If a patient did deteriorate on the ward, there was instant access to a Resident Medical Officer (RMO), who was based on the ward during the day. During the evening and at weekends the RMO was on call if the ward required him.
- The RMO was trained in advanced life support skills and all nursing staff on the ward were trained in basic life support skills.
- There was an escalation policy in place for patients who were in need of intensive medical input. Patients were transferred to the local acute hospital by emergency ambulance. There had been very few instances of a patient deteriorating whilst on the ward; however, we were told of one instance, which had occurred in the past 12 months, where a patient had haemorrhaged. The RMO managed the patient until an emergency ambulance arrived. A full RCA was completed for this event and the escalation policy was appropriately implemented.
- There was a service level agreement in place with the local acute hospital to provide emergency blood supplies to FTH. We found this agreement had not been reviewed at the time of the inspection, a matter which was immediately rectified. During the time between our announced and unannounced inspection, the policy and procedure had been clarified and emergency bloods would be delivered to FTH through an emergency ambulance. There were plans in place to test this procedure in practice.
- Patients in the recovery area were not always managed in line with association of anaesthetists of Great Britain and Ireland (AABGI) guidelines. In particular we did not observe any carbon dioxide monitoring or heart monitoring being undertaken in recovery, which contravenes the AABGI guidelines for the immediate post-operative period. In addition we observed an occasion when a pulse oximeter reading was indicating a patient's oxygen saturation level was deteriorating. The recovery practitioner did not give oxygen to the patient, although oxygen was readily available in the recovery area. We also observed the rough removal of a laryngeal mask from a patient in the recovery area.
- There was evidence in patient records that every patient's nutrition needs were assessed using the malnutrition universal screening tool (MUST) and every patient underwent a pressure ulcer risk assessment using the Waterlow assessment tool.

Nursing staffing

- Nurse staffing was planned and organised with reference to the acuity of patients. In general there were good levels of staffing in theatres, recovery and on the wards. There was also appropriate skill mix in place in all clinical areas. However, we were told that, when there was only one list being undertaken, which was eight patients, the staffing establishment was one registered nurse and one health care assistant. This level of staffing was potentially insufficient to respond appropriately to an emergency situation. If a patient became unwell and required intensive support and assistance, there would be no qualified nurse overseeing the care of other patients. We raised this with the matron at the time of our inspection and received immediate assurances that more than one qualified nurse would be on duty at any one time. When we returned on the unannounced we saw evidence that the ward was adequately staffed at all times.
- The hospital used a high number of agency staff, although the majority of these worked regularly at the hospital. Twenty-five percent of staff working at the hospital were employed by them, which included the matron and ward manager.

Surgical staffing

- The hospital held practising privileges for eight surgeons and 24 anaesthetists.
- There were three RMOs who provided medical cover 24 hours a day 52 weeks a year. Each RMO was present for 24 hours a day over a two week period. The RMO provided out of hours and weekend cover. The RMO was very rarely called upon to provide out of hours cover as the patients who remained in the hospital were usually

well and did not require medical attention. The RMO we spoke with enjoyed the work at the hospital and felt the cover arrangements were sufficient because he was very rarely called upon for out of hours cover.

- Consultant surgical and anaesthetic cover was provided by the medical practitioner who undertook the procedure. If there was a surgical problem, out of hours, the surgeon would attend to see the patient.

Major incident awareness and training

- There was a hospital major incident plan and all staff we spoke with knew where to find the folder. Major incident training did not form part of mandatory training programme.

Are surgery services effective?

Evidence-based care and treatment

- Care and treatment was mostly delivered in line with national guidelines. Each patient was placed on a surgical pathway, which we found to be fully completed. The exception that we found was the treatment delivered in recovery, which was not in line with national recommendations nor reflect current best practice guidelines. An example of this was whilst patients were in recovery they were not managed in line with the association of anaesthetists of Great Britain and Ireland (AABGI) guidelines. In particular we did not observe any carbon dioxide monitoring or heart monitoring being undertaken in recovery, which contravenes the AABGI guidelines for the immediate post-operative period.
- We did not see evidence of the full implementation a robust local clinical audit programme. The hospital was just starting to engage with the private healthcare information network (PHIN).Providers were not expected to contribute to PHIN until September 2016.This would enable it to benchmark itself against other, similar private providers in the future.

Pain relief

- The post-operative pain needs of patients were assessed and advised upon during the pre-operative assessment. This was reflected in the records we inspected.
- Pain levels were also assessed post-operatively using a formal pain tool and formed part of the regular post-operative checks.
- We were informed that pain management, after discharge, formed part of discharge arrangements. Patients were advised on what pain relieving medication to take after they were discharged home.

Nutrition and hydration

- First Trust Hospital sent patients information on fasting times for food and liquids prior to attending for their surgical procedure.
- The advice and information patients were given for pre-operative fasting of foods and liquids was in line with recent AAGBI recommendations.
- On admission staff checked whether the pre-operative fasting guidelines had been met and if they had not, surgery was postponed.
- If a patient's surgical procedure was delayed, patients were included in the two hourly comfort round observations and fluids or light food were given as appropriate.
- Staff monitored nutrition and hydration post operatively through the post-operative checks and the observational comfort rounds.

Patient outcomes

- The hospital reported one unplanned transfer of an inpatient to another hospital in the reporting period April 2015 to March 2016, which was better than the national average.
- Data provided by the hospital, prior to the inspection, showed an above average unplanned readmission rate. During our inspection we found that the data had included readmissions where patients had their initial surgery at a different hospital and the readmission rate for First Trust Hospital was lower than the national average.
- The royal college of surgeons (RCS) recommends that providers routinely collect and report on patient outcomes for all patients receiving surgical procedures, such as breast augmentation and cosmetic eye surgery. The hospital did not collect this information at the time of inspection.

- Any patient information which was collected related to activity rather than the quality of treatment, such as how many patients were seen on a monthly basis.
- The provider had been in negotiation with its two main referring providers to obtain the relevant data for the submission to Private Healthcare Information Network (PHIN). It was also in the process of seeking to obtain the quality outcomes for its patients from the referring providers. At the time of our inspection the data was limited and, from the data provided, it was not possible to comment on the patient outcomes other than the patient feedback information which was very positive. The hospital was beginning to make arrangements to ensure that surgical cosmetic procedures were coded in accordance with national coding guidance.

Competent staff

- Doctors working at the hospital did so under practising privileges. Practising privileges refer to medical practitioners not directly employed by the hospital, who have permission to practice there. The hospital had a policy for granting and reviewing practising privileges. All doctors who worked under practising privileges provided evidence of their disclosure and barring service (DBS) checks and indemnity insurance. This was verified by the hospital's medical advisory committee (MAC).
- There were some roles within the hospital where core competencies had been identified and staff were measured against them. Examples of this were the healthcare competencies for theatre. However, there were other roles for which competencies had not been identified. An example of this was the recovery practitioner role. We raised this with the hospital and they immediately responded by undertaking a rapid piece of work to identify core competencies for the recovery practitioners. This was undertaken by looking at national guidance and seeking external professional assistance. When we returned for the unannounced inspection there was a set of core competencies in place for recovery practitioners and a plan to measure each recovery practitioner's performance against them.
- All staff we spoke with had completed an annual appraisal in the past year.

Multidisciplinary working (in relation to this core service only)

- We observed strong and productive working relationships between theatre and ward staff. They liaised well to provide seamless care for patients.
- The hospital had a range of external relationships with other hospitals and companies to provide services to it. These included pharmacy, water testing, pathology, medical devices, infection control, clinical waste, decontamination services, haematology, fire alarms and occupational health. These relationships were underpinned with service level agreements. During the inspection we found that the service provided to service medical devices was problematic and required review.

Seven-day services

- The hospital usually provided services Monday to Friday and was closed over the weekend. However, it did sometimes undertake weekend surgical lists. If a surgical list was undertaken at the weekend the full complement of surgical and operating department staff and ward staff were rostered for duty.

Access to information

- We observed that all staff had access to the information they needed to care for their patients. We observed there were full details of the pre-operative assessment in notes, full operation details and full observation checks. When a patient was discharged a summary letter was sent to their GP.
- We saw an instance where an incident had been raised because a patient's notes were not available on the day of surgery. The patient's operation was delayed until the notes arrived.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Consent was taken under a two stage procedure. Initial consent was taken at the pre-operative assessment and then consent was taken again on the day of admission. We were able to observe consent being taken on the day of admission on three occasions. On all occasions the process was very thorough and conducted in line with national guidelines. Full risks and benefits were discussed with the patients.
- There was a hospital consent document in place in all patient records. From the 16 records we reviewed, we saw this was fully completed in all cases apart from two.

In these instances the hospital consent form merely stated 'see notes'. However, there was evidence of full consent taken in the notes in that both patients had signed a document which contained all essential information.

Are surgery services caring?

Compassionate care

- We observed kind and compassionate care being delivered at every stage of the patients' journey.
- We read 20 Care Quality Commission comment cards, all of which were highly complementary of the way in which they were treated by staff.
- Data provided by First Trust Hospital (FTH) showed that patients were very positive about the support and care provided by the staff at FTH.
- Even though the patients we observed in recovery were of the same gender, we found that their privacy and dignity was not being sufficiently protected.
- The recovery area was a very small room which held two patient trolleys. There was a mobile screen just outside of the recovery room and we were told this was brought into the recovery area in the event that there were two patients of mixed gender recovering in the room. On three occasions, we observed two patients being cared for in recovery and the screen was not used.

Understanding and involvement of patients and those close to them

- The patients and relatives who we spoke with reported how they had been involved in decisions about their treatment at all stages of their patient journey.
- We observed a detailed consent being taken where the surgeon gave full details of the risks and benefits in a very respectful manner and allowed sufficient time for the patient to ask questions and for those questions to be answered.
- The hospital carried out patient feedback satisfaction surveys and the feedback provided was collated and discussed at team brief.

Emotional support

- We observed staff providing emotional support to patients at different stages of the surgical process. We saw an anaesthetist being supportive to a nervous patient and we observed nursing staff supporting patients complaining of pain.
- Staff and patients confirmed that counselling was available for patients as part of the preoperative planning and consent process, if required.

Are surgery services responsive?

Service planning and delivery to meet the needs of local people

- The service had a very regular patient flow through the system. Surgical lists were reviewed a week in advance by the management team and staffing and housekeeping decisions were subsequently made.
- The hospital reported a 54% increase in activity since September 2015. It had adapted to this increased demand by increasing the use of a second surgical list. It had become more common than not to have a second list.

Access and flow

- The hospital provided surgery for patients who had been referred from three cosmetic surgery companies
- Patients were discharged with follow up appointments with their referring provider. Contact information for if the patients had any concerns was given to the patients on discharge.
- Data provided by the hospital showed one cancellation for non-clinical reasons in the twelve months prior to our inspection.

Meeting people's individual needs

- The hospital used a telephone interpretation and translation service for patients who did not speak English as a first language.
- The only religious and spiritual support available was from a copy of the bible in patient rooms. However patients would only be in for a short period of time.

Learning from complaints and concerns

- Data provided by the hospital identified nine complaints were received in the reporting period April 2015 to March 2016. The level of complaints was significantly lower than the average of other independent hospitals. The hospital had a complaints procedure and we saw examples of appropriate complaint management.
- The matron was able to give us examples of how they had listened to complaints and changed their practice as a result. We were told of an instance where a complaint was made because a surgical procedure was delayed and the patient was kept fasted for longer than necessary. From this, staff decided to include all patients in the observational comfort rounds to ensure that communication was occurring and adapting the fasting requirements, if it was needed.
- The hospital had a compliments and complaints policy and a procedure which outlined the process taken following the receipt of a complaint. We noted that the complaints policy referred incorrectly to the predecessor organisation and not the CQC. We were able to review examples of complaint management. The complaints policy did not make reference to the duty of candour responsibilities where a complaint was identified as moderate or severe harm. The Hospital Manager provided a quarterly report on all complaints received by the hospital for consideration by the Medical Advisory Committee (MAC).

Are surgery services well-led?

Vision and strategy for this this core service

- There was a clear vision and strategy for the hospital. Staff we spoke with were able to describe the vision for the service, which was to become a high quality cosmetic surgery provider.

Governance, risk management and quality measurement for this core service

- The hospital had introduced revised governance arrangements in January 2016 but these changes were not yet embedded in the hospital. The hospital senior managers were aware further work was required to raise awareness and to give them greater assurance that policies and procedures were being followed. An audit programme had been developed and the hospital had held its first clinical governance meeting but no minutes were available at the time of our inspection.
- The service had produced a risk register with associated risk assessments and action plans.
- The service had a Medical Advisory Committee chaired by the registered manager, which were held quarterly. Minutes from these meetings showed that the service did not always follow its own processes and terms of reference for the committee. For example the minutes of the last three committee meetings showed that the committee did not have the correct medical representation and the process for agreeing practising privileges had not been adhered, to in line with the hospital's own policy.
- Staff told us there were informal staff meetings, as required; however there were no set agendas or minutes recorded for these meetings. There were morning and afternoon safety huddles in theatres every day.
- Many of the hospital policies and procedures did not refer to up to date guidance and best practice, suggesting that comprehensive review of these documents did not take place. Policies were taken to the Medical Advisory Committee (MAC) for approval. During our inspection, we found that, out of 94 policies, 61 were noted to be out of date. Managers we spoke with told us there was an action plan in place to review all the policies and this was confirmed by data provided by the hospital.
- We checked the staff files for eight doctors and saw there was evidence of indemnity insurance for all of them.
- Whist the provider did seek feedback from patients regarding their care, they did not perform quality measurements such as collecting patient reported outcomes (Q-PROMS) information from patients, as recommended by the Royal College of Surgeons (RCS). Patient satisfaction with the outcomes of cosmetic surgery 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.

- The hospital was beginning to make arrangements to ensure that surgical cosmetic procedures were coded in accordance with national coding guidance.

Leadership / culture of service related to this core service

- Staff spoke very positively about the leadership of the service. They felt engaged with and enjoyed working at the hospital. Staff told us managers had been supportive if they had experienced any difficulties. They also told us they felt comfortable approaching senior clinicians and managers about difficult issues.
- The provider sought feedback from all patients regarding the care they had received.
- There was a very positive culture amongst managers and clinicians evident at FTH. Managers were open and honest with us about the challenges that they had identified prior to the inspection taking place. They were receptive to resolving issues of safety and governance that we raised with them.

Public and staff engagement

- All patients were asked to complete a satisfaction survey about their experience at the hospital. The provider reviewed the responses each week at a briefing meeting and any remedial actions were acted upon immediately. Feedback from patients was compiled every three months. The report from January 2016 to March 2016 showed over 95% of patients had completed the questionnaire. Overall feedback from patients was positive; however, a number of patients had noted the lack of hand washing by staff which was subsequently being addressed by the senior managers.
- We did not see evidence of patients being directed to the Royal College of Surgeons (RCS) website as advocated by the RCS Professional standards for cosmetic surgery (2016), where patient information was available about cosmetic surgery.

Innovation, improvement and sustainability

- The senior managers had acknowledged the need to respond to the increase in activity over the last twelve months. A new governance committee had been set up to help focus the service on improvement and sustainability.

Outstanding practice and areas for improvement

Areas for improvement

Action the provider MUST take to improve

The provider must take action to ensure that.

- Ensure there are robust governance arrangements in place.
- Review the Medical Advisory Committee to ensure it is effective and complying with terms of reference and due diligence.
- Develop a robust detailed risk register that includes full risk assessments and associated action plans are in place.
- Ensure quality monitoring and audits are in place and clear actions identified to ensure the provision of high quality care.
- Ensure formal written agreement with the local NHS trust for the access to blood transfusion is documented, in place and up to date.
- Ensure there is a safe process for the monitoring of processes and procedures for the management of medicines.

Action the provider SHOULD take to improve

- Consider how the requirements of the duty of candour regulation are met.
- Work with referring providers to ensure the provider has appropriate assurance for the full patient pathway.
- Continue to develop formal staff competences for all clinical nursing and medical roles.
- Develop more robust audit processes to ensure that staff are complying with trust policies.
- Review the contract for the servicing and upkeep of equipment with clear monitoring systems and labelling of equipment to provide assurance that equipment is safe and fit for purpose.
- Review how they are meeting the recommendations from the Review of the Regulation of Cosmetic Interventions, in particular the use of collecting appropriate data to monitor quality outcomes.
- Continue to review staffing to meet the changes in acuity and activity within the service.
- Review clinical practice to make sure the service is following best practice in the recovery area, in line with association of anaesthetists of Great Britain and Ireland (AABGI) guidelines for the immediate post-operative period.
- Should consider the inclusion of female genital mutilation (FGM) training as part of the trust wide safeguarding training due to the nature of some of the surgical procedures.

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 17 HSCA (RA) Regulations 2014 Good governance Regulation 17. (1) of the Health and Social Care Act 2008 (Regulated Activity) Regulations 2014: Good Governance Systems or processes must be established and operated effectively. How the regulation was not being met: Policies and procedures did not away reflect up to date guidance. Care did not always reflect current best practice. Systems for monitoring and reviewing the service were not robust and embedded within the service.

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.