Eyesurge London Limited

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Inspection report

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Date of inspection visit: 23 February 2022 and 4 March 2022
Date of publication: 29/04/2022

This report describes our judgement of the quality of care at this service. It is based on a combination of what we found when we inspected, information from our ongoing monitoring of data about services and information given to us from the provider, patients, the public and other organisations.

Ratings

Overall rating for this location	Inadequate
Are services safe?	Inadequate
Are services effective?	Inadequate
Are services responsive to people's needs?	Inadequate
Are services well-led?	Inadequate

Summary of findings

Overall summary

This is the first time we have rated this location. We rated it as inadequate because:

- The service did not provide mandatory training in key skills to all staff. The service did not control infection risk well. Staff did not assessed risks to patients. They did not manage medicines well. The service did not manage safety incidents well or learned lessons from them.
- The service did not always provide care and treatment based on national guidance and evidence-based practice. Managers did not monitor the effectiveness of the service and did not make sure staff were competent for their roles.
- The service did not obtain feedback from people and it was not easy for people to raise concerns about care received.
- Leaders did not understand and manage the priorities and issues the service faced. The service had a vision for what it wanted to achieve but no strategy to achieve this vision.
- Leaders did not have effective governance processes or identify risks and issues. The service did not actively engage with patients and was not committed to improving services continually.

However,

- People could access the service when they needed it.

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Surgery	Inadequate	

Summary of findings

Contents

Summary of this inspection

Background to Eyesurge London Limited

Eyesurge London Limited provides surgical procedures and provides a range of cosmetic surgical and ophthalmic procedures to self-funding patients aged 21 years and over. All patients receiving care at the service are patients of surgeons using the provider's operating facilities under practising privileges. Practising privileges are a well-established system of checks and agreements, whereby doctors can practise in hospitals without being directly employed by them.

The patients receive their pre-operative consultation and the majority have their post-operative care delivered at the surgeon's own consulting room. The service can if necessary provide theatre staff to support the surgeon during the operation.

At the time of the inspection there was a registered manager and nominated individual in place. Following the inspection, the registered manager informed the Care Quality Commission (CQC) that she would be absent from the service for a period of three months.

The service has not been inspected since its registration on 28 February 2019 and this was the first time the service had been inspected and rated.

'I am placing the service into special measures. Services placed in special measures will be inspected again within six months. If insufficient improvements have been made such that there remains a rating of inadequate overall or for any key question or core service, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating the service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. The service will be kept under review and, if needed, could be escalated to urgent enforcement action. Where necessary another inspection will be conducted within a further six months, and if there is not enough improvement we will move to close the service by adopting our proposal to vary the provider's registration to remove this location or cancel the provider's registration.'

How we carried out this inspection

We inspected this service using our comprehensive inspection methodology. We carried out an unannounced inspection on 23 February 2022. During the inspection we visited the theatre and recovery area and reviewed policies and other documentation. We met with one of the directors and spoke with two members of staff.

Following the inspection, on 28 February 2022 we conducted telephone interviews with four members of staff including the registered manager, nominated individual, clinic manager and operations manager. We revisited the service unannounced on 4 March 2022 to collect additional information relating to medicines management and staffing and looked at patient records and a range of documents.

There were no patients using the service at the time of our inspection.

The inspection team comprised of a lead CQC inspector, CQC inspection manager and a CQC specialist advisor. The inspection team was overseen by Nicola Wise, Head of Hospital Inspection.

You can find information about how we carry out our inspections on our website: https://www.cqc.org.uk/what-we-do/how-we-do-our-job/what-we-do-inspection

Summary of this inspection

Areas for improvement

Action the service MUST take that is necessary to comply with its legal obligations. Action a service SHOULD take is because it was not doing something required by a regulation but it would be disproportionate to find a breach of the regulation overall, to prevent it failing to comply with legal requirements in the future, or to improve services.

Action the service MUST take to improve:

- Must ensure all staff have mandatory training in key skills.
- Must ensure all staff complete safeguarding training.
- Must ensure there are measures in place to protect patients, staff and others from infection.
- Must ensure equipment and control measures are in place to protect patients, staff and others from infection.
- Must ensure staff complete an updated risk assessments for each patient.
- Must ensure that employment checks are complete, and records of these checks held at the service.
- Must ensure checks for granting practicing privileges are complete and reviewed annually.
- Must ensure the proper and safe management of medicines.
- Must ensure records of patients' care and treatment are complete.
- Must ensure incidents are reported and investigated.
- Must ensure all policies and procedures are up to date reflecting national guidelines and are relevant to the service being delivered.
- Must ensure the effectiveness of the care and treatment provided is monitored.
- Must ensure the Care Quality Commission (CQC) is informed of any changes to the registered details of the service.
- Must ensure there are appropriate arrangements in place for people with a disability to use the service.
- Must ensure there are effective governance processes.

Action the service SHOULD take to improve:

- Should ensure theatre lists to document activity in the theatre are maintain.
- Should ensure the national guidelines for nil by mouth prior to general anaesthetic are followed.
- Should ensure patients pain is monitored and recorded.
- Should ensure that staff have annual appraisals.
- Should ensure patients can contact the service for advice and support after their surgery out of hours.
- Should ensure feedback from patients who use the service is obtained.
- Should ensure the national recommendations from the Royal College of Surgeons (RCS) Professional Standards for Cosmetic Surgery April 2016 'cooling off' period are followed.
- Should ensure that staff have the skills and abilities to run the service.
- Should ensure there is a strategy for the service.
- Should ensure there is an open culture where patients, their families and staff could raise concerns without fear.
- Should ensure risks and issues are identified, escalated and actions are identified to reduce their impact.
- Should ensure data is collected and analysed.
- Should ensure patients and staff are actively and openly engaged with.
- Should ensure there is a commitment to continually learning and improving the service

Our findings

Overview of ratings

Our ratings for this location are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Surgery	Inadequate	Inadequate	Not inspected	Inadequate	Inadequate	Inadequate
Overall	Inadequate	Inadequate	Not inspected	Inadequate	Inadequate	Inadequate

Inadequate

Surgery

Safe	Inadequate
Effective	Inadequate
Responsive	Inadequate
Well-led	Inadequate

Are Surgery safe?

Inadequate

We had not previously rated safe at this location. We rated it as inadequate.

Mandatory training

The service did not provide mandatory training in key skills to all staff.

The service did not have a training matrix which set out the training staff were required to complete. There was no evidence of the mandatory training employed staff had completed. We saw training certificates for one member of staff for training that had been completed when they had worked with another employer. One member of staff we spoke with told us they had completed training via e- learning, however we did not see any records to confirm this. Another member of staff told us they had not completed any training since they started working for the provider. There was no evidence that medical staff working under practising privileges were up to date with their mandatory training.

There were no systems or processes in place for managers to monitor the completion of mandatory training and alert staff when they needed to update their training.

Safeguarding

Staff had not completed training on how to recognise and report abuse.

There was no evidence staff had received safeguarding training specific for their role on how to recognise and report abuse. The training certificates for one member of staff who stated they had completed safeguarding adults and safeguarding children level 3, had been undertaken whilst working for another provider. Another member of staff told us they had completed training in both safeguarding adults and safeguarding children level 3 training. However, we did not see any records to confirm this

During discussions two members of staff demonstrated they knew how to identify adults at risk of suffering significant harm. However, not all staff knew who to inform if they had concerns or who was the services safeguarding lead. There were no records that staff working under practicing privileges and self-employed nurses and operating theatre practitioners had completed any safeguarding training.

The service had an up to date safeguarding adult policy which reflected national guidance.

Inadequate

Surgery

Cleanliness, infection control and hygiene

The service did not control infection risk well.

Not all areas were clean, the theatre area had high level dust. The theatre's daily cleaning check list showed the theatre had not been cleaned since 12 February 2022. However, there had been a surgical procedure undertaken on 22 February 2022, the day before the inspection. Following the inspection, the service provided cleaning schedules for the seven month period August 2021 to February 2022. The records showed cleaning had taken place three days per week from August to December, two days per week in January and from February 2022 five days per week. This information was not available during the inspection when requested and the cleaning check lists for February 2022 conflicted with the information we saw during the inspection.

There was limited evidence staff followed infection control principles. The service did not undertake infection control audits. The clinic manager told us they did not undertake hand hygiene audits and any monitoring of hand hygiene had been observational only. Following a data request the service provided us with an audit tool for hand hygiene and stated they planned to commence hand hygiene audits but gave no date when these would commence.

The service could not demonstrate patients were routinely screened for Methicillin-Resistant Staphylococcus Aureus (MRSA) prior to admission.

Disposable curtains were in use to screen patients, these were not dated to indicate when they came into use and when they were due to be renewed. This meant staff did not know when they were last changed.

The sluice area was cluttered and used to store sterile equipment and clinical waste. Intravenous fluids and sterile galley pots were noted to be stored alongside or under full domestic and clinical waste bags. A suction machine was stored on the draining board of the sink. Cleaning solutions and mops were not locked away. The control of substances hazardous to health (COSHH) cupboard was unlocked and had liquids that did not need to be stored in it.

There was no evidence staff cleaned equipment after patient contact. None of the equipment seen was labelled to show when it was last cleaned. Staff had access to personal protective equipment (PPE). There were adequate supplies of PPE in the theatre. Hand gel dispensers were evident. The service had a Covid 19 infection control policy.

During the follow up inspection on 4 March 2022, we noted five syringes removed from their packages were stored in the controlled drugs (CD) cupboard with medicines that would be used in the event of an emergency. As these were no longer sterile, they should have been disposed of once the surgical list had been completed.

Environment and equipment

The facilities, premises and equipment did not keep people safe. Staff did not manage clinical waste well.

The service did not have suitable facilities to meet the needs of patients. The service had expanded the range of surgical procedures it provided over the last 12 months. It was initially providing mainly eye surgery but was now providing cosmetic surgery. The service had one theatre, two consultation rooms, one used for minor surgical procedures and post operative follow up appointments and a recovery room. We were provided with conflicting information during our inspection about the use of specific areas in the clinic. For example, we were initially told the room labelled as the recovery room was used for this purpose and had a monitor and trolley located in it. This room was not fit for purpose as it was also used to store surgical gowns, pillows and a variety of other equipment. Later in the day the clinic manager stated this room was not used to recover patients and patients would be recovered in the consultation room that only had tip back chairs.

Oxygen cylinders were not stored safely. Cylinders were stored in the staff changing room, they were not secured to the wall and were located near a water heating unit. We identified one empty cylinder stored next to the full cylinders. When alerted to this risk staff were unclear how oxygen should be stored safely despite the service's medicine policy referencing the procedure for safe storage of oxygen.

The resuscitation trolley was located in the corridor, it was not secure or fit for purpose. It had a locked door on the front with the key left in it, the draws of the trolley were not secured using tamper tags, meaning all medicines and equipment could be accessed by unauthorised people. There was a resuscitation trolley check list but this had not been completed since December 2021, demonstrating staff were not undertaking daily safety checks. We found missing equipment including face masks, medicines and fluids and incorrect strengths of medicines that would be required in an emergency. Some equipment on the trolley was not relevant to the service being provided or the provider's regulated activities such as a paediatric ambu bag. The sharps bin on the trolley had no date it was assembled. The service was using the 2015 Resuscitation Council's UK's guidelines and not those issued in 2021.

The service had not undertaken annual servicing of equipment or Portable Appliance Testing (PAT). The service's equipment list included 33 items such as an oxygen concentrator, defibrillator, ECG machine, none of the listed equipment had been serviced or PAT tested. This meant staff were not assured the equipment was fit for purpose.

Staff did not dispose of clinical waste safely. Staff we spoke with stated the service had permission from the building owner to use the general refuge area to store their yellow clinical waste bin alongside residential household waste. We noted several clinical waste bags were stored on top of the yellow waste bin; we were told this was because the bin was full. When asked for the clinical waste contract we were provided with a collection notice that stated this was undertaken annually. When this was raised with the clinic manager, she stated this was wrong but could not provide evidence that clinical waste was collected more frequently.

Staff did not carry out daily safety checks of specialist equipment. During the follow up inspection on 4 March 2022, we requested evidence that pre-surgical checks of the anaesthetic machine were undertaken and documented. The service said that checks were done but no records were kept.

Assessing and responding to patient risk

Staff did not complete and update risk assessments for each patient or remove and minimise risks.

The service did not have a documented list of what patients they would and would not accept. The service used the American Society of Anaesthesiologists (ASA) classification of physical health to assess a patients' suitability for treatment at the clinic. Staff told us that most of the patients were ASA 1, normal and healthy patients. We saw no evidence of these assessments.

Staff used the World Health Organisation (WHO) safer surgery checklist in theatres, which was designed to prevent avoidable mistakes. Checklists were completed in the patient records we reviewed for those who had surgery under general anaesthetic. Staff told us that they did not audit WHO checklists. However, following a data request the service provided details of two audits undertaken in December 2021 and January 2022. These audits did not review all five steps of the WHO checklist. The results showed 100% for completion of step one – briefing and step two - sign in. Step 3 – time out, step 4 sign out and step 5 debrief were not audited, therefore we were not assured that WHO check lists were completed correctly.

The theatre logbook contained patients' demographics and implant stickers to provide an audit trail of patients and the implant used and if necessary facilitate any re-call of products.

Inadequate

Surgery

All surgery was undertaken as day cases with patients discharged on the same day. There was no printed post-surgery information available for patients.

There was no evidence staff completed risk assessments for each patient on admission / arrival, using a recognised tool. The only risk assessments we noted were completed were for venous thromboembolism risks for patients who were having general anaesthetic.

We were not assured that should a patient deteriorate this would be identified and appropriate action taken to meet their needs. There was no specific deteriorating patient policy. The clinic manager was unclear which version of NEWS the clinic used despite a copy of this being filed in the resuscitation folder. There was a patient transfer policy, but this included conflicting advice of the actions to take should a patient need to be transfer to a centre who could provide a higher level of care. The service level agreement (SLA) that we were told was in place and provided with, should a transfer be required focused on billing arrangements and not transfer arrangements.

Staffing

The service could not be assured staff had the right qualifications, skills, training and experience to keep patients safe from avoidable harm.

The service employed three staff, the clinic manager, operations manager and a health care assistant (HCA). The service's recruitment processes documented in their recruitment policy had not been followed for any of the three staff employed by the service. The service was unable to provide evidence that relevant recruitment checks including references, disclosure and barring service (DBS) checks and professional registration checks had been obtained prior to these individuals commencing work.

The service did not employ nursing staff. If nurses were required to support in theatres, they were employed daily as self-employed nurses. There was no information to confirm these staff had provided the service with all the necessary checks such as DBS checks, references, photographic identification, or that they had completed an application form or that they held personal indemnity before they worked at the location.

The Medical Advisory Committee (MAC) minutes stated the clinic manager was responsible for granting practising privileges to nursing staff to allow them to work at the service. We noted several self-employed nurses had worked at the service but there was no evidence that they had been granted practising privileges.

A review of the recruitment documents for a sample of self-employed nurses and the pharmacist demonstrated that pre-employment checks had not been consistently undertaken. The service held no or very few documents for these individuals, despite the manager stating these recruitment checks had been completed.

Medical staffing

The service did not directly employ any medical staff. There were 24 consultants including consultant ophthalmologists, anaesthetists and plastic surgeons who were reported to have been granted practising privileges to work at the service.

The service had not fully completed the recruitment checks for any of the consultants who had been granted practising privileges. We identified eight of 24 consultants had no DBS, six of 24 consultants had no references, five of 24 consultants had no application forms and four of 24 consultants had no photographic identification on file.

Not all medical staff using the service's operating theatre had been granted practising privileges. The service's theatre log documented the name of the surgeon and first assistant undertaking the procedure. Not all consultants in the log who

had undertaken procedures at the service were listed as having been granted practicing privileges. The manager stated that sometimes verbal temporary practising privileges were granted by the directors of the service. However, these temporary practising privileges were not time limited and there was no evidence of in what circumstances these would be issued. We noted two medical advisory committee (MAC) meetings had taken place since these members of staff had commenced undertaking procedures in the service and there was no evidence that they had submitted an application for practising privileges or that the individuals had been discussed during either of the two meetings.

We were told that sometimes consultants brought their own anaesthetist or scrub nurse to assist with procedures. These anaesthetists and scrub nurses had not been granted practising privileges and had not submitted any recruitment documents such as their right to work, qualifications or DBS. Leaders could not explain what or if any action would be taken when this occurred.

Records

Staff did not always keep detailed records of patients' care and treatment.

All patients' records were paper based. The five patient records reviewed were all legible, but we noted some gaps in their completion. For example, not all records had the 'day case surgery mandatory pre- operative information' completed. This meant the service may not have access to the patient's medical history, current medication or arrangements post discharge.

The service did not record and maintain theatre lists to demonstrate the patients who were scheduled for procedures daily. The manager stated this information was available in several places for example in emails from the consultant's secretary when they were booking the theatre slot, or by text and WhatsApp messages but this information was not collated into one document which demonstrated activity in theatre for the day and the procedures that were to be undertaken.

Medicines

The service did not use systems and processes to safely prescribe, administer, record and store medicines.

The service's medicines management policy was last reviewed in May 2021. However, the policy did not identify the provider on the front page, made no reference to the provider and included tracked changes. It was not clear if the policy had been approved for use or was still in draft format.

The service was holding and storing controlled drugs without a Home Office licence. The service's controlled drug audit in September 2021 identified the service did not hold a Home Office licence. Following the inspection, the service provided information that a controlled drugs licence application to the Home Office had been made but due to this application not being appropriately completed, additional information had been requested to enable it to be processed. We were told one of the directors was the accountable officer but had not submitted notification of this to the CQC and did not demonstrate they understood the responsibilities of this role. For example, they had authorised the clinic manager and two other individuals who were self-employed nurses at the clinic to order CDs, which they stated they would approve before the order was placed. The service was unable to provide any evidence of this process as the clinic manager stated all orders were made electronically to a wholesale medical supplies internet provider and there were no order records.

Controlled drugs (CD) were stored securely, records showed CDs were only checked when two trained members of staff were available. At our initial visit we found no discrepancy between the logbook and CDs held. However, on our second visit to the service we noted there was a discrepancy in the number of one of the CDs which did not match the number

recorded in the CD logbook. We were told no patients had been seen since our previous inspection as the service was suspended, the staff we spoke with could not provide an explanation why there was a discrepancy. The clinic manager did not seem overly concerned when this was reported to them and only stated the action they would take when prompted. We were not provided with any evidence that this action had been taken.

Other medicines were not stored securely to prevent unauthorised access. The medicine cupboard was located in the recovery room, it was unorganised, unlocked and easily accessible. Some medicines were out of date with expiry dates in November and December 2021 this included Tropicamide eye drops and Acetazolamide.

Medicines requiring refrigeration were stored in a lockable fridge which had not been locked. We found fridge temperatures were not recorded daily and had not been checked since 3 February 2022. Therefore, the service could not be assured medicines were stored within the correct temperature range and were safe for patient use. Some of the medicines stored in the fridge had been reconstituted with no date of when this had occurred while others were past their expiry date. Two vials of medicine had been part used and had their lids sellotaped back on. This posed an infection control risk. These risks were raised with the clinic manager, but no immediate action was taken and on our second visit to the service eight days later the out of date medicines and those which had potentially not been stored at the correct temperature had still not been disposed of.

Several pre-loaded intraocular lenses used in cataract surgery were past their expiry date of November and December 2021 and stored in the same cupboard as in date lenses. This was highlighted to the manager immediately but on our return visit the lenses had not been disposed of.

The resuscitation trolley had missing medicines and intravenous fluids. There was no anaphylaxis box and some medicines that would be required in an emergency were missing or were the wrong strength. This posed a risk that timely treatment would not be delivered to a patient in an emergency.

There were no effective arrangements for the disposal of medicines and controlled drugs. The manager stated CDs were disposed of in a blue bin along with other medicines. There was no book to track what was placed in the bin and we noted medicines were also placed in other sharps bins. The clinic manager demonstrated no knowledge of the correct procedure to dispose of CDs or an awareness the current procedure was not in line with regulations or the instructions outlined in the service's medicines' management policy. We were told the service had a contract to remove out of date and waste medicines, the service level agreement (SLA) we saw was for clinical waste and stated an annual collection.

Incidents

The service did not manage patient safety incidents well.

Staff did not always report incidents. The September 2021 controlled drug audit identified one discrepancy had been found at the time of audit. The action from the audit was to complete an incident form. This had not been completed.

The service maintained an incident log to track incidents and record when they were closed. The log we reviewed for the period March 2021 to February 2022 included two incidents, one closed and one open, dating back to October 2021. Following our inspection, a revised log was submitted which included three additional incidents, one dated November 2021 which had been closed and two incidents in February 2022 which related to the inspection. It was unclear why conflicting information had been submitted.

Inadequate

Surgery

Staff told us that incidents were presented to the Medical Advisory Committee (MAC) which had been established in September 2021 and met three monthly. The minutes of the MAC meetings for September 2021 and January 2022 did not include a record of incidents having been discussed.

It was not clear how managers shared learning from incidents as the service did not hold staff team meetings. Therefore, there could be missed opportunities for learning and reducing the risk of similar incidents re-occurring.

Are Surgery effective?

Inadequate

We had not previously rated effective at this location. We rated it as inadequate.

Evidence-based care and treatment

The service did not always provide care and treatment based on national guidance and evidence-based practice.

We were not assured staff had access to relevant, up to date policies based on best practice or national guidance. Some of the service's policies referred to another provider, had this provider's logo on them and had not been adapted to reflect the service provided at this location. These included policies and procedures that had been recently reviewed and updated such as the medicines' management and practising privileges policies. There was no clear process for the approval of policies. The clinic manager stated they were updating all policies but there was no plan of in what order these would be done or the timescale for completing this task. One of the directors stated they had recently reviewed all policies and was unaware that some of the policies on the provider's electronic system had other provider's logos on them or did not reflect the service being provided.

Staff told us patients' pre-operative assessment was undertaken off site by their consultants. There was no evidence provided that staff followed NICE guidance or the professional standards for cosmetic surgery 2016 to ensure that patients had relevant tests prior to surgery, to minimise the risk of complications or harm. The service did not use the Royal College of Surgeon's (RCS) audit tool that covers key aspects of pre-operative assessment and consultation.

Nutrition and hydration

There was no evidence provided that patients were advised about fasting times prior to surgery. The pre–operative check list did include 'nil by mouth' for patients undergoing general anaesthetic. National guidance is patient should be nil by mouth, at least six hours from food and two hours from drinking, prior to surgery. There was no evidence this guidance was being adhered to.

Staff told us they could order food and hot and cold drinks from local cafés as no food was prepared at the service. A coffee machine was available in the reception.

Pain relief

There was no evidence that patients' pain was assessed using a recognised tool and they were given pain relief in line with individual needs and best practice.

Inadequate

Surgery

Patients were prescribed discharge medicines to manage their post-operative pain. Staff told us that patients were usually given their prescription on discharge, but no medicines were provided from the service these were obtained from the patient's local pharmacy.

Patient Outcomes

Staff did not monitor the effectiveness of care and treatment.

Staff told us the service did not audit surgical outcomes. This meant patients are or may be exposed to a risk of harm from a lack of oversight of clinical practice to ensure care met best practice and was in line with expected service standards.

The service did not participate in relevant national clinical audits. The service did not participate in the Q- Patient Reported Outcome Measures (Q-PROMs) for cosmetic surgery procedures. Completion of PROMs, pre- and post-operatively, allows for a patient's own measurement of their health and health-related quality of life, and how this has been changed by the surgical intervention. PROMs are distinct from more general measures of satisfaction and experience, being procedure-specific, validated and constructed to reduce bias effects.

At the time of our inspection the service had not engaged with the Private Healthcare Information Network (PHIN) and were not submitting data in accordance with legal requirements regulated by the Competition Markets Authority (CMA). The clinic manager stated that the service planned to submit data to PHIN but gave no date when this would commence.

The service did not have a comprehensive audit programme and did not undertake repeated audits to check improvement over time.

Competent staff

The service could not be sure staff were competent for their roles.

There was limited evidence that staff were experienced, qualified and had the right skills and knowledge to meet the needs of patients. There were limited pre-employment checks to confirm staff's suitability to work at the service.

The operations manager was noted to be undertaking the health care assistant (HCA) role in theatre. There was no evidence that they had been trained and assessed as competent for this role.

The service had a temporary staff induction pack which included staff who worked under practising privileges or were self-employed. The service was unable to provide evidence that any temporary staff had completed an induction. Staff who had recently joined the service on a permanent basis stated they did not have a formal induction.

The service did not undertake annual appraisals, to support and develop the skills and knowledge of staff or address poor staff performance. The provider had a service provider agreement / practising privileges policy for individual consultants who worked under practising privileges. However, the policy did not identify the provider on the front page and made no reference to the provider. The policy also stated consultants granted practising privileges were required to provide evidence that they had an appraisal with their main employer, revalidation and professional registrations. At the time of our inspection the service was not able to provide evidence that any of the 24 consultants who worked at the service had an annual appraisal in the last 12 months. Following the inspection, the service submitted evidence that demonstrated 41% of consultants had an appraisal in the last 12 months. There was no explanation why this evidence was not available at the time of our inspection.

Inadequate

Surgery

Multidisciplinary working

The service was not able to provide evidence that information was shared between the service and the patient's general practitioner (GP) in order to ensure safety of the patient.

There was no formalised multidisciplinary team working. Treatment provided was consultant-led and they had overall responsibility for the patient's care.

Seven-day services

Services were available to support timely patient care.

Services were not provided seven days a week. The service operated Monday to Friday and on Saturday by appointment. Staff told us the theatres normally operated from 9:00 am with patients being admitted from 7:30am, and patients could still be on site until 8:30pm.

Entries in patient notes stated they were advised they could contact the service for help or advice 24 hours a day, seven days a week. It was not clear how this access could be provided as the service did not provide an out of hour service.

Health promotion

Staff did not give patients practical support and advice to lead healthier lives.

The service did not have relevant information promoting healthy lifestyles and support. The service stated any relevant health promotional information was supplied via trusted third parties such as www.patient.co.uk and www.nhs.uk/condition and other advisory sources and services. We were not provided with evidence of when the service had done this.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

Staff did not always follow national guidance to gain patients' consent.

Staff gained consent from patients for their care and treatment, but this was not always in line with legislation and guidance. For example, one record we reviewed showed there was a week between the consultation and the procedure being undertaken. This was not in line with the national recommendations (Royal College of Surgeons (RCS) Professional Standards for Cosmetic Surgery April 2016) 'cooling off' period. It is recommended that there is a minimum of two weeks between consultation and procedure. In other records we reviewed, consent forms had been completed but it was not clear if patients had waited a minimum of two weeks between consultation and surgery.

The service had a consent policy which was last reviewed in May 2021. However, the policy did not identify the provider on the front page and included tracked changes. It was not clear if the policy had been approved for use or was still in draft format. The policy made no reference to the provider and included the consenting of patients who would not be treated at the service as they did not meet the provider's eligibility criteria of only accepting those patients classified as ASA1.

Are Surgery responsive?

Inadequate

We had not previously rated responsive at this location. We rated it as inadequate.

Inadequate

Surgery

Service delivery to meet the needs of local people

The service did not provide care in a way that met the needs of people accessing the service.

The service provided a range of cosmetic procedures to self-funding patients both from the local area and other parts of the country. Managers planned and organised services to meet the needs of the patients booked for surgery. All admissions were pre-planned, and patient details were sent to the service by the consultants in advance. Patients could normally access treatment between Monday and Friday 9:00am to 5:00pm. Sometimes clinics would run later to accommodate patients.

The facilities and premises were inappropriate for the services delivered. Staff were not clear which room would be used for the post-operative recovery of patients. There was limited storage resulting in all rooms being cluttered.

Meeting people's individual needs

The service did not take account of patients' individual needs and preferences.

Staff did not have access to communication aids to help patients become partners in their care and treatment. There was no hearing loop, information or signage suitable for visually impaired patients.

The service was not accessible to those with mobility issues. There were no accessible toilets, the seating in reception was not appropriate for those with limited mobility, there were no hoists to move patients between wheelchairs and the operating trolley or transfer board slides to move patients between the trolley and operating table in theatre.

Staff told us they would provide translation services if needed or patients could bring a family member. The use of family members for translation is not in line with best practice.

Access and flow

People could access the service when they needed it.

Patients could arrange an appointment by telephone or make an enquiry via the service's website. However, the service's website differed from the name registered with the CQC which could cause confusion if patients tried to locate the service on the CQC website.

All appointments were booked in advance. The service had undertaken 87 surgical procedures between July 2021 and February 2022. This included 10 procedures using general anaesthetic and 77 procedures using conscious sedation or local anaesthetic. We were not assured all these procedures had been undertaken by consultants and nursing staff who had been granted practicing privileges to operate at the service.

Learning from complaints and concerns

It was not easy for people to give feedback and raise concerns about care received.

Patients could not easily provide feedback on the service they received. The service had no systems or processes in place to collect patient satisfaction information. The service did not display information about how to raise a concern or complaint either at the service or on their website.

There had been one complaint received within the last 12 months, which had been investigated and closed. Complaints were not reported and discussed at the Medical Advisory Committee (MAC).

Inadequate

Surgery

The service had a complaints' policy which was last reviewed in June 2021. However, the policy made no reference to the provider and was not relevant to the service provided.

Are Surgery well-led?

Inadequate

We had not previously rated well-led at this location. We rated it as inadequate.

Leadership

Not all leaders had the skills and abilities to run the service. They did not understand and managed the priorities and issues the service faced.

Leaders were unable to demonstrate there was effective leadership of the service. The service did not have a clear leadership structure with defined lines of responsibility and accountability. While individual members of staff had the necessary clinical skills there was no evidence that they had the skills and experience to effectively manage the service. The registered manager was not present on either day we visited, and we were provided with conflicting reasons for why they could not attend to meet with us. Following our inspection we were informed this individual would be absent from the service for a period of three months, The day to day operational management was overseen by the clinic manager, who stated they were in the process of applying to become the registered manager, but no documentation had been received by the Care Quality Commission (CQC) to process this application.

Leaders did not demonstrate an understanding of the challenges to quality and sustainability for the service. The senior staff did not understand the day-to-day issues at the service. They had not identified the issues identified by the inspection team and did not demonstrate that they understood the severity of the issues and concerns fed back to them. On our second visit we noted that very limited action had been taken to address the concerns identified and raised with the managers by the inspection team at our previous inspection.

Vision and Strategy

The service had a vision for what it wanted to achieve but no strategy to turn it into action.

The service's vision was 'to provide a high-quality day care surgical service, by combining outstanding clinical expertise, cutting edge technology, and patient-centred healthcare.' We could not see evidence that this vision was embedded in the service or any strategy or plan of how this would be achieved.

Culture

Staff were enthusiastic about the care they delivered to patients. There was no evidence the service had an open culture where patients, their families and staff could raise concerns without fear.

Staff were enthusiastic about the services they provided for patients and stated they worked well as a team. However, there were no opportunities for further learning and development. Staff did not have annual appraisals or regular one-to-one meetings were development needs and concerns could be raised openly.

There were no systems or processes in place for those staff working under practising privileges to speak up about concerns or raise issues about risks.

Inadequate

Surgery

There were no systems or processes in place to ensure compliance with duty of candour. Senior staff did not demonstrate that they were aware of their responsibilities under duty of candour and the need to be open and transparent and give patients and families a full explanation when things went wrong.

Governance

Leaders did not have effective governance processes.

The service lacked an effective clinical governance structure. The newly set up a Medical Advisory Committee (MAC), chaired by an external consultant had met three times. It was unclear how well attended this meeting was as minutes of the first meeting showed two of the five consultants had sent their apologies and apologies were not recorded in the second set of minutes.

The service did not have effective systems, such as audits and risk assessments, to monitor quality and safety. There was no annual audit plan in place and limited audits were undertaken. The minutes of the MAC reported that the service had performed well in recent medicine audits. We were not provided with the scope of this audit or its findings. However, during our inspection we identified numerous medicine management concerns which if medicine management was audited on a regular basis should have been identified and addressed. Following our inspection, the service provided an audit schedule for 2022, it was unclear when this had been drafted and approved as the clinic manager informed us during the inspection the service did not have an audit plan.

We were told clinical indicators were discussed at the MAC, these indicators included safeguarding referrals, mandatory training, audits of the World Health Organisation (WHO) check lists. It was unclear if these indicators related to this service as there was no reference to the provider on the paperwork and a number of the clinical indicators were listed as not applicable. Some of the indicators such as WHO check list audits and mandatory training were showing as 100% compliance in Quarter 4 2021. Evidence collected during this inspection demonstrated the WHO check list audits were incomplete and mandatory training records were not held for all staff. It was unclear what data was used to inform these audits.

Following our inspection, the service provided minutes of two management meetings held in January 2021 and three emails to demonstrate meetings were planned. One of the emails dated 01 March 2022 had 12 meetings with future meeting dates. The minutes submitted lacked detail, they did not provide a summary of the discussions held and some lacked a record of attendees. The service was unable to provide evidence that incidents and complaints were discussed at any meeting.

The service provided the terms of reference for their integrated governance committee (IGC) this committee was not in operation at the time of the inspection and it was unclear when it was due to meet for the first time. There was no reference to this committee in the MAC minutes and it was unclear how the MAC linked into this committee.

Management of risk, issues and performance

Leaders did not identify and escalate relevant risks and issues or identify actions to reduce their impact.

Following our inspection, the service provided a risk management register which identified 64 risks. This register lacked details including when the risk was added to the register, who the identified risk owner was and the date the risks were last reviewed. There were no action plans in place to mitigate the risks identified. The risk register did not include the risks that were identified during the inspection. It was unclear who was responsible for reviewing and updating the risk register and at which meeting risks were discussed.

Inadequate

Surgery

The service did not have a systematic programme of clinical audits to monitor quality and performance. There was no data to evidence how the service was performing or to identify areas for improvement.

The service maintained a (Central Alert System) CAS register which demonstrated alerts including Medicines and Healthcare products Regulatory Agency (MHRA) safety guidelines were logged.

The service had a business continuity plan 2021/2022 which outlined how unexpected risks were to be managed.

Information Management

The service did not collect reliable data and analyse it.

Clinical audit and performance data were not collected and used to improve the quality of service.

The service had a Caldicott and data protection policy which was last reviewed June 2021. However, the policy did not identify the provider on the front page and made no reference to the service. The policy set out details of an electronic medical record system that the service planned to use, during the inspection we saw no evidence that this record system was in operation. We were not assured the service managed data and information in line with data protection legislation. Staff did not receive training in information governance.

The service did not submit any statutory notifications to the Care Quality Commission as required under Regulation 15 Care Quality Commission (Registration) Regulations 2009 which requires providers to notify incidents, events and changes to the service that affect the service or people using it. The service had failed to inform the CQC that it was operating under another name to the one registered with the CQC. The provider has a legal duty to inform the CQC when there are any changes to the registered details of the service.

Engagement

Leaders did not actively and openly engage with patients.

The service did not collect patient satisfaction data, there was no survey or other tool to collect patient's views and allow them to feedback on their experience of using the service. Therefore, there could be missed opportunities to follow up concerns or issues and make changes to improve the service.

Learning, continuous improvement and innovation

Staff were not committed to continually learning and improving services.

During the inspection we found no evidence that leaders were committed to continually learning and improving the service**.**

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
Diagnostic and screening procedures Surgical procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance • Must ensure incidents are reported and investigated.

Regulated activity	Regulation
Diagnostic and screening procedures Surgical procedures Treatment of disease, disorder or injury	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care • Must ensure there are appropriate arrangements in place for people with a disability to use the service.

Regulated activity	Regulation
Diagnostic and screening procedures Surgical procedures Treatment of disease, disorder or injury	Regulation 15 CQC (Registration) Regulations 2009 Notifications – notice of changes • Must ensure the Care Quality Commission (CQC) is informed of any changes to the registered details of the service.

Regulated activity	Regulation
Diagnostic and screening procedures Surgical procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment • Must ensure all staff have mandatory training in key skills. • Must ensure staff complete an updated risk assessments for each patient.

This section is primarily information for the provider

Requirement notices

Regulated activity	Regulation
Diagnostic and screening procedures Surgical procedures Treatment of disease, disorder or injury	Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment • Must ensure all staff complete safeguarding training.