Roberto Viel and Maurizo Viel

London Centre for Aesthetic Surgery

Inspection report

15 Harley Street
London
W1G 9QQ
Tel: 02076364272
www.lcas.com

Date of inspection visit: 22 November 2022
Date of publication: 11/01/2023

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 caring?	Insufficient evidence to rate
Are services responsive to people's needs?	Insufficient evidence to rate
Are services well-led?	Inadequate

Summary of findings

Overall summary

We rated the service as inadequate because:

- Managers did not make sure staff were competent. The service did not have processes to monitor the professional registration of the bank nurse working in the service. They did not have assurance of checks in place for agency nurses used to support the delivery of services as they did not keep records of agency usage. They did not have processes in place to provide assurance that staff had up to date training in key skills, understood how to protect patients from abuse, and managed safety well.
- The service did not control infection risk well. Processes for checking medicines and emergency equipment were not regularly carried out. A significant amount of medicines stored in the treatment room had expired and medicines requiring refrigeration were stored at room temperature. The controlled drugs accountable officer had not received training for this role. Controlled drug entries in the register were not always recorded in line with required standards of the controlled drug regulations.
- Risks to patients were apparent in relation to poor maintenance and availability of clinical equipment, the presence of expired single use clinical equipment and environmental risks that had not been sufficiently assessed or mitigated. There was limited evidence the service managed safety incidents well and learned lessons from them due to limited reporting of events and learning opportunities.
- Consent processes did not include evidence of a cooling off period when patients were making decisions about cosmetic surgery. There was little evidence of recognised national guidance informing clinical protocols within the service. The provider had no processes to collect performance measures and supply these to the Private Healthcare Information Network (PHIN).
- Leaders did not have the necessary knowledge, skills or abilities to run the service. Leaders did not operate effective governance processes throughout the service. Staff did not use systems to manage performance effectively. They did not identify, review or manage risks and issues effectively.

However:

- People could access the service when they needed it and did not have to wait too long for treatment. The service planned and took account of patients' individual needs. Staff were focused on the needs of patients receiving care.
- The service engaged well with patients and made it easy for them to give feedback.

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Surgery	Inadequate 	We rated the service as inadequate. See the summary above for details.

Summary of findings

Contents

Summary of this inspection

Background to London Centre for Aesthetic Surgery

The London Centre for Aesthetic Surgery is operated by 'London Centre for Aesthetic Surgery' and is a small independent clinic, which has been registered since April 2002. The clinic provides cosmetic surgery services for private patients over the age of 18 years. Cosmetic procedures were carried out under local anaesthetic or conscious sedation with an anaesthetist present.

Care was delivered by the provider, a doctor supported by anaesthetists who operated 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 service employed one nurse on a zero hours contract and used agency nursing staff as required.

Patients are admitted for planned day case surgical procedures. The service does not provide overnight accommodation. Facilities include one treatment room, two recovery rooms and two consultation rooms.

The registered manager is the owner of the service. The service is registered to provide the following regulated activities;

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

The clinic also offers cosmetic procedures such as dermal fillers, fat harvest and fat injections. We did not inspect these services as they are outside of the scope of CQC registration.

Following our comprehensive inspection in November 2022, the service was rated inadequate and we suspended the registration of the provider for 8 weeks.

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 visited the service and spoke with staff. At the time of the inspection surgical procedures were not being conducted and only outpatient appointments were being offered. We spoke with three staff including the surgeon and registered manager, the practice manager and an administrator. We observed staff interacting with a patient, interviewed the registered manager and practice manager, reviewed five patient records, observed the care environment and reviewed a variety of governance documents.

Summary of this inspection

We carried out an unannounced inspection on 28 November 2022 using our comprehensive inspection methodology and rated the service. We previously inspected the service in 2017 but did not rated the service as CQC did not have a legal duty to rate cosmetic surgery services.

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.

Areas for improvement

Action the service MUST take to improve:

- The service must ensure the proper and safe management of medicines including storage in line with manufactures' guidance and undertaking regular checks.
- The service must ensure the administration of controlled drugs are recorded in line with required standards of the controlled drug regulations.
- The service must ensure that the controlled drugs accountable officer has undertaken training for this role.
- The service must ensure that clinical equipment is available and checked on a regular basis.
- The service must ensure all single use items are within their expiry date.
- The service must ensure that the treatment room used for surgical procedures has adequate air flow.
- The service must ensure that the water system is maintained, water safety risk assessments are completed, and action taken to mitigate any identified risks.
- The service must ensure there are suitable arrangements in place for the safe transfer of patients in an emergency.
- The service must ensure that there are systems and processes in place to identify, regularly review, record and monitor business, operational and clinical risks.
- The service must ensure that all staff have mandatory training in key skills.
- The service must ensure all staff complete safeguarding training.
- The service must ensure that prescription pads held within the service are monitored to minimise the risk of misuse.
- The service must ensure equipment and control measures are in place to protect patients, staff and others from infection
- The service must ensure that infection prevention and control audits are carried out and action is taken on the findings.
- The provider must implement processes to collect performance measures and supply these to the Private Healthcare Information Network (PHIN).
- The service must ensure there are effective governance processes.
- The service must ensure incidents are reported and investigated.
- The service must ensure all policies and procedures are up to date, reflecting national guidelines and are relevant to the service being delivered.
- The service must ensure that employment checks including professional registration status, training completed, and records of these checks held at the service for all staff and those granted practising privileges.
- The service must ensure that records of agency nurse usage are maintained, and that assurance is provided by the agency of recruitment practices and competency checks.
- The service must ensure records of patients' care and treatment are complete and all parts of the records are stored securely.
- The service must ensure WHO check lists are completed for all patients

Action the service SHOULD take to improve:

Summary of this inspection

- The service should undertake appraisals for all staff working within the service.
- The service should ensure that psychological assessments are clearly recorded in patient records as part of pre-procedure assessment processes.
- The service should submit Q-PROM data for cosmetic procedures as requested by The Royal College of Surgeons.

Our findings

Overview of ratings

Our ratings for this location are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Surgery	Inadequate	Inadequate	Insufficient evidence to rate	Insufficient evidence to rate	Inadequate	Inadequate
Overall	Inadequate	Inadequate	Insufficient evidence to rate	Insufficient evidence to rate	Inadequate	Inadequate

Inadequate

Surgery

Safe	Inadequate
Effective	Inadequate
Caring	Insufficient evidence to rate
Responsive	Insufficient evidence to rate
Well-led	Inadequate

Are Surgery safe?

Inadequate

We rated safe as inadequate.

Mandatory training

The service did not make sure that everyone completed mandatory training.

There was no training matrix that identified the training staff including those working under practising privileges were expected to complete. The practice manager had identified her own training. Staff had access to mandatory training. However, we found that not all staff had completed this and training updates were not regularly undertaken. For example, there was no up to date record of the nurse's training, other than immediate life support training. The practice manager told us she was in the process of completing her mandatory training at the time of the inspection. However, there was no record of completed training in areas such as information governance, health and safety and moving and handling, despite the dates having passed.

Records of training for medical staff, working under practising privileges were not always held. For example, there was no record of advanced life support training for one of the anaesthetists. We were told they had completed this training through their NHS post but there was no record of this held by the service.

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 had training on how to recognise and report abuse and procedures were not clear on who to contact in the event of concerns.

Staff training records did not include evidence that up to date safeguarding training had been completed by staff. We saw that one member of staff had level 3 safeguarding training scheduled on their training plan, however, the date for this had passed and the training was incomplete.

Inadequate

Surgery

The service had a safeguarding policy and the surgeon was the service's identified safeguarding lead, who had completed level 3 safeguarding training and was responsible for reporting concerns. However, the policy did not contain current contact details for local authority safeguarding leads. The surgeon practiced at the service for one week in a month and was overseas for the rest of the month, staff did not have clear guidance on how to escalate safeguarding concerns that may be identified in the absence of the lead.

Cleanliness, infection control and hygiene

The service did not control infection risk well. Equipment and premises were not kept clean and in good working order. Control measures were not consistently in place to protect patients, staff and others from infection. The service had processes to identify surgical site infections.

Clinical and treatment room areas were not visibly clean, and the environment was not well-maintained. Surfaces and equipment were visibly dusty in the treatment room, recovery and the storeroom. Surgical scrub handwash was passed its expiry date. A cleaning schedule was in place. The practice manager told us that cleaning had been reduced during the Covid pandemic due to a reduction in activity. The cleaning schedule we reviewed showed a daily cleaning schedule, however, we noted that daily tasks such as vacuuming, and cleaning of bathrooms and sinks were being carried out across the week.

Infection prevention and control (IPC) audits were not carried out regularly. We reviewed annual IPC audit records up until 2019 but there was no evidence these audits had continued following the nurse who undertook these audits had left the service in 2019. The provider had also stopped using a regular contractor for IPC advice and support, it was unclear why this service was no longer being used.

Staff worked to identify surgical site infections. They audited infection rates as part of their ongoing post-operative follow up. We reviewed clinical infection audits that included post-operative complications such as infection. Between January 2022 and October 2022 there had been no identified post-operative infections.

We were told that staff cleaned equipment after patient contact, however, equipment was not labelled to show when it was last cleaned.

Environment and equipment

The design, maintenance and use of facilities, premises and equipment did not keep people safe. Staff managed clinical waste well.

The design of the environment did not follow national guidance. The treatment room did not have an air flow system. This was not in line with best practice that a standard treatment room used for surgical procedures needs to have at least 10 air changes per hour. This lack of air flow increased the risk of service users being exposed to the risk of airborne contamination. There was a fan heater on the floor in the treatment room and the service's air conditioning system had not been serviced, this posed a potential risk of circulating dust particles and an increased infection risk.

We found water testing had not been undertaken on a regular basis. There was no record of water flushing, temperature checks, legionella testing or a risk assessment that covered the water supply in the clinic. We noted a sensor operated tap in one of the consulting rooms was not working and had no water flow. A hand operated tap in a recovery room had no water flow. There was no record of water flushing, temperature checks, legionella testing or a risk assessment that covered the water supply in the clinic.

Staff did not carry out regular checks of specialist equipment. Emergency equipment in the treatment room, including a defibrillator had not been regularly checked. Records of these equipment checks held in the treatment room were dated 2018.

The service did not have enough suitable equipment to help them to safely care for patients. Clinical equipment was not properly maintained. For example, we identified that a defibrillator, blood pressure monitors and pulse oximeters (to measure oxygen levels) had last been calibrated in January 2020, this should have been done annually in line with best practice. The only suction machine was a liposuction machine, which was not suitable for clearing the patient's airway.

Single use items of clinical equipment such as surgical tubing and instruments were not regularly checked to ensure they were fit for purpose. We found several items of expired equipment in the treatment room, this included suction tubing and an ambu bag (a handheld device to provide manual ventilation to patients who are not breathing).

Staff disposed of clinical waste using appropriate clinical waste arrangements. However, we found sharps bins in the treatment room that were not appropriately labelled or had not been disposed of within the recommended three months from first use.

Assessing and responding to patient risk

Staff identified patients at risk of deterioration, however, emergency transfer arrangements were not in place and psychosocial assessments were not clearly recorded. The service made sure patients knew who to contact to discuss complications or concerns.

There was a clear admission criterion in place and patients who were accepted for treatment were generally fit and well with a low risk of developing complications. The surgeon assessed patients prior to a procedure during an initial consultation. This included the completion of a health questionnaire and the identification of specific risk areas. Where a patient had additional risks identified they were assessed as to the appropriateness of the procedure, or the appropriateness of undertaking the procedure in the treatment room environment. Where patients were assessed as at increased risk and the risk could not be mitigated, the procedure would not be carried out.

Staff knew about and mitigated specific risk issues, including the risk of venous thromboembolism (VTE). All patients undergoing a procedure in the treatment room wore VTE stockings. Blood tests carried out prior to the procedure included a check of blood clotting risks. We saw that patients were prescribed antibiotics following some procedures, where there was an increased risk of infection.

The WHO (World Health Organisation) surgical safety checklist is a system to safely record and manage each stage of a patient's journey from admission to the treatment room and to recovery and discharge from the treatment room. The clinic used the WHO checklist to monitor safety for individual patients undergoing procedures. However, we found this was not always completed. For example, between September and October 2022 six of 13 files did not have a completed World Health Organisation (WHO) safety checklist completed for patients who were undergoing a procedure under local anaesthetic. This had been an area identified for improvement at a previous CQC inspection, but we found no evidence that this had been actioned.

Staff monitored patients' heartrate, blood pressure and oxygen levels prior to and during a procedure to identify any deterioration. The clinic had an emergency transfer protocol in place for the transfer of patients who became unwell or suffered an adverse event. However, we were told that the service level agreement with an independent hospital for emergency transfer to hospital had been cancelled during the Covid-19 pandemic when the service had been reduced. The service level agreement had not been reinstated, despite procedures being undertaken at the clinic in the months

prior to our inspection. We were told that in the event of a patient requiring hospital admission, a private ambulance would be used, however, there was no written agreement with a private ambulance provider in place. The clinic was in premises that had a lift; however, the lift could not accommodate a patient stretcher, therefore evacuation would be difficult. There was no risk assessment for how the patient would be evacuated from the clinic while maintaining their airway.

Resuscitation Council UK guidelines displayed in the treatment room were out of date. The guidelines displayed were dated 2015, these had been updated in 2021.

The surgeon told us they completed psychosocial assessments as part of their assessment of patients prior to undertaking a procedure. However, the recording of this was not always clear in patient's records.

Following a procedure patients were given contact details for the clinic and a mobile telephone number for the surgeon. They were told to use these contact details if they had concerns.

Nurse staffing

The service had limited assurance that they had enough nursing with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment.

The service could not demonstrate they had enough suitably qualified nursing staff to keep patients safe. As the service only operated clinical activity one week per month, they employed one bank theatre nurse on a zero hours contract who worked two days for the one week of clinical duty. This individual was supported by agency nurses and the service could not provide assurance that these nurses were appropriately qualified to undertake the role they were employed to undertake..

The bank nurse was responsible for booking the agency staff to meet the service's demands. The service did not hold any records of the agency nursing staff who had worked at the service and had no assurance that they were appropriately qualified and suitable for the roles undertaken. In addition, the service did not have a process in place for checking the Nursing and Midwifery (NMC) registration of the nurse employed.

Medical staffing

The service had medical staff with the right qualifications and skills and experience, including those through a practising privileges arrangement, to provide care and treatment. However, records of training were not consistently maintained.

The service did not directly employ any medical staff. The provider was a surgeon who undertook cosmetic procedures. They worked one week a month and were based in another clinic overseas for the remaining period. There was limited cover during times when the surgeon was overseas, with advice and support available by telephone only.

The clinic's two consultant anaesthetists worked under practising privileges to provide conscious sedation for the procedures and held NHS contracts. Practising privileges are a well-established system of checks and agreements, whereby doctors can practise in hospitals without being directly employed by them. The service had not fully completed the recruitment checks for one of the consultants who had been granted practising privileges.

The clinic held staff records for one of these individuals which included evidence of indemnity, recruitment and some training but not advanced life support training for one of the anaesthetists. The practice manager told us they had been assured the training had been completed as part of the anaesthetist's NHS role but there had been difficulties getting access to the record for this training. We were told the service was only using one anaesthetist; however, we noted the second anaesthetist had been used in September 2022. We were not provided with a staff file for this individual.

Records

Staff kept records of patients' care and treatment; however, these were not always completed appropriately. Records were easily available to all staff providing care, however not all records were stored securely.

Patient paper notes were kept securely in a locked cabinet and password protected electronic records were maintained. The five sets of patient paper records we reviewed were not completed consistently. For example, one patient record included an incomplete procedure checklist, a second had no record of their recovery care. We also found that operation records were not always clear as the handwriting was difficult to read. This legibility issue had not been identified in any of the records' audits carried out.

The service audited records, we reviewed the results of these audits from May, September and November 2022. We noted that on occasions the standard of record keeping fell below the provider's expected standard. For example, there were gaps in World Health Organisation (WHO) safety checklist completion for patients who had a procedure under local anaesthetic. There was no evidence action had been taken to address the identified issues.

Staff did not always follow best practice to keep patient care and treatment confidential. While we saw evidence in records of patients recording their consent for photographs to be taken of before and after procedures, these pictures were not stored securely within the service. We found a folder containing photographs in a store cupboard that could be accessed by staff other than those involved in patient care and treatment.

Medicines

The service used systems and processes to prescribe, administer, record and store medicines. However, these systems and processes were not effective resulting in expired medicines being stored with in date medicines and medicines being stored inappropriately. Prescription pads were not monitored to prevent the risk of misuse.

The clinic had a service level agreement in place for the supply of medicines including controlled drugs. The provider had a home office licence for the storage and use of controlled drugs (CDs) that had been issued earlier in 2022, as their licence had expired during a time when the service was closed due to the restrictions of the Covid pandemic. During the period without a home office licence they used a CQC registered mobile sedation service.

Medicines were not appropriately stored or disposed of. We found 13 different medicines that had expired, including oral and intravenous medicines. This included medicines that were for use in an emergency. We found one medicine that was labelled as requiring refrigeration that was stored at room temperature and had expired. This posed a risk of patients receiving medicines that were out of date or ineffective as they had been stored incorrectly.

Medicines were prescribed and administered by the surgeon or anaesthetist participating in the procedure. Medicines administration was recorded in the patient record. The administration of controlled drugs was recorded in the CD register.

Inadequate

Surgery

We saw that entries in the CD register included crossings out which was not in line with best practice in relation to CD registers, where the original entry is required to be clearly legible. For example, we reviewed an entry where the type of controlled drug (ampoule rather than capsule) had been entered in error and had been scored through and a stock balance entry error that had been written over.

The practice manager was the CD accountable officer. However, they had not completed training in this area. This had been raised at the previous inspection as an area that should be addressed but no action had been taken.

Prescribing documents were stored securely, however, there was no process in place to record or monitor prescription form serial numbers with a view to preventing misuse.

Incidents

The service did not manage patient safety incidents well. Staff did not recognise and report incidents and near misses. Managers ensured that actions from patient safety alerts were implemented and monitored.

The service had an incident reporting policy with an incident form to be completed in the event of an incident. However, the form did not include space or prompts to include the patient's or staff details. We were told that no safety incidents had occurred in the last two years. However, we noted in the record of one patient, they had experienced a complication which resulted in them returning to the treatment room from the recovery for further treatment. As this was not recorded as an incident, there was no record of review or learning to identify if changes to practice were required.

Staff understood the duty of candour. There was a policy and process in place that included ensuring openness and transparency.

Are Surgery effective?

Inadequate

We rated effective as inadequate.

Evidence-based care and treatment

The service did not always provide care and treatment based on national guidance and evidence-based practice. Some policies did not reference relevant guidance and some guidance was out of date. The manager did not check to make sure staff followed guidance.

Clinical policies had been regularly reviewed; however, they did not all reference up to date best practice and national guidance. For example, while the patient assessment policy referenced NICE guidance for routine preoperative tests for elective surgery, the operational and patient centred care policies did not include relevant Royal College of Surgeons references.

Monitoring care delivery did not always include checking that staff followed guidance. For example, an audit of consent did not include monitoring of a cooling off period of at least two weeks between stages to allow the patient to reflect on the decision. This was not in line with the standards published by the Royal College of Surgeons.

Inadequate

Surgery

We were told that patient assessments included an assessment of their psychological and emotional needs; however, this was not always clearly recorded in patient records. We also saw reference in the patient assessment policy that the nurse would undertake a nursing evaluation on admission and discharge. However, we did not see a record of this in patient's notes.

Nutrition and hydration

Patients were not required to fast prior to procedures.

Most procedures were under local anaesthetic, the rest under sedation, so patients were able to eat and drink. The provider had water and hot drinks available for patient comfort. Snacks were available on treatment days within the clinic.

Pain relief

Staff assessed and monitored patients regularly to see if they were in pain and gave pain relief in a timely way.

Staff assessed patients' pain using a recognised tool and gave pain relief in line with individual needs and best practice. Staff recorded pain scores to evaluate the effectiveness of pain relief.

Pain relief was prescribed by the anaesthetist or surgeon and was recorded in the patient's records. This included prescriptions for pain relief to take home following the procedure as appropriate.

Patient outcomes

Staff monitored the effectiveness of care and treatment. However, they did not participate in recognised patient reported outcome measures or legally required reporting of performance measures.

The service monitored patient outcomes such as infection rates, unplanned returns to theatre and post-operative complications. Records for 2022 showed there had been no infections, post-operative complications or unplanned returns to theatre.

The service did not make sure that patient reported outcomes (Q-PROMS) were collected for patients undergoing certain procedures such as liposuction.

The provider had no processes in place to collect performance measures and supply these to the Private Healthcare Information Network (PHIN). This is a requirement of the Private Healthcare Market Investigation Order (2014). There was no evidence of systems and processes being in place to benchmark performance or improvement activities.

Competent staff

The service did not make sure staff were competent for their roles. The manager did not appraise staff's work performance.

The processes for ensuring that staff were experienced, qualified and had the right skills and knowledge to meet the needs of patients were not effective. Training records for the nurse who supported the service on treatment days were not up to date. There was no evidence that the nurse assisting the anaesthetist during sedation held an aesthetic or safe sedation qualification.

Inadequate

Surgery

There were no records of the agency nurses working at the clinic, however, we were told that agency staff worked regularly. We were told the agency ensured staff had completed appropriate training, however, there was no recorded assurance of this held by the service. There was no record of induction for agency staff.

There was no record of staff appraisals for the nurse or administrative and management staff. We were told that a responsible officer had previously provided oversight and clinical support and advice on behalf of the provider. However, this role had not been replaced following changes during the Covid-19 pandemic.

Multidisciplinary working

Doctors, nurses and other healthcare professionals worked together as a team to benefit patients.

Staff did not hold regular multidisciplinary meetings due to the nature of the service, small staff team and infrequent treatment days. However, we were told that staff could access other healthcare professionals when they needed to but did not see evidence of this. This included access to psychology services and other consultant surgeons as part of reciprocal referral arrangements as required.

Seven-day services

Patients could contact the service seven days a week for advice and support after their surgery.

The surgeon was available to be contacted out of hours for advice and support to patients who had received treatment at the clinic in the event of concerns or queries. When the surgeon was based overseas, patients could speak to the surgeon by phone or were directed to an alternative surgeon at another centre if they needed to be seen. If the patient required an appointment, arrangements were made with another consultant to review the patient. Patients were made aware of these arrangements before they consented to treatment. We were told there had been very few occasions when patients saw another consultant.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

Staff supported patients to make informed decisions about their care and treatment. There was limited evidence that the service followed national guidance and ensured that patients gave consent in a two-stage process with a cooling off period of at least 14 days between stages.

Staff understood how and when to assess whether a patient had the capacity to make decisions about their care. However, there were no records of staff having completed mental capacity act training.

Staff made sure patients consented to treatment based on all the information available. We were told they provided patients with written information about treatment, including information about risks and benefits of procedures.

Staff clearly recorded consent in the patients' records. However, this did not include evidence of a two-stage process with a cooling off period of at least 12 days between stages. For example, three out of four patient records we reviewed in relation to consent showed that consent had been signed on the day of the procedure. One patient record showed that consent had been given 15 days prior to the procedure, in line with guidance for a minimum 14 day cooling off period.

Records showed that patients consented to the use of before and after procedure photographs for these to be used by the consultant when discussing procedures with prospective patients.

Inadequate

Surgery

Are Surgery caring?

Insufficient evidence to rate

Caring was inspected but not rated due to insufficient evidence.

Compassionate care

Staff treated patients with compassion and kindness.

Staff took time to interact with patients in a respectful and considerate way. We observed one interaction between a staff member and a patient and saw that the staff member was kind, caring and considerate of the patient's needs.

We were told staff understood and respected the individual needs of each patient and showed an understanding and a non-judgmental attitude when caring for or discussing patients with mental health needs. But due to the lack of clinical activity on the day of our inspection we did not observe this.

Emotional support

Staff provided emotional support to patients to minimise their distress. They understood patients' personal, cultural and religious needs.

We were told staff gave patients and those close to them help, emotional support and advice when they needed it. This included referring patients for psychological support when needed.

Staff we spoke with understood the emotional and social impact that a person's care, treatment or condition had on their wellbeing and on those close to them.

Staff supported patients, families and carers to understand their condition and make decisions about their care and treatment.

We were told staff made sure patients understood their care and treatment. Staff supported patients to make informed decisions about their care. They provided them with written information about the procedure they were considering. The samples of information leaflets we saw were comprehensive and explained both the benefits and risks of the procedure, to support patients to make an informed decision. Patients were encouraged to discuss procedures with the surgeon or nurse. Patients always attended a consultation prior to making a decision about the procedure and whether to go ahead with it.

Patients gave positive feedback about the service.We reviewed the results of 11 patient surveys and saw that patients were consistently satisfied with the level of service they received. Detailed feedback included that one patient felt 'safe and in very good hands' and that 'the team was incredible'. Another patient fed back that staff were 'extremely kind, helpful and knowledgeable' and that they felt 'in good hands and could trust everything I was told about the procedure.'

Inadequate

Surgery

Are Surgery responsive?

Insufficient evidence to rate

Responsive was inspected but not rated due to insufficient evidence.

Meeting people's individual needs

The service was inclusive and took account of patients' individual needs and preferences. Staff made reasonable adjustments to help patients access services. There was a system for referring patients for psychological support before starting treatment, if necessary, however records of assessments were limited.

Patients could access the service either through a recommendation, word of mouth, or through an internet search. The clinic did not do any NHS work and did not receive referrals from the NHS.

The provider undertook cosmetic surgery, outpatient consultations, and treatments one week a month. The service did not carry out treatments that required an overnight stay. The surgeon was available via the telephone for appointments outside of the one week a month they attended the clinic.

All patient consultations, pre-assessments, and minor treatments were carried out at the clinic. Procedures that could not be undertaken at the clinic due to a lack of facilities were carried out at a larger independent hospital, where extra facilities and equipment were available for the patient procedure. There was a lift available for patients who had limited mobility but no other facilities to support those patients with mobility issues such as accessible toilets.

The service had information leaflets available for patients and we were told these could be translated into different languages spoken by the patients when needed.

Managers made sure patients could get help from interpreters or signers when needed. The service arranged for interpreters and we saw this incorporated into service policies such as consent.

Access and flow

People could access the service when they needed it and received the right care.

At the time of the inspection, treatments were not being carried out. The provider told us they had decided to stop treatments for a few weeks until action to improve the premises could be taken. Consultations with patients to provide after care and follow up on an outpatient basis continued to be carried out.

When treatments were carried out, these were done on a same day basis. We were told patients were followed up over the telephone and evaluated by a nurse the day after surgery. They were then offered a face to face follow up with the consultant a few weeks after the procedure.

Learning from complaints and concerns

It was easy for people to give feedback and raise concerns about care received. The service treated concerns and complaints seriously, investigated them and shared lessons learned with all staff.

Inadequate

Surgery

Patients knew how to complain or raise concerns. The service provided patients with information about how to raise a concern through information leaflets during their consultation and treatment.

The manager investigated complaints and identified themes. Staff knew how to acknowledge complaints and patients received feedback from the manager after the investigation into their complaint. There had been one complaint in the last year. We reviewed the records of communication with the patient and saw that this had been regular and in line with the service's complaints policy. There was evidence that the complaint had been resolved and the patient was satisfied in how their concerns had been addressed.

The managers shared feedback from complaints with staff and learning was used to improve the service. This involved discussions about complaints at governance meetings attended by the owner of the service and the practice manager.

Are Surgery well-led?

Inadequate

We rated well-led as inadequate.

Leadership

Leaders did not have the skills and abilities to run the service. They had not managed the priorities and issues the service faced. They were approachable in the service for patients and staff. They did not support staff to develop their skills.

The service had a clear leadership structure, the surgeon was the registered manager supported by the practice manager. The registered manager was based at the clinic one week a month and the rest of the time they were overseas but available to patients and staff by telephone. Staff we spoke with told us the surgeon was available and approachable. The day to day operational management was overseen by the practice manager who worked at the service two days a week to oversee the running of the clinic. Other employed staff included an administrator and a bank nurse who worked two shifts per month on treatment days.

Leaders did not demonstrate an understanding of the challenges to quality and sustainability for the service. They had not identified the issues identified by the inspection team and had not addressed issues raised at the last inspection. We had concerns that procedures had been carried out in the service while there were inadequate supplies of functioning equipment and emergency medicines due to a lack of maintenance and medicine checks.

Staff training had not been sufficiently prioritised, and we saw from minutes of meetings that delays to sourcing appropriate training had been made due to cost implications. There were no records of assurance for the monitoring of the bank member of staff's training or the suitability of agency staff working within the service.

Vision and Strategy

The service had a vision for what it wanted to achieve, however, plans to implement the vision were still in the process of development.

Inadequate

Surgery

We were told that the vision was to develop a partnership, where improvements could be made to the environment the service operated in. There was recognition of some of the risks associated with the current premises and the need to address environmental issues in the premises that impacted on safety. A meeting with a prospective business partner was planned in the days after the inspection. However, there were no clearly documented plans of how the vision would be achieved.

Culture

Staff felt respected, supported and valued.

There were no clinical activities taking place at the time of our inspection, therefore we spoke to a limited number of staff. However, those we spoke with told us that staff felt respected and we observed staff who were focused on the needs of patients.

There were limited systems in place for staff working under practising privileges or agency to raise concerns or issues about risks. There was no policy or protocol in place for raising concerns or the process for staff to follow should they wish to.

There was a duty of candour policy in place and the manager was aware of their responsibilities in relation to this. The policy followed the principles of 'being open' and included holding a 'being open' discussion. However, as there were no incidents reported or recorded, it was not clear that there were systems in place for identifying incidents that may be subject the duty of candour.

Governance

Leaders did not operate effective governance processes, throughout the service.

Staff we spoke with were clear about their roles and accountabilities. The registered manager and practice manager had regular opportunities to meet, discuss and review the performance of the service.

Governance meeting minutes demonstrated that issues such as staffing, staff training, patient satisfaction and the future for the service were discussed. Policies had been reviewed by the surgeon and practice manager. We were told that prior to the Covid- pandemic policy development had included an external review; however, this was now not possible due to changes to availability of the support services previously used. We noted that policies did not directly reference legislation and guidance. For example, while there was reference to NICE guidance relating to pre-operative clinical tests, there was limited reference to relevant standards such as the Professional Standards for Cosmetic Surgery (Royal College of Surgeons, 2016). A quality policy made reference to quality improvement, however, this consisted of a statement of the service's commitment to quality improvement and did not include processes for how quality was reviewed and improved.

The service had some systems and processes for auditing and monitoring quality and safety., An audit plan was in place where clinical monitoring was carried out and included ongoing monitoring of post-operative complications, infections and unplanned returns to theatre. We saw that there had been no such incidents in 2022. However, we also saw that an unplanned return to theatre in 2021 had not been recorded as an incident or learning event.

Management of risk, issues and performance

Leaders did not use systems to manage performance effectively. They had not identified and escalated relevant risks and issues. Staff did not contribute to decision-making to help avoid financial pressures compromising the quality of care.

Inadequate

Surgery

Risks, issues and performance were not managed effectively. During the inspection we identified several risks relating to the environment, equipment, medicine and staff training. The provider recognised there were environmental issues impacting on the quality of the service but had not identified some of the other risks we identified during our inspection. They had made a decision to stop undertaking procedures until the improvements had been made. They had plans in place to work in partnership to facilitate the improvements. However, the service had continued to undertake procedures up until November 2022 and consultations continued to be carried out at the time of our inspection.

The risks not identified by the provider included equipment not being maintained and a significant amount of medicines, including emergency medicines expired. In addition, arrangements to assess and mitigate risks relating to infection prevention and control, legionella risk, fire safety and health and safety had not been effectively identified or managed.

We noted that financial pressures were a contributing factor that had compromised the quality of care. For example, essential maintenance of the air conditioning system had not been undertaken. Meeting minutes showed that while training for the nurse was encouraged, non-clinical staff training had been paused in 2021 due to financial constraints.

Information Management

Information systems were secure. Data was collected to help staff understand performance. However, we saw limited evidence of data being used to make improvements. Policies relating to reporting notifications to external organisations were not clear.

Patient paper records were locked in a filing cabinet that was only accessible to authorised staff. Electronic records of consultations were also held, using a dedicated database that was encrypted and secure.

Data relating to surgical procedures and patient outcomes were collected. The data we reviewed was limited due to limited activity within the service, so it was not possible to see that this demonstrated an improvement approach to the quality of the service.

The process for submitting notifications to external organisations as required was not clearly set out in service policies. For example, an adverse event policy referenced the requirements in line with the reporting of injuries, diseases and dangerous occurrences Regulations 1995 (RIDDOR). However, it did not reference the requirement for reporting to the Care Quality Commission (CQC). The service had not submitted any statutory notifications to CQC 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. This was despite a decision being taken by the provider not to carry out regulated activities for a period of two months.

There were limited records to demonstrate that staff had completed up to date training in information governance. For example, neither the practice manager or the bank nurse had evidence they had completed training updates for this.

Engagement

Leaders and staff actively and openly engaged with patients. Staff engagement was undertaken on an ad hoc basis.

Patient surveys were sent out to patients following their surgery. Survey results were collated, and feedback reviewed as part of the governance meetings. Feedback we saw had been positive.

Inadequate

Surgery

We were told that staff meetings did not take place. This was due to the size of the service and that clinical staff were either bank or working under practising privileges. The registered manager met regularly with the practice manager and administrator and we were told that if this coincided with other staff working at that time then they were encouraged to join the meeting.

Learning, continuous improvement and innovation

There was limited evidence of continuous learning and improvement.

There was limited assurance of the recognition and recording of things that went wrong. As a result, evidence of learning and improvement opportunities was limited. In addition, we saw evidence of safety breaches within the treatment room that had not been fully identified and acted on by the provider.

We saw evidence that a complaint from a patient stated they had not felt prepared for the outcome of their procedure, this was reviewed as part of the surgeon's appraisal. The learning from this complaint included changes being made to the information given to patients, making this more explicit.