

CC Kat Aesthetics Limited

CC Kat Aesthetics

Inspection report

20 Calthorpe Road
Edgbaston
Birmingham
B15 1RP
Tel: 01214567930
www.cckat.com

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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

Good 

Are services safe?

Good 

Are services effective?

Good 

Are services caring?

Good 

Are services responsive to people's needs?

Good 

Are services well-led?

Outstanding 

Summary of findings

Overall summary

Our rating of this location improved. We rated it as good because:

- The service had enough staff to care for patients and keep them safe. Staff had training in key skills, understood how to protect patients from abuse, and managed safety well. The service-controlled infection risk well. Staff assessed risks to patients, acted on them and kept good care records. They managed medicines well. The service managed safety incidents well and learned lessons from them.
- Staff provided good care and treatment and managed pain relief well. Managers monitored the effectiveness of the service and made sure staff were competent. Staff worked well together for the benefit of patients, advised them on how to lead healthier lives, supported them to make decisions about their care, and had access to good information. The service had expanded access times.
- Staff treated patients with compassion and kindness, respected their privacy and dignity, took account of their individual needs, and helped them understand their conditions.
- Staff understood the emotional impact of cosmetic surgery and worked with patients to manage expectations and support positive body image and mental health.
- The service planned care to meet the needs of people, took account of patients' individual needs, and made it easy for people to give feedback. People could access the service when they needed it and did not have to wait too long for treatment.
- Leaders ran services well using reliable information systems and supported staff to develop their skills through an extensive programme of engagement. Staff understood the service's vision and values, applied them in their work, and used provider standards to challenge the status quo. Staff felt respected, supported, and valued. They were focused on the needs of patients receiving care and creating a working environment that promoted innovation and development. Staff were clear about their roles and accountabilities.
- The service engaged meaningfully with patients and the wider cosmetic surgery community to plan and manage services and all staff were committed to improving services through research and exploration of new evidence-based practice.

However:

- There was room for more consistency in the use of wipeable furniture in some areas to promote better infection control.

At our last inspection of the service, we found a breach of Regulation 12 under the Health and Social Care Act 2008. This reflected a need for improved medicines management processes and better governance arrangements. At this inspection we found significant and sustained improvements along with areas of innovative practice.

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Surgery	Good 	We rated this service as good because it was safe, effective, caring, responsive, and well led. Please see the main summary.



Summary of findings

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Summary of this inspection

Background to CC Kat Aesthetics

CC Kat Aesthetics is operated by CC Kat Aesthetics Limited and registered at this location in February 2019 after operating elsewhere in Birmingham since 2008. The service provides day case cosmetic surgery to self-funding patients aged 18 years and over and private dentistry.

The service has a dedicated surgical suite with admission room, operating theatre, and recovery room as well as consultation and post-operative care rooms. A dental suite is located within the hospital and is equipped for implants, orthodontics, and cosmetic treatments. The service provides day case surgery although provision is in place in the event a patient needs extended recovery time overnight.

Services are provided from a converted property in Edgbaston set in private grounds with a garden and car park.

The service has 2 registered managers in post and is registered to provide the following regulated activities:

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

The service provides unregulated aesthetic services, such as laser skin treatment. We do not inspect unregulated care and these services are not included in the report or reflected in the ratings.

How we carried out this inspection

We carried out an unannounced comprehensive inspection of the service on 27 September 2023. Our inspection team included a CQC lead inspector, a consultant specialist advisor, a nurse specialist advisor, and a dental specialist advisor, with support from an off-site CQC operations manager.

During our inspection we spoke with staff and patients and observed clinical practice. After our inspection the provider sent us over 100 items of evidence to help us complete our judgement of care.

Our findings from inspecting dentistry are incorporated into the cosmetic surgery core service of the report and ratings.

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>.

Outstanding practice

We found the following outstanding practice:

- The provider had developed and implemented a comprehensive environment and social governance strategy. Aimed at achieving 'net zero' carbon emissions by 2030, the provider was reviewing the policies and practices of suppliers and partner organisations to secure a consistent environmental impact reduction. The provider knew from patient feedback that sustainability was increasingly important to them, and this programme aligned corporate ethics with matters important to patient's values.

Summary of this inspection

- Staff proactively sought new techniques and medicines to reduce pain during surgical procedures. The provider supported piloting and implementation of new processes with evidence of appropriate safety standards. This included implementation of new pain management that significantly reduced recovery time, from 6 days to 3 days.
- The provider had developed an effective protocol for the use of twilight sedation, which was pain free and meant patients were discharged more quickly. The hospital was a pilot site for this procedure and was recognised internationally for its work. The innovative approach meant 99% of patients were home within 1 hour of the completion of surgery.
- There was a pervasive focus on mental health across the service. Staff recognised the social and emotional impact of cosmetic surgery, including its positive impact when patients achieved their goals and their challenges when it did not. The service used an international standard psychosocial assessment for each patient and staff spent time with them to ensure their requested treatment was as risk free as possible.
- The provider had strong links with national and international professional groups that supported mentoring clinical trainees. This helped establish regional expertise in cosmetic surgery and provided junior professionals with access to specialist experience.
- The surgical team was active in international research and regularly presented their work at conferences on anaesthesia and cosmetic surgery innovations. The provider ensured such work resulted in manifestly improved care options and clinical outcomes for patients.
- The whole team had a demonstrably inquisitive nature about the specialist field and continuously worked to incorporate holistic care into the service. This led to the introduction of a well woman clinic.
- The provider was research active in international cosmetic surgery groups and encouraged surgeons to develop innovative updates or improvements to existing procedures. Improved surgical procedures for abdominoplasty (“tummy tuck”) had reduced the risk of complications, reduced recovery time, and improved comfort for patients during the procedure.

Areas for improvement

Action the service **MUST** take 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 future, or to improve services.

Action the service **SHOULD** take to improve:

- The service should consider how infection control risk can be managed in areas with fabric seats.






Our findings

Overview of ratings

Our ratings for this location are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Surgery	Good	Good	Good	Good	Outstanding 	Good
Overall	Good	Good	Good	Good	Outstanding 	Good

Surgery

Safe	Good 
Effective	Good 
Caring	Good 
Responsive	Good 
Well-led	Outstanding 

Is the service safe?

Good 

Our rating of safe improved. We rated it as good.

Mandatory training

The service provided mandatory training in key skills to all staff and made sure everyone completed it.

Staff received and kept up to date with their mandatory training, which was comprehensive and met the needs of patients. Staff completed up to 38 modules depending on their role. All staff completed a core programme of 13 modules. These included infection prevention and control (IPC), safeguarding, health and safety, and fire safety. At the time of our inspection all staff were up to date with training.

Doctors were self-employed and the provider required them to maintain the same level of training as employed colleagues. This provided patients with assurance that all staff were consistently trained.

Clinical staff completed training on recognising and responding to patients with mental health needs and dementia. The service provided elective care on request from patients and this training helped guide staff who had concerns about patient wellbeing and ability to understand and consent to treatment.

Managers monitored mandatory training and alerted staff when they needed to update their training. Training was a combination of e-learning and practical sessions and staff spoke highly of the range and quality of training.

Safeguarding

Staff understood how to protect patients from abuse. They had training on how to recognise and report abuse and knew how to apply it.

Staff received training specific for their role on how to recognise and report abuse. All clinical staff were trained to level 3 safeguarding children and adults. The clinic manager, who was the safeguarding lead, was trained to level 4. All staff completed the government's national PREVENT training, which aimed to reduce the risk of radicalisation.

Surgery

Staff could give examples of how to protect patients from harassment and discrimination, including those with protected characteristics under the Equality Act. The team was acutely aware of the many reasons patients sought cosmetic surgery and worked with them to ensure the service offered an accessible, inclusive service.

Staff knew how to make a safeguarding referral and who to inform if they had concerns. The nature of the service meant safeguarding concerns were rare and there had been no instances of a safeguarding referral in the previous 12 months. However, staff recognised the risks associated with forced cosmetic surgery relating to human trafficking and coercive control. They knew how to recognise the signs of such issues and how to get help, including in an urgent situation.

Staff were trained to recognise and act on suspicion or cases of female genital mutilation and followed the NHS England reporting duty.

The service did not provide care to people under the age of 18. Staff completed safeguarding children training and the provider maintained an appropriate policy to help provide safe environment for children and young people who may be present, such as when they accompanied a parent.

Cleanliness, infection control and hygiene

The service controlled infection risk well. The service used systems to identify and prevent surgical site infections. Staff used equipment and control measures to protect patients, themselves, and others from infection. They kept equipment and the premises visibly clean.

Clinical areas were clean and had suitable furnishings which were clean and well-maintained. Staff cleaned clinical spaces between patients using the provider's policies and national standards.

The provider had a comprehensive range of audits and checks that provided assurance of cleaning standards, including deep cleans and decontamination. This included individual hand hygiene practice audits of individual staff and a monthly whole-clinic IPC review.

Audits reflected consistently good practice with effective cleaning standards in all clinical areas. Audits of common areas such as hallways found a need for greater attention to detail from contracted cleaners. The practice manager worked with the contractor to rapidly improve and sustain standards.

The dental team carried out audits specific to the dental suite and preparation areas. In the previous 12 months IPC, decontamination, and hand hygiene audits found 100% compliance with expected standards.

During our inspection staff demonstrated good attention to detail in managing infection risks, including the effective use of personal protective equipment, good hand hygiene practices, and adherence to the aseptic non touch technique.

Staff worked effectively to prevent, identify, and treat surgical site infections. The clinical team continuously sought opportunities to develop the latest surgical techniques and reduce infection risk. In the previous 12 months there were no instances of surgical site infections.

Environment and equipment

The design, maintenance and use of facilities, premises and equipment kept people safe. Staff were trained to use them. Staff managed clinical waste well.

Surgery

The design of the environment followed national guidance, including the Department of Health and Social Care (DHSC) health technical memoranda and healthcare building notices. While clinical spaces included fully compliant handwashing facilities and sealed floors, chairs in the reception area were fabric. This presented a risk of bacteria build-up because fabric cannot be decontaminated as easily as wipe-clean covers used in healthcare environments.

Staff carried out daily safety checks of specialist equipment and the provider had a programme of planned preventative maintenance. This ensured equipment was dependable and ready for use. Staff had access to on-call engineers in the event of equipment failure. There had been no such instances in the previous 12 months.

The service had enough suitable equipment to help them safely care for patients. Emergency equipment, including for resuscitation and difficult airway management, was located throughout the hospital. Emergency supplies were comprehensive and were better than national minimum standards. The difficult airway kit included fibre optic scopes and the emergency medicines supply included antidotes for local anaesthetic toxicity.

Emergency equipment was clearly signed, which supported staff who worked in the hospital infrequently. Staff documented a series of checks of emergency equipment, including daily security and stock checks and detailed weekly and monthly reviews. This ensured equipment was always available for use in an emergency. Staff documented fast action to replace failed or used equipment and planned consumable stock replacement in advance by tracking expiry dates.

Staff disposed of clinical waste safely and in line with the DHSC health technical memorandum (HTM) 07/07 The Safe Management and Disposal of Healthcare Waste (2013) and the Health and Safety (Sharps Instruments in Healthcare) Regulations 2013.

The dental team used an effective waterline management system to reduce the risk of bacteria build-up, including Legionella. The provider had a Legionella prevention protocol in place that included regular water flushing from all outlets in the hospital and temperature tests. The provider was compliant with HTM 04/01 in relation to safe water management in healthcare.

The dental suite was equipped with an ultrasonic bath and staff documented weekly filter and strainer checks, cleaning, and calibration. Ultrasound baths allow staff to clean and decontaminate medical equipment.

Maintenance and safety records for the dental intraoral laser were up to date and reflected good practice. A laser protection officer worked with the team to maintain compliance with safe standards of practice.

A dedicated maintenance manager was based on site and provided routine facilities support in addition to on-demand urgent requests from staff.

The hospital was located in a refurbished residential building. While it was equipped to a high standard and was compliant with national safety requirements, the size and layout presented challenges to staff and patients when moving around the building. Staff worked together to adapt training and standard operating procedures to improve safe access and movement. For example, staff moved patients from the theatre to the recovery room by wheelchair instead of a trolley following testing of new processes.

Maintenance and administration staff took a lead role in fire safety. They maintained comprehensive checks and documentation of regular fire equipment checks and carried out a 6 monthly unannounced evacuation drill. This was

Surgery

appropriate for the age and complexity of the building. During our inspection staff had a good knowledge of emergency procedures and kept fire escape routes and exits free from clutter. The senior team had acted on the action plan from a full fire risk assessment in late 2022 to implement improvements to the environment, including better safety features for storage areas.

Assessing and responding to patient risk

Staff completed and updated risk assessments for each patient and removed or minimised risks. Staff identified and quickly acted upon patients at risk of deterioration. The service made sure patients knew who to contact to discuss complications or concerns.

Staff used the national early warning scores (NEWS2) tool to identify deteriorating patients and escalate their care. Records indicated staff acted quickly at the first sign of deterioration and good surgical team processes meant they were prepared to provide urgent care.

Staff completed risk assessments for each patient before surgery, using a recognised tool, and reviewed this regularly, including after any incident. Risk assessments included for venous thromboembolism, excessive bleeding, sepsis, and aspiration.

The service maintained links with psychology and psychiatry services. Staff completed psychosocial referrals and risk assessments for patients thought to be at risk of self-harm or where they sought cosmetic surgery repeatedly without an improvement in their wellbeing or feelings of self-worth.

Staff shared key information to keep patients safe when handing over their care to others. For example, shift changes, handovers or multidisciplinary referrals included all necessary information.

Surgeons carried out a pre-surgical assessment of each patient. This included a review of their medical history, current medicines, and surgical safety score using an international standard. Patients needed to have a body mass index (BMI) lower than 30 for surgery to be safe. Where patients with a BMI higher than this asked for surgery, staff worked with them to reduce their weight to reduce the risk associated with surgery.

The service held a service level agreement (SLA) with a nearby private intensive care provider to provide emergency cover by anaesthetists who were able to transfer and admit patients to an acute setting if their condition deteriorated. Staff provided elective treatment to patients clinically well enough to promote a swift recovery and meet their goals. This meant acute deterioration was unlikely and the expertise and rapid response assured by the SLA provided a high level of risk response cover. In the previous 12 months the service had 1 emergency transfer out.

Staff completed life support training to a level commensurate with their role. Non-clinical staff were trained in basic life support, nurses and doctors in immediate life support, and anaesthetists in advanced life support.

The provider had a range of risk management policies to ensure patient safety. For example, those undergoing sedation were required to attend with an escort. The service capped surgery time at a maximum of 4 hours to ensure recovery could take place within the day case period and without the need for general anaesthetic.

The service required patients over the age of 65 to undergo a full blood count, urea and electrolyte check and an electrocardiogram (ECG) prior to surgery to ensure they were not at additional risk.

Surgery

The service had a good track record of managing patients who required unplanned care. For example, the team provided overnight care to a patient who repeatedly fainted after surgery. This was an appropriate decision based on the patient's needs and the availability of local urgent care services. The service established an overnight medical team and completed a dynamic risk assessment to ensure care was safe.

The provider monitored clinical reasons for surgeons who declined to proceed with a requested procedure. In the previous 12 months, surgeons declined 13 treatments. All related to the potential risks of proceeding with treatment due to the patient's body mass index, a preexisting condition, or where the surgeon could not safely meet the patient's expectations for outcomes.

Some patients travelled considerable distances for treatment at the clinic. Where a patient had a procedure under sedation, including twilight anaesthesia, the service required them to have an escort to help them travel home. Where the patient lived more than 1 hour to travel after treatment staff required them to book nearby accommodation. This was a risk management measure that meant the patient did not jeopardise recovery or risk complications through strenuous activity immediately after surgery.

The dental team reviewed each patient's medical history, prescribed medicine, and individual risk factors before proceeding with treatment.

During our inspection we observed pre-operative checks led by nurses, surgical safety checklists, and post-operative recovery care. In all cases staff carried out thorough, methodical safety checks and risk assessments.

Staffing

The service had enough staff with the right qualifications, skills, training, and experience to keep patients safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed and adjusted staffing levels and skill mix, and gave bank, agency, and temporary staff a full induction.

The service had enough staff to keep patients safe. The provider employed a dedicated team of 3 nurses and 12 non-clinical staff such as administrators and receptionists, and a maintenance manager. A team of bank nurses and operating department practitioners (ODPs) supplemented the permanent team and had the same levels of appraisal, training, and qualifications, as permanent staff.

A typical surgery team included an anaesthetist, a surgeon, a scrub nurse, an ODP, and a runner. The recovery room was staffed with a nurse-to-patient ratio of 1:3. The dental team organised their staffing levels based on demand and planned procedures.

With the exception of the clinic director, clinicians worked on a self-employed basis under practising privileges. All clinicians were surgeons and a team of 8 had practising privileges at the time of our inspection alongside 6 anaesthetists, 1 dentist, and 1 GP. Dental nurses worked with the dentist on a pre-planned basis.

Operating department practitioners worked with specific anaesthetists, which helped to build consistent teams and working relationships.

Surgeons spent 1 day with the clinic director on joining the service before they could practice unsupervised. This helped embed practice standards and local procedures in addition to the provider's induction.

Surgery

The senior team had worked to stabilise staffing over the previous 3 years. As a result, the service had very little turnover and a low annual sickness rate of 1%.

The provider operated the hospital with teaching opportunities for student nurses and trainee doctors. Senior staff included everyone, including students and bank staff, in emergency scenario simulations and training opportunities.

The service based surgical staffing levels on the criteria for a general aesthetic service. This was part of a safety standard that meant appropriate clinicians were available in the event of a problem with sedation.

All doctors and dentists working under practising privileges had up to date criminal record checks and indemnity insurance. The provider maintained a continual record of this, and the practice manager liaised with each clinician to arrange updates.

Records

Staff kept detailed records of patients' care and treatment. Records were clear, up to date, stored securely and easily available to all staff providing care. Staff recorded all cosmetic implants on the Breast and Cosmetic Implant Registry (BCIR).

Patient notes were comprehensive, and all staff could access them easily. The dental team documented the reason for the patient's visit as well as an up-to-date medical history.

The dental team documented the use and justification of x-rays in line with the Ionising Radiation (Medical Exposure) Regulations guidance. They completed clinical records in line with the Faculty of General Dental Practice FGDP and the College of General Dentistry standards.

When patients transferred to a new team, there were no delays in staff accessing their records. Staff sought consent to share records with each patient's GP. When staff made a referral to another specialist, they included relevant records.

The senior team audited a sample of clinical records every quarter as part of a clinical oversight programme. While the sample was random, they ensured it included each practitioner who had worked in that period. Results from the previous 12 months demonstrated consistently good practice with key elements of patient information always completed. The auditor found a need for improved documentation of appointment times as the only area for improvement. The practice manager worked with clinical staff to implement this, and results had improved.

Staff supplemented the clinical records audit with a review of the treatment register to ensure procedures delivered followed the provider's standards and guidelines.

Dental record audits reflected consistently good practice, with a wide range of risk assessments, lifestyle reviews, and risk/benefit treatment options discussed with each patient. The dental team completed a 6-monthly audit of 100 patient records. The last audit took place in June 2023 and found 100% compliance with expected standards.

Records were stored securely with restricted access. Clinicians had remote access to the records of their own patients, which they included in the consent process. The provider kept copies of all patient records in line with their registration responsibilities.

Medicines

The service used systems and processes to safely prescribe, administer, record and store medicines.

Surgery

Staff followed systems and processes to prescribe and administer medicines safely. They reviewed each patient's medicines before surgery to identify any contraindications.

Staff completed medicines records accurately and kept them up to date. They discussed potential medicine side effects with each patient during pre- and post-operative consultations. This was part of the overarching safety and engagement culture and patients provided positive feedback. In the previous 12 months, 100% of patients said staff provided enough information about managing medicine side effects after discharge.

Staff stored and managed all medicines and prescribing documents safely. They completed weekly medicine stock checks and liaised with the supplying pharmacy and clinicians planning treatment to ensure stock would meet patient needs.

The clinical lead managed an antimicrobial stewardship programme, which included a 'prudent prescribing' standard that guided clinicians to use antimicrobial medicines only when clinically justified. This was in line with British National Formulary guidelines. Clinicians typically used prophylactic antibiotics 60 minutes before the first surgical incision.

The practice manager used a comprehensive series of audits to monitor medicine safety, including for prescribing, stock control, and the management of controlled drugs in line with Home Office requirements. Audits found consistently good standards of practice, with over 99% compliance in the previous 12 months.

Staff completed daily temperature monitoring of medicine storage areas, including fridges. Where temperatures fell outside the usual range, staff acted quickly to ensure medicines remained safely available for use.

The service stocked emergency medicines, including adrenaline, antidotes for local anaesthetic toxicity, and muscle relaxants.

Incidents

The service managed patient safety incidents well. Staff recognised and reported incidents and near misses. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support. Managers ensured that actions from patient safety alerts were implemented and monitored.

Staff knew what incidents to report and how to report them. They raised concerns and reported incidents and near misses in line with the provider's policy.

Clinicians worked substantively in other services and used their knowledge and learning of incidents elsewhere to inform safe practice.

Staff understood the duty of candour. They were open and transparent and gave patients and families a full explanation if and when things went wrong. The provider had a policy that clearly defined the threshold and trigger for the duty of candour.

Staff received feedback from investigation of incidents and discussed this along with improvements to patient care in team meetings.

Surgery

There was evidence senior staff investigated incidents thoroughly and implemented changes as a result. For example, a patient had aspirated after surgery and required an emergency transfer to the nearest emergency department. The investigation found the patient had not disclosed acid reflux to staff during the pre-surgical consultation. After the incident investigation, the provider updated the pre-surgical policy and staff asked each patient if they had a history of acid reflux.

In the previous 12 months staff reported 59 incidents, of which 18 related to a surgical complication. None of the reported events had resulted in patient harm and in each case, staff worked with patients to resolve side effects or unexpected issues. There had been 1 instance of a retained surgical item when staff did not remove a throat pack following a procedure. The surgical team identified this error before completing the procedure and took appropriate steps to correct it. The practice manager implemented the duty of candour and remained in contact with the patient during the investigation, led by the medical director. As a result of the incident the provider revised staff training and updated the throat pack policy.

The senior team investigated each event to categorise severity, track themes, and identify learning. In the previous 12 months staff reported 2 non-clinical incidents classified by the provider as severe. These related to a Legionella risk and a conduct issue with a self-employed doctor. In both cases the provider took immediate action to protect patients and staff. The identification of both issues reflected monitoring and safety systems that worked well in practice.

The provider had a system to ensure clinical teams adhered to national patient safety alerts, including those issued by the Medicines and Healthcare products Regulatory Agency. The registered managers and clinic director worked together to ensure surgeons, nurses, and dentists were aware of the latest guidance and incorporated these into policies and audits.

Is the service effective?

Good 

Our rating of effective improved. We rated it as good.

Evidence-based care and treatment

The service provided care and treatment based on national guidance and evidence-based practice. Managers checked to make sure staff followed guidance. The service met cosmetic surgery standards published by the Royal College of Surgeons.

Staff followed up-to-date policies to plan and deliver high quality care according to best practice and national guidance. The provider based training, policies, and procedures on best practice standards from organisations relevant to the care offered, such as the Royal College of Surgeons, the World Health Organization (WHO), the Resuscitation Council UK, and the National Institute for Health and Care Excellence.

Specialist services established their own evidence base for standards of practice. Guidance was based on standards issued by the Faculty of General Dental Practice, the College of General Dentistry, the British Medical Ultrasound Society, and the Royal College of Obstetricians and Gynaecology.

Surgical teams used a modified WHO safety checklist suitable for the procedures performed. The checklist required structured communication amongst the team in line with international standards. During our inspection staff followed the WHO checklist and demonstrated consistent adherence to expected standards.

Surgery

Staff routinely referred to the psychological and emotional needs of patients during treatment planning and in team meetings and referrals.

Evidence based care was a core aspect of the provider's vision and values and the clinic director encouraged the whole team to stay abreast of medical advancements. As clinicians worked substantively elsewhere, this approach enabled the service to identify and learn from national and international practice.

Surgeons used the American Society of Anaesthesiologists (ASA) physical status classification system to check the health of each patient ahead of surgery. The ASA system has 6 classifications that enable clinicians to establish how well a patient will tolerate surgery. The provider's policy required patients to be assessed at levels 1 or 2 for treatment to proceed. The team used this score alongside RoFCAR to establish the likelihood the patient's requested treatment would meet their goals.

The service used a rolling programme of 15 audits to establish evidence of standards of practice and identify opportunities for improvement. The registered managers maintained oversight of all results and worked with their teams to drive consistency and improvements.

The medical director monitored international updates and findings to procedures and medicines as part of a well embedded system to ensure care and treatment were always evidence based. For example, the US Food and Drug Administration (FDA) had issued concerns about a type of plasma used for body sculpting that was not reflected in UK national alerts. The medical director worked with surgeons who used the plasma to review the FDA's concerns and identify if local policies needed to be changed as a result.

Nutrition and hydration

Staff followed national guidelines to make sure patients fasting before surgery were not without food for long periods.

All surgery was planned to take place on a day case basis and required only minimal adjustments to patients' usual eating and drinking habits. Staff worked with each patient to establish individual adjustments before and after surgery. In an instance where staff decided to keep a patient in recovery overnight, they provided food and drink for them.

Recovery nurses provided patients with drinks and snacks post-operatively. They planned in advance for specific nutritional requirements relating to culture and religion.

Pain relief

Staff assessed and monitored patients throughout treatment 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 prescribed, administered, and recorded pain relief accurately. Anaesthetists managed local anaesthesia and clinicians prescribed post-operative pain relief, included up to 4 days of nerve blockers.

Staff proactively sought new techniques and medicines to reduce pain during surgical procedures. The provider supported piloting and implementation of new processes with evidence of appropriate safety standards. For example, staff trialled the use of a new medicine for pain management procedures and found this halved the duration of pain relief needed.

Surgery

The provider had developed an effective protocol for the use of twilight sedation, which was pain free.

Patient outcomes

Staff monitored the effectiveness of care and treatment. They used the findings to make improvements and achieved good outcomes for patients.

The service submitted data to the Private Healthcare Information Network (PHIN) as part of the national drive to improve evidence-based patient outcomes in private care.

The service used a patient-reported outcome measures (PROMs) model to track and assess the effectiveness of care based on how well procedures met patient's expectations. PROMs results were consistently good. In the previous 12 months, 97% of patients said they felt they looked better after surgery than beforehand and 87% of patients said the results were the same or better than they expected.

The service adapted PROMs to account for the personal and sensitive aspects of seeking cosmetic surgery. For example, they asked patients how they felt about body image, both clothed and unclothed, about the appearance of reshaped body parts, and the fit of specific items of clothing, such as bras. Results indicated all patients felt more positively after surgery. Staff used results relating to specific procedures to make changes in how they managed expectations, including through the use of effective marketing. For example, patients generally reported more satisfaction with the outcome of blepharoplasty procedures (a procedure that removes excess skin from the upper eyelids) than with face lifts. Staff analysed PROMs to identify opportunities to help patients better understand the likely outcomes of face lift surgery.

Managers used information from the audits to improve care and treatment. The senior team carried out a monthly audit of the WHO surgical safety checklist using a random sample of procedures. In the previous 12 months the service reported 93% compliance. This was an average that included 6 instances of 100% compliance. The senior team identified themes in areas that needed improvement, such as more consistent attention to detail when signing each section of the form and contemporaneous completion of patient information. To address the issues, staff implemented new daily checks of post-operative documentation, which they could correct inconsistencies or missing information immediately.

Some types of treatment, such as facelifts, neck lifts, and breast reductions or uplifts, had a high risk of complication if the patient smoked, including electronic cigarettes. The service required patients to stop smoking at least 4 weeks before such treatments and this formed part of the consent process.

A nurse-led wound dressing clinic provided patients with post-surgical care to ensure treatment achieved the planned outcomes.

Clinicians provided advice to patients on pre-operative care, such as the use of non-prescribed anti-bruising supplements and the cessation of some common painkillers, vitamins, and oil capsules. This helped to improve outcomes.

Surgeons carried out a post-operative call to each patient the day after surgery to discuss their recovery and address side effects.

The senior team carried out a 6-monthly clinical oversight audit including 5 to 10 cases for each clinician. This contributed to monitoring of safety, patient outcomes, and complications. The audits found consistently good practice with no ongoing areas of concern.

Surgery

The dental team audited x-rays for clarity, justification, accurate diagnosis, and quality. Results from the previous 12 months demonstrated consistently good standards, with 100% of x-rays meeting patient needs and expected standards.

Competent staff

The service made sure staff were competent for their roles. Managers appraised staff's work performance and held supervision meetings with them to provide support and development.

Staff were experienced, qualified, and had the right skills and knowledge to meet the needs of patients. The provider encouraged staff to develop through additional professional competencies. For examples, nurses completed wound management training.

Nurses and operating department practitioners completed practical assessments of competencies as part of their induction.

Managers gave all new staff a full induction tailored to their role before they started work. All surgeons new to the hospital completed a series of observations of twilight anaesthesia and total intravenous anaesthesia (TIVA) prior to leading their own procedures.

Managers supported staff to develop through yearly, constructive appraisals of their work. Staff spoke positively of appraisals and said they were helpful for their development.

Managers made sure staff attended team meetings or had access to full notes when they could not attend. Team leaders convened meetings for their own teams at least 2-monthly and the practice manager led monthly whole-team meetings.

Permanent clinicians were mentors for The British Association of Aesthetic Plastic Surgeons (BAAPS) fellows. This programme was highly regarded by surgeons and the industry group and fellows provided consistently positive feedback. A fellow who recently completed a placement noted it had been a "once in a career opportunity" and an "invaluable experience."

The dental team maintained up to date training in the latest treatment techniques. They understood the new classification of periodontal and peri-implant diseases and conditions.

Multidisciplinary working

Doctors, nurses, and other healthcare professionals worked together as a team to benefit patients. They supported each other to provide good care.

Clinical staff coordinated quarterly multidisciplinary (MDT) meetings. They chose 3 cases that reflected complex or unusual care and identified opportunities to introduce new treatment techniques, such as with innovative technology or a different use of medicines. In addition, the MDT team reviewed policies and standard operating procedures to help provide treatment for patients with complex needs or elevated risks. For example, the team coordinated risk management for patients living with type 1 diabetes who were otherwise fit and healthy and met the provider's other health criteria.

The dental team had agreements in place with other providers and referred patients for panoramic x-rays and computed tomography scans if further investigation was needed.

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A private GP was based in the hospital 2 days per week to support holistic care. For example, if surgeons found a need for onward referral, they discussed options with the GP. Regular referrals included to dermatologists, endocrinologists, and psychologists.

The GP referred patients who presented with evidence of skin cancer, such as basal cell carcinoma, to the local NHS hospital under an agreement with the Integrated Care Board (ICB).

Staff used a list BAAPS-approved list of psychologists to provide psychological assessments for patients. Professionals on this list were registered by the Health and Care Professions Council and were trained to work with people with needs relating to cosmetic surgery.

Seven-day services

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

The hospital opened Monday to Friday and alternate Saturdays. Pre-surgical assessments, dentistry, well women services, and GP services operated on scheduled days.

A clinician was available 24 hours, 7 days a week for post-operative support.

Health promotion

Staff gave patients practical support and advice to lead healthier lives.

The service had relevant information promoting healthy lifestyles and staff tailored this to individual needs. They assessed each patient's health at the pre-assessment stage and identified any changes the patient needed to make before they could proceed with surgery. For example, most procedures had a maximum body mass index (BMI) due to the need for effective anaesthesia.

The service offered a weight loss clinic to support patients who needed to reduce their BMI before surgery could be offered. This included an exercise plan, nutritional support, and medical advice.

The dental team provided a wide range of health promotion information and intervention support. This included for oral hygiene, gum disease prevention, cancer risk assessments, and smoking and alcohol cessation.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

Staff supported patients to make informed decisions about their care and treatment. They 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. They understood how to support patients.

Staff understood how and when to assess whether a patient had the capacity to make decisions about their care. They gained consent from patients for their care and treatment in line with legislation and guidance at each stage of the treatment process.

Staff made sure patients consented to treatment based on all the information available. Surgeons spent considerable time with each patient to make sure they fully understood the potential risk and benefits of treatment.

Staff clearly recorded consent in the patients' records. The senior team audited consent as part of clinical oversight. In the previous 12 months the service recorded 99% compliance.

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Staff received and kept up to date with training in the Mental Capacity Act (MCA) 2005. They understood the relevant consent and decision-making requirements of legislation and guidance, including the Mental Health Act and the MCA and they knew who to contact for advice.

The service adhered to the national standard of a 14-day cooling off period between consultation and surgery. Staff encouraged patients to extend this until they received a written treatment plan from the consultant after their first assessment.

The dentistry team required patients to sign a consent form after they received a written treatment plan.

Staff asked each patient for consent to contact their GP to request relevant care records and provide post-operative care details. The service provided elective, private care that did not need a patient to obtain their GP's approval. Where patients did not wish to disclose their GP, or where they did not have a GP, such as those visiting from outside the UK, staff ensured patients understood how to obtain post-operative care.

We observed consent processes during consultations as part of our inspection. Doctors communicated clearly with patients, so they fully understood the potential risks and benefits of the proposed treatment. They made it clear the outcomes from cosmetic surgery could be predicted to a good extent but there was always an element of uncertainty.

The MDT adapted consent documentation and processes for specific treatments to make information more accessible and treatment specific. For example, the service introduced a mole clinic that required patient consent but less detailed information and consideration than an invasive cosmetic procedure. Using feedback from staff and patients, the team adapted the consent process to reflect the procedure and its risks more proportionately.

Patients consented to the use of clinical photography at different stages of their procedure. Staff captured and stored these digitally and used them to plan surgery and to help establish post-operative and recovery outcomes for patients.

Is the service caring?

Good 

Our rating of caring stayed the same. We rated it as good.

Compassionate care

Staff treated patients with compassion and kindness, respected their privacy and dignity, and took account of their individual needs.

Staff were discreet and responsive when caring for patients. They took time to interact with patients and those close to them in a respectful and considerate way. We observed many examples of this during our inspection and it was clear staff had a focus on compassionate care. Feedback from patients supported this. For example, a recent patient commented, "Thank you for all your kindness and care."

Patient feedback was consistently positive. Staff encouraged all patients to complete feedback at the post-operative stage, so it reflected the various stages of care. In the previous 12 months 99% of patients said they were satisfied with

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care and 94% said they had a positive overall experience. An external specialist organisation sought patient experience alongside the provider's own survey. In the previous 12 months, 100% of patients rated the service as good, very good, or excellent. A recent patient commented, "It's been a wonderful experience, and I couldn't have been in safer or better hands."

Staff followed policy to keep patient care and treatment confidential. They discussed private matters in appropriate spaces and protected records with good security measures. Patients commented positively on this aspect of care and in the previous 12 months 98% said they were satisfied with the level of privacy staff provided when discussing treatment.

Staff understood and respected the individual needs of each patient and showed understanding and a non-judgmental attitude when caring for or discussing patients with mental health needs. For example, where patients presented with anxiety or depression, staff worked with them to secure appropriate support before proceeding with treatment.

Staff adapted the way they used the building to promote privacy and dignity. For example, the dressing clinic and dental service both had separate screened waiting areas, which patients valued in feedback. In the previous 12 months 99% of patients said they were happy with the dignity and respect showed to them by staff.

Staff asked patients about privacy needs during their first consultation and understood the intimate and private nature of cosmetic surgery. They planned in advance to meet specific requests, such as private waiting space.

Patient feedback for the dentistry service was consistently positive. A recent patient said, "Nothing but a positive experience and looking forward to the results."

Emotional support

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

Staff gave patients and those close to them help, emotional support and advice when they needed it. Staff recognised the significant emotional and potential social impact of cosmetic surgery and worked with each patient to achieve a balance between the scope of care and their expectations. This was reflected in patient feedback. For example, in the previous 12 months 100% of patients said they had someone in the hospital to speak with about their worries and fears.

We observed staff speak with patients who were anxious or distressed with intuitive compassion. They worked to build a rapport with each patient to understand their reasons for seeking surgery and ensuring their proposed treatment was likely to meet these needs. For example, a patient sought breast reduction after changes to their body following childbirth. Staff recognised this was a complex discussion and skilfully communicated with the patient to ensure they had explored alternatives.

Patient feedback was consistently positive in the emotional aspect of care. In the previous 12 months 100% of patients said consultants showed them understanding when assessing care needs. A recent patient noted, "Thank you for giving my confidence back."

Understanding and involvement of patients and those close to them

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

Staff made sure patients and those close to them understood their care and treatment. They talked with patients in a way they could understand and focused on managing expectations about treatment outcomes.

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Consultants met with patients at least twice before surgery and offered more meetings if the procedure was complex or the patient needed more information to help them make a decision.

Patients and their families could give feedback on the service and their treatment and staff supported them to do this. Patients commented positively on the time staff took to discuss care options with them. In the previous 12 months, 100% of patients said the consultant explained everything in a way that was easy to understand. In the same period, 100% of patients said they felt involved in care decisions to the extent they wished, and over 99% said they had enough time with a consultant ahead of treatment.

Surgeons worked closely with patients to manage their expectations and ensure treatment goals were realistic. Where patients were unsuitable for surgery, surgeons made sure they explained their decision-making process to the patient, including future options if their condition changed.

Patients rated the hospital highly in helping them understand care options and involving them in decision-making. In the most recent independent patient survey, 99% of patients said staff gave them time to discuss their concerns and fears, provided explanations of care options, and had confidence in the ability of staff. A recent patient noted, "I have felt so reassured looked after," and another said, "You made me feel so comfortable and at ease the whole time and you did a fabulous job."

Dental patients completed a separate survey and rated the service consistently well. In the previous 12 months, 100% of patients said the dentist was good at explaining tests and treatment and involving them in decisions about care.

Is the service responsive?

Our rating of responsive stayed the same. We rated it as good.

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 assessment before starting treatment, if necessary.

The service provided elective care to patients seeking cosmetic procedures. The provider had developed and expanded the service to offer a greater range of treatment options in response to demand. This included establishing a multidisciplinary team that offered complementary services in addition to regulated care. Over 99% of procedures were carried out on a day case basis and the team had trialled, developed, and implemented 2 new approaches to anaesthesia that offered reduced recovery time and more flexibility in appointments. This was part of an overriding ethos of patient-centred care.

The hospital was not registered to provide overnight care. The provider had service level agreements in place for the transfer and admission of patients on an unplanned basis in the event of a treatment complication. Staff could also plan for a transfer and admission in advance as part of a treatment plan.

The clinical team used the Royal Free Hospital London Centre for Appearance Research (RoFCAR) cosmetic procedures checklist as part of the pre-operative assessment process. The RoFCAR included questions about much the patient

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worried about their appearance and the extent to which it impacted their lives, such as avoiding social activities. The clinical team used the results to establish the extent to which surgery could achieve the patient's goals. This approach helped staff to identify mental health needs and to flag potential risks in proceeding with a requested surgery, such as if it was likely to cause psychological distress to the patient. The RoFCAR tool required patients to discuss how they expected their life to be different after treatment in their own words and without the use of a checklist.

As part of the RoFCAR framework, staff spent time with each patient to understand their motivations for seeking cosmetic surgery, particularly if this was their first procedure or if doctors noted an unusual frequency of procedures. Staff considered personal circumstances and feeling such as self-confidence, preoccupation with appearance, and the extent to which the patient was happy with their sex life. This approach helped ensure surgery was appropriate and likely to meet individual needs.

The dental team included social history in consultations with patients, which they used to guide treatment plans. This helped identify risk to oral health and treatment efficacy, such as smoking and drinking habits.

Staff had provided detailed post-operative information to patients to help them manage recovery. The team developed this information based on patient feedback and learning from outcomes. They included advice and guidance to help manage expectations, such as the length of time to expect bruising at a surgical site and when to resume bathing. Staff provided patients with post-treatment contact details. In the patient survey, 98% said they knew who to contact after treatment if they were worried.

The provider was based in repurposed historic premises that were built before current requirements and best practice for access by people with reduced mobility. The local authority had declined an application by the provider to install a passenger lift. The senior team implemented alternative access improvements including a manual ramp that provided step-free access from the street to the ground floor. Staff had moved furniture in the clinic to create a more accessible environment and surgical theatres and recovery were located on the ground floor. Where patients presented for care with more advanced mobility needs, staff coordinated access to other providers with premises equipped for access.

The provider had a service level agreement (SLA) with an interpreting service that provided remote and in-person language support for speakers of other languages, including British Sign Language interpreters.

The service was available for adults over the age of 18. To ensure patients with comorbidities or those over the age of 65 were able to access care with minimal risk, the provider had established an SLA with laboratories able to process bloodwork for patients to check for comorbidities that might preclude treatment.

Staff asked patients about their cultural, religious, and personal needs at the consultation stage. The provider had an embedded ethos of individualised care and empowered staff to adapt services to meet individual needs. For example, staff arranged an all-female surgical team for a patient to help meet their religious needs.

A GP worked in the hospital 2 days per week. They offered a wide range of medical services based on referrals from consultants but focused primarily on dermatology care.

Staff had developed systems to meet the needs of international patients who sought treatment whilst visiting the UK. This included a check of language needs and arrangements to obtain their medical records, with a translation if they were not written in English. A nurse pre-arranged contact expectations with the patient before they left the UK and helped identify appropriate follow-up services in the event the patient experienced a complication when they returned home.

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Access and flow

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

Patients accessed the service by booking a consultation through the provider's website or directly with a surgeon. Waiting times depended on the capacity and availability of the specialist and the need for the patient to adhere to a cooling off period.

Over 99% of procedures took place on a day case basis and each patient had a follow-up within 24 hours and a further review 3 months after treatment.

The service had significantly improved access options and flexibility for patients since 2019. This included extended opening hours, wider communication options, and more rapid access to the patient's preferred clinician. Patients reported year-on-year improvements in these measures in the independent survey, including a 12% improvement in satisfaction, from 81% in 2019 to 93% in 2023, with telephone access to clinicians.

The provider had a cancellations policy to support patients in the event their clinician was unwell and had to cancel a procedure at short notice. As clinicians were self-employed, they were responsible for offering rebooking options to patients and the provider facilitated this process through a centralised booking system. In the previous 12 months there had been no instances of cancellations by the provider or a clinician due to staff availability.

Staff provided same-sex recovery accommodation.

The dental service opened 3 days per week, with plans to expand this in early 2024. Patient feedback was mixed about access to the service, with a 40% patient satisfaction rate with opening times and availability.

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. The service included patients in the investigation of their complaint. The service had a system for referring unresolved complaints for independent review.

Patients knew how to complain or raise concerns. The service clearly displayed information about how to raise a concern in patient areas and on the website.

Staff understood the policy on complaints and knew how to handle them. They were trained to resolve minor issues with patients at the time they were raised and to discuss these with the senior team to help them understand any recurring issues.

Managers investigated complaints and identified themes. The service received 13 complaints in the previous 12 months, 11 of which related to dissatisfaction with the outcome of a procedure. In each case the clinical director or operating surgeon met with the patient, discussed their concerns, and reviewed their care records. Surgeons discussed possible results along with healing times, risks, and areas of uncertainty before agreeing to proceed with treatment. The service had developed this process as a result of learning from past complaints and continued to ensure communication was effective and clear. The investigation of each of the 11 complaints found no errors in treatment or planning. The clinic director worked with each complainant to achieve a resolution, such as a scar revision or additional treatment.

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The service was a member of the Independent Sector Complaints Adjudication Service. Contact information was in the complaints policy provided to patients and staff knew to signpost them in the event a complaint could not be resolved.

Is the service well-led?

Outstanding



Our rating of well-led improved. We rated it as outstanding.

Leadership

Leaders had the skills and abilities to run the service. They understood and managed the priorities and issues the service faced and worked tirelessly to address them. They were visible and approachable in the service for patients and staff and had a clear track record of effective, evidence-based leadership strategy. They supported staff to develop their skills and take on more senior roles through 'stretch' goals.

The senior leadership team (SLT) consisted of the clinic director, medical director, anaesthetic lead and director of dental services, and the clinic manager and deputy clinic manager. The clinic manager and the deputy clinic manager were CQC registered managers and responsible for day-to-day management of regulated activities.

All staff we spoke with felt positively about the leadership team and departmental managers, who they said were supportive, approachable, and friendly. Staff said they appreciated the 'flat' hierarchy that meant they worked alongside managers, contributing to a leadership system based on respect.

A named member of the team was the designated lead for each specialty or department. For example, the practice manager was the safeguarding lead, and the deputy practice manager was the health and safety lead.

Members of the SLT were present in the hospital whenever it was open and offered a range of communication options with staff, including on-demand discussions and an 'open door' policy. The SLT sought training opportunities in effective leadership and applied this specifically to the cosmetic surgery setting.

Students and doctors undergoing mentorships commented positively on their experiences of the leadership team. A recent fellow said the service had "... visionary management focused on innovative, patient-centred care." This was reflected in the wide range of improvements since our last inspection, which the SLT had fully embedded into the service.

Vision and Strategy

The service had created a vision for what it wanted to achieve and an ambitious strategy to turn it into action, developed with stakeholders across the sector. The vision and strategy were focused on sustainability of services and aligned to international plans within the cosmetic surgery speciality. Leaders and staff understood the provider's core values and knew how to apply them.

The service's aim and vision were to be recognised as a world class medical and cosmetic healthcare provider. This was reflected in the team's continuous search for emerging treatments and evidence-based care. The SLT was focused on developing "excellent clinical environments" and had refurbished and upgraded the hospital's features as part of this.

The provider had established relationships with a wide range of other specialist services to offer holistic care that was safer and more closely aligned to patient's desired outcomes.

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Staff worked to a motto of “making life beautiful” and their work to provide patient-centred care that helped patients feel happier about themselves reflected this.

Culture

Staff felt respected, supported, and valued. They were focused on the needs of patients receiving care and proactively sought opportunities for joint working and continuous improvement. The service promoted equality and diversity in daily work and provided personalised opportunities for career development. The service had an open culture where patients and staff could raise concerns without fear and in which senior staff genuinely wanted to understand challenges.

The SLT had carried out a long-term programme of improvement in the working culture and wider delivery of care. This included the introduction of staff appreciation and recognition programmes and an award scheme. The provider maintained an annual budget that staff could access for training unrelated to their employment role. For example, 1 member of staff undertook drama and acting training to help improve their confidence when communicating with people.

The SLT said they wanted the culture to inspire staff and give them a sense of duty and accountability. Staff we spoke with embodied these goals and were demonstrably proud of their work. They reported a good working environment with demands and pressure that were balanced and well-managed.

A Freedom to Speak Up Guardian (FTSUG) was in post and worked within the provider’s whistleblowing and concerns policy to provide staff with opportunities for confidential discussions or escalation of concerns. The FTSUG made sure all staff knew how to contact them and how they could help. All staff we spoke with said this was a good system and meant they always had someone to talk to separately from their line manager.

Non-clinical staff said they felt respected and their contribution to the service was recognised by the clinic director and other senior staff. For example, 1 member of staff said the working culture was “very caring”. Another individual told us, “I always feel listened to, suggestions are always acted on.”

The SLT had identified an opportunity to introduce more consistency amongst working practices and support for surgeons working under practising privileges. To drive this, the provider introduced a new surgeon handbook. This helped professionals from a wide range of other services standardise their work in this hospital so that the provider was assured of practices.

The provider had developed an extensive ethical framework, based on international standards, to manage patient expectations and the wellbeing of those seeking inappropriate, unsafe, or excessive treatment. Staff had a good understanding of their ethical responsibilities and made sure patients benefited from this by receiving elective care that was likely to improve their lives.

The provider adapted risk assessments and working practices to accommodate staff with needs relating to health and personal circumstances. For example, they adapted working patterns and responsibilities to support staff who were unwell or pregnant.

Surgery

The provider carried out a 6-monthly staff survey to gauge satisfaction and identify opportunities for improvement. Survey results showed sustained improvement over the past 18 months, such as an increase in satisfaction with the provider from 85% to 100%. Staff mostly rated the leadership team well and said they felt part of a team and were recognised for their work. The provider had recognised a need for more constructive, inclusive communication from senior staff and implemented a range of initiatives to address this.

Fellows who joined the hospital on mentorship programmes, and student nurses, commented on the culture in feedback. A recent fellow noted, “What was lovely was seeing the team talk to patients not just about body image goals but [also] about their families, lifestyle, fashion, friends and pets.” A student nurse commented that they had seen “lifechanging care.”

Governance

Leaders operated highly effective governance processes, throughout the service and with partner organisations. Governance was measured quantitatively and qualitatively, and the service had substantial evidence of improvement and assurance as a result. Staff at all levels were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service.

The provider had significantly improved and restructured the clinical governance system since our last inspection. The medical director was an external, independent professional, and chaired the clinical governance committee as clinical governance lead. The clinic director, director of anaesthesia and dental services, non-surgical services lead, clinic manager and deputy clinic manager were committee members and provided oversight and assurance of good practice.

The provider structured clinical governance leadership on ethical principles, integrating independent specialists with permanent staff to provide assurance decision-making was free from bias and separated clinical safety interests from the financial goals of the business. This reflected broad improvements in governance integrity and meant the clinic director, who was the business and brand owner, had good checks and balances in place. For example, the director of anaesthesia worked under practising privilege arrangements and had no ownership of the business.

The clinic director chaired the medical advisory committee (MAC), and 7 multidisciplinary clinical and non-clinical professionals formed the committee. The group met quarterly and reviewed practising privilege arrangements for clinicians, the introduction of new treatment options and medical devices. The structure meant there was broad representation of key services, including management, dentistry, anaesthesia, and finance, in decision-making processes.

Governance systems with professionals who delivered non-surgical services met the needs of patients and provided assurance of good standards of practice. The private GP had joined the clinical governance team, and a consultant gynaecologist would shortly join following the planned introduction of family planning regulated activities.

Where care was provided under a service level agreement, the provider ensured a representative of each organisation was present at governance meetings.

Management of risk, issues, and performance

Leaders and teams used systems to manage, assess, and improve performance effectively. They identified and escalated relevant risks and issues and identified actions to reduce their impact. Risk management was holistic, and the provider had extensive, tested plans to cope with unexpected events. Staff contributed to decision-making to help avoid financial pressures compromising the quality of care.

Surgery

Staff described and demonstrated a risk-averse culture in which they prioritised safety over and above requests for cosmetic surgery. While surgeons worked under practising privileges, the clinic director and provider team maintained overall decision-making responsibilities. The senior team cancelled proposed surgeries where they found unacceptable levels of risk in the pre-operative assessment.

The senior team used a risk register to identify, track, and mitigate key risks to the service. Each risk had a named, accountable member of the team and regularly documented updates. At the time of our inspection a key risk was scrub nurse and operating department practitioner (ODP) staffing. The SLT had established a team of bank nurses and ODPs to provide reliable cover and had expanded a recruitment campaign for permanent staff.

The provider had separated clinical and commercial governance to ensure financial goals did not influence clinical decision-making. This addressed a key risk in private care and meant clinical staff were focused solely on patient outcomes.

Patients had access to 24-hour post-operative clinical support. This included non-emergency, secure text-chat service staffed by registered nurses during office hours and an emergency telephone line staffed by a senior member of staff out of hours. The provider had a service level agreement with a private intensive care provider and 2 agencies who could provide operating department practitioners and nurses at short notice.

The practice manager had completed a root cause analysis masterclass, which helped them to carry out expert investigations of incidents as part of a broader risk management system.

The provider had developed, tested, and implemented a key performance indicator (KPI) dashboard as a live, continual measure of risk and performance. The dashboard included 31 separate measures in operational performance and patient outcomes, which the senior team benchmarked against the provider's expected standards. Safety measures included wound infections, instances of delayed wound healing, and missed pre-operative risk assessments. The dashboard also included patient experience, such as instances of nausea and vomiting and unplanned complications during procedures.

KPIs were consistently positive and reflected good standards of safety and effective planning. For example, instances of wound infections were significantly below the 3% acceptable threshold set by the provider. Similarly, the service reported an average 0.8% delayed wound healing, which was significantly better than the provider's acceptable limit of 2%. The hospital reported an average complication rate of 1%, which was significantly better than the provider's acceptable limit of 7%.

In the previous 12 months the hospital reported an unplanned return to theatre rate of less than 1%, which was within the provider's 1%-3% acceptability range. In the same period 7 surgical procedures exceeded the estimated duration by over 1 hour. This reflected 1% of all surgical procedures. In each case the surgical team carried out a review of the procedure and care planning to identify opportunities for improved practice. As part of the safety-positive culture, the senior team supported extended procedures where this was in the clinical interests of the patient and accepted this was a known risk with some procedures.

The provider worked with surgeons to ensure care was provided in a safe, risk-averse way. Staff carried out a pre-surgical assessment on the day of the planned procedure to make sure the patient was clinically fit. In the previous 12 months, staff cancelled 7 procedures on the day due to medical risks such as elevated blood pressure, a positive nicotine test result, and the onset of cold symptoms.

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The dental team audited compliance with the Ionising Radiation (Medical Exposure) Regulations (IR(ME)R) 2017, including in the use of x-rays only when clinically indicated and reducing frequency and exposure. The 2023 annual audit reflected 100% compliance with radiography standards, including in the justification of x-rays.

The senior team carried out emergency drills twice each year. These were simulation exercises designed to test staff response to incidents such as a patient collapse or anaphylaxis. A recent drill involved the activation of a patient alarm to assess staff response time. The results from simulations to date were good and staff demonstrated a rapid response in line with their training and the provider's policies.

Business continuity and major incident systems were in place and had been tested during a regional power failure in January 2023. This occurred during a surgical procedure and staff successfully used back-up systems and protocols to safely complete the procedure.

The clinical team continuously sought new ways of working to reduce risks to patients. Such discussions took place in a collegiate atmosphere in which multidisciplinary specialists reviewed evidence to determine best practice. For example, recent learning identified a potential benefit of raising patient blood pressure for haemostasis before the surgeon closed their wound. Similarly, surgeons introduced a new complication check regarding eyeball abrasion prior to beginning surgery. This resulted from findings that even a slight opening of the eyelid during treatment could cause damage.

Information Management

The service collected reliable data and analysed it. Staff could find the data they needed, in easily accessible formats, to understand performance, make decisions and improvements. The information systems were integrated and secure. Data or notifications were consistently submitted to external organisations as required.

Staff facilitated a consistent focus on confidentiality and data protection, both within their legal responsibilities and reflecting the wishes of patients to maintain privacy. All staff had training in the General Data Protection Regulations and the senior team provided updates following changes in guidance or learning from incidents.

The provider had a policy in place to govern the use of medical photography. In all cases clinicians obtained patient consent for photography and saved the images to a secure platform connected with each patient's record.

The clinic manager was the data protection officer, and the provider was registered with the Information Commissioner's Office, which is the UK supervisory authority for data protection.

The service responded quickly to a data protection incident that involved an error in the use of social media. This led to improved training amongst staff and better assurance of the marketing policy.

The provider submitted data to the Private Healthcare Information Network (PHIN) as part of the national strategy to improve outcome and safety data in the private sector.

Engagement

Leaders and staff actively and extensively engaged with patients, staff, and local organisations to plan and manage services. They collaborated with partner organisations to help improve services for patients. This approach demonstrably led to high quality care.

Surgery

The provider recognised some types of care, or extensions of treatment, could not be provided in house. This included overnight admission and critical care in the event of a complication. To ensure patients had access to a full range of services both as part of treatment planning and as a risk management strategy if there was a complication, the provider established service level agreements with other providers, including private hospitals and ambulances.

Staff described engagement with patients as a tool to provide "...an atmosphere of comfort and support and to make the healthcare journey less daunting for patients." This was reflected in the provider's vision and strategy, and we observed staff work with patients to help them feel safe and understand their treatment.

The service encouraged patients to provide formal feedback on their care and treatment at their first post-operative appointment to help staff understand how well the care pathway had worked overall. The senior team collated and reviewed feedback data internally and discussed findings and trends in clinical governance meetings.

An external independent organisation carried out an annual audit of patient experience gathered through an improving practice questionnaire. They tracked recommendation rates and satisfaction scores across similar services nationally and benchmarked these on a long-term basis. To date, the audit included over 270,000 patient surveys and this provider included data in the patient handbook as a tool to engage patients in the service's track record.

The dental service ran a separate survey tailored to the smaller number of patients using the service. To date all feedback had been positive, with the exception of opening hours. The lead dentist planned to expand opening hours early in 2024.

Staff worked together to use social media communication channels to the benefit of patients. They had established a private app-based discussion group for patients who had completed treatment. This helped individuals share advice on recovery as well as discuss their experiences. Staff invited new patients to join the group as part of a support structure where they could ask questions in a safe environment.

Feedback from patients indicated care and treatment had a profound impact on their lives. Recent feedback noted, "Thank you so much for changing my life." Another patient said, "I am eternally grateful to you for helping me fulfil this dream."

Learning, continuous improvement and innovation

All staff were demonstrably committed to continually learning and improving services through inquisitive working, professional development, and research. They had an advanced understanding of quality improvement methods and the skills to use them. Leaders encouraged innovation and participation in research.

There was a pervasive, overarching culture of curiosity amongst the team that led to a drive for continuous improvement of care and practices. Staff were empowered and encouraged to contribute ideas for change and a multidisciplinary senior team worked with them to consider options for piloting new schemes. This formed part of a wider approach to development and innovation, based on the principles of a teaching hospital, that meant the team proactively and inquisitively explored new ways of working. For example, staff tested a new post-operative procedure that changed how they moved patients to recovery by observing the impact of 150 transfers with the new system. This provided an evidence based for changing the standard operating procedure.

Non-surgical services had developed in the provider in line with demand from patients. The provider had applied to add family planning as a regulated activity so they could offer contraceptive care to the well woman clinic. This resulted from learning from staff who felt the service could offer a wider variety of care for women experiencing the menopause.

Surgery

The surgical team was active in international research and regularly presented their work at conferences on anaesthesia and cosmetic surgery innovations. The provider ensured such work resulted in manifestly improved care options and clinical outcomes for patients. For example, recent collaborative work at an international anaesthesia symposium helped to create a learning community for the use of a new sedative that reduced post-operative recovery time from 6 days to 3 days.

The hospital was the first clinic in the country to implement medicine trials for pain relief that shortened recovery time by 3 hours. This helped patients to be discharged home more quickly than was traditionally expected.

The organisation that carried out long-term measures of patient satisfaction in the private sector found the hospital maintained an overall 97% quality score. This was a substantial statistic, with over 250,000 contributing patients, and the result placed the hospital significantly higher than the national average.

Staff incorporated developments and learning elsewhere into policies and their practice. For example, from attending British Association of Aesthetic Plastic Surgeons (BAAPS) meetings, staff found a previously unknown increased risk of post-operative deep vein thrombosis amongst some patients. They discussed this with colleagues across the service to change the risk assessment process. Similarly, staff involved in international research identified findings that magnesium could improve post-operative shivering. In such cases staff established a period to pilot new approaches to care to ensure they were safe and appropriate.

The provider had developed and implemented a comprehensive environment and social governance (ESG) strategy. Aimed at reducing the environmental impact of the hospital, staff had prepared a range of initiatives to reduce waste and pollution and align operations with the global trend of reducing impact on the planet. For example, the service was working with the building owner to benchmark carbon emissions from power usage year-on-year and use this to sustain a reduction by 2030. Senior staff responsible for procurement were reviewing supply chains with manufacturers to assess their respective ESG policies and ensure they were aligned with the hospital's ethos.

The 'social' aspect of the ESG reflected the provider's drive to embed social responsibility in day-to-day operations. For example, staff supported non-profit organisations that provided education to underprivileged young people and humanitarian medical expertise. The provider supported staff to take part in fundraisers in the local community. Such work as part of the ESG reflected a well-structured, comprehensive approach to future proofing the service and ensuring it served patients, staff, and the community without causing avoidable harm.

The provider was research active in international cosmetic surgery groups and encouraged surgeons to develop innovative updates or improvements to existing procedures. For example, the clinic director had been formally recognised by the BAAPS for their work to change the surgical procedure for abdominoplasty ("tummy tuck"). Their updated process reduced the risk of complications, reduced recovery time, and improved comfort for patients during the procedure.

The service had been 1 of the first in the UK to develop the use of new sedation and anaesthetic techniques that significantly reduced recovery time for patients. The use of 'twilight anaesthesia', or procedural sedation, was a form of anaesthetic that meant the patient was asleep but could breathe by themselves. Twilight anaesthesia had multiple benefits for patients, including a fast recovery time that meant patients were often home 1 hour after surgery. Staff monitored the effectiveness of the system and to date it was over 99% successful, with just 1 patient per 2500 needing to spend an extended period in recovery. The service found a 3-day reduction in post-operative recovery time based on the national standard for some treatments. This reflected an understanding that patients sought treatment to improve their confidence and social lives and so valued a quick recovery period.

Surgery

Staff had followed the international use of a new sedative to establish its safety before introducing the medicine locally. The medicine delivered rapid sedation and fast recovery and the hospital was the first in the UK to introduce it, which was recognised by the Association of Anaesthetists.

The service was trialling a new long-lasting pain relief medicine in patients who underwent an abdominoplasty. The medicine had been proved to be safe and provide pain relief for up to 72 hours. However, it was significantly more expensive than the current medicine and staff aimed to assess the benefit of its wider introduction based on patient feedback.