London Centre for Aesthetic Surgery

Quality Report

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

Overall summary

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 adult patients over the age of 18 years. Patients

are admitted for planned day case surgery procedures. The service does not provide overnight

accommodation for patients. Facilities include one treatment room, two recovery rooms and two

consultation rooms.

We inspected this service using our comprehensive inspection methodology. We carried out the inspection on 21 March 2017.

To get to the heart of patients' experiences of care and treatment, we ask the same five questions of all services: are they safe, effective, caring, responsive to people's needs, and well-led?

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

Services we do not rate

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

We found the following areas of good practice:

- Staffing levels and skills mix were sufficient to meet patient needs and staff assessed and responded to patient risks.
- Medicines were safely, administered, stored, and given to patients in a timely manner.
- Patient records were detailed with clear plans of the patient's pathway of care.
- Patient consent was obtained prior to commencing treatment. Patients were provided with information to enable them to make an informed decision.
- A cooling off period was observed for patients undergoing cosmetic surgery procedures. This was in line with cosmetic surgery guidelines.
- We spoke to two patients. They were positive about the care and treatment they had received.
- Staff treated patients with dignity and respect and patients were kept involved in their care.
- Equipment we checked had been tested for electrical safety and serviced as required.

Summary of findings

- There were arrangements to ensure patients received adequate food and drink that met their needs and preferences.
- There were processes to audit patient and clinical outcomes on a quarterly basis and these were discussed in the Medical Advisory Committee (MAC) meetings.
- There was appropriate management of quality and governance and mangers were aware of the risks and challenges they needed to address.
- There was clear visible leadership within the services. Staff were positive about the culture within the service and the level of support they received.

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

- The treatment room was cluttered and disorganised. There were no clearly defined separate clean and dirty zones within the treatment room. The Department of Health Building Note (HBN) 00-09: Infection control in the built environment states that clean and dirty areas should be kept separate and the workflow patterns of each area should be clearly defined. Maintaining separate clean treatment and contaminated zones, helps reduce the risk of infection.
- The World Health Organisation (WHO) surgical safety checklist was not routinely used for all patients and there were no audit arrangements to test staff practice and adherence to the WHO checklist.
- The provider had no processes 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).
- The safeguarding policy did not reflect national guidelines, for example, there was no reference made to female genital mutilation (FGM), slavery, sexual exploitation and PREVENT.
- We were told there were routine checks to ensure anaesthetic equipment was working correctly, but these were not recorded.
- The practice manager had not received the appropriate training for their role as the accountable officer for controlled drugs.
- The controlled drugs register did not contain entries for supply, administered, and destroyed, which is recommended and regarded as good practice.

Following this inspection, we told the provider that it should make other improvements, even though a regulation had not been breached, to help the service improve.

Professor Edward Baker

Deputy Chief Inspector of Hospitals

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Background to London Centre for Aesthetic Surgery

The London Centre for Aesthetic Surgery is operated by The London Centre for Aesthetic Surgery. The service opened in 2002. It is a private clinic in Harley Street, London. The clinic accepts referrals from local independent GPs and self-referrals from patients living in London and nationally.

The clinic has had a registered manager that has been in post since 2002. The registered manager is the practice owner.

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 the scope of CQC registration.

Our inspection team

The team that inspected the service comprised a CQC lead inspector,Jane Brown and a specialist advisor with expertise in surgical procedures.

The responsible Head of Hospital is Nick Mulholland

Information about London Centre for Aesthetic Surgery

The clinic provides outpatient appointments and day surgery and is registered for the following activities:

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

During the inspection, we visited all areas of the clinic. We spoke with four members of staff, including the registered nurse, consultant, anaesthetist and practice manager. We spoke with two patients and reviewed six sets of patient's records.

There were no special reviews or investigations of the service ongoing by the CQC at any time during the 12 months before the inspection. The service has been inspected twice and the most recent inspection took place in January 2014, which found that the clinic was meeting all standards of quality of care that it was inspected against.

Activity

In the reporting period October 2015 to September 2016 there were 85-day case episodes of care recorded at the clinic; all of these were funded by insurance or self-paying patients.

There were 277 outpatient total attendances in the reporting period; all of these were funded by insurance or self-paying patients.

Cosmetic procedures were carried out under local anaesthetic and conscious sedation.

One consultant (who was the owner), of the practice and four anaesthetists worked at the service under practising privileges. The centre employed one registered nurse and two non-clinical staff. The accountable officer for controlled drugs was the practice manager.

Track record on safety

- There were no never events.
- There were no clinical incidents relating to surgical activity
- There were no serious injuries.
- No incidences of hospital acquired meticillin-resistant Staphylococcus Aureus (MRSA).
- No incidences of hospital acquired methicillin-sensitive Staphylococcus Aureus (MSSA).
- No incidences of hospital acquired Clostridium Difficile (cdif).
- No incidences of hospital acquired E-Coli.

Summary of this inspection

- One complaint was received in the reporting period.No complaints were referred to the Ombudsman or ISCAS (Independent Healthcare Sector Complaints Adjudication Service) in the same reporting period.

Services accredited by a national body:

- The Human Tissue Authority

Services provided at the hospital under service level agreement:

- Clinical and or non-clinical waste removal
- Interpreting services
- Grounds Maintenance
- Laundry
- Maintenance of medical equipment
- Pathology and histology

Summary of this inspection

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?

We found the following areas of good practice:

- Staff knew how to report incidents of all severities.
- Medicines were stored safely and staff administered medicines to patients in accordance with the clinics policy.
- All staff had completed or were booked for mandatory safety training.
- Staff had a good understanding of safeguarding and knew of the steps to take if reporting a safeguarding concern.
- Patients were appropriately risk assessed, their condition was monitored, and there were procedures in place to respond to any deteriorating condition.
- Equipment was serviced regularly and all electrical testing had been completed and was in date.
- There was an agreement with a local larger independent hospital to transfer patients who unexpectedly required an overnight stay.
- There were sufficient competent staff to deal with patient's care and treatment.

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

- The treatment room was cluttered and did not allow for effective infection prevention and control techniques and was not in line with the Department of Health, Health Building Note (HBN) 00-09: Infection control in the environment.
- The WHO surgical safety checklist was not used for all patients having minor surgical treatment. The checklist was only used for patients who had conscious sedation.
- The safeguarding policy did not reflect up-to-date guidelines. There was no reference to female genital mutilation and sexual exploitation.
- The Mental Capacity Act 2005 was not included as part of mandatory training.
- Anaesthetists did not record their daily check of equipment.
- The controlled drugs register did not contain entries for supply, administered, and destroyed, which is recommended and regarded as good practice.

Are services effective?

We found the following areas of good practice:

Summary of this inspection

- Patients received care according to national guidelines, such as National Institute For Health and Clinical Excellence (NICE) and The Royal College of Surgeons.
- Patients were prescribed pain relief and their pain symptoms were managed effectively.
- There were systems, which ensured anaesthetists were compliant with the revalidation requirements of their professional bodies.
- Staff sought consent from patients prior to treatment and allowed the two-week 'cooling-off', period to ensure patients had sufficient time to make decisions on treatment of care.
- The clinic audited patient outcomes on a quarterly basis and these were discussed in MAC meetings.

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

- The provider had no processes to supply performance measures to the Private Healthcare Information Network (PHIN).
- The practice manager who was the responsible officer for controlled drugs had not received the necessary training.

Are services caring?

- Staff were caring and treated patients with dignity and respect.
- Patients were involved in their treatment of care.
- Feedback from patients was positive.
- Clear information was provided about the costs of treatment and procedures.
- The clinic provided information on alternative therapies if patients wished to access them.

Are services responsive?

- Services were planned to meet the needs of patients.
- Patients were offered follow up appointments to ensure they had received the right level of care.
- Complaints about the clinic were dealt with in a timely manner and information relating to complaints was shared with staff.

Are services well-led?

- The was a clear governance structure in place with Medical Advisory Committee (MAC) meetings, which monitored the quality of the service.
- There was effective teamwork and good leadership, which created a positive culture

Surgery

Safe	
Effective	
Caring	
Responsive	
Well-led	

Are surgery services safe?

Incidents

- The London Centre for Aesthetic Surgery (LCAS) had not reported any never events in the period from October 2015 to March 2016. Never events are serious patient safety incidents that should not happen if healthcare providers follow national guidance on how to prevent them. Each never event type has the potential to cause serious patient harm or death but neither need have happened for an incident to be a never event.
- The centre had a Critical and Untoward Incident Policy, which provided staff with reporting responsibilities and guidance, on the timescales for the reporting of incidents and the procedures to follow. Staff were expected to complete an incident report form and submit this to the practice manager or registered manager. A critical incident form was completed for more serious incidents as defined by the policy. Discussion with staff demonstrated they knew the reporting procedures to follow when reporting incidents.
- There had been no incidents reported during the reporting period. The staff we spoke with were aware how to report incidents and could describe the process. They had a good understanding of what an incident was and the different types of severities.
- We were told any incidents would be investigated by the Medical Advisory Committee (MAC) and discussed in their quartley meetings. However, as there had been no reported incidents, no discussions had taken place.
- No staff had received root cause analysis (RCA) training for serious incidents. RCA are investigations to identify why and how safety incidents happen.
- The practice manager told us any feedback and learning from incidents would be given face-to-face to staff members due to the small size of the service.
- The duty of candour (DoC) is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain 'notifiable safety incidents' and provide reasonable support to that person.
- There was a policy for the duty of candour (DoC) which staff were aware of and they said they but there was no official training for staff. However, the theatre nurse was able to explain the principles and finer details associated with it.

Clinical Quality Dashboard or equivalent

- Independent health providers do not have to use safety thermometer data to monitor areas such as falls, pressure sores, or venous thromboembolism (VTE).
- No incidents of patient harm were reported by the clinic. The provider did not display safety information at the clinic or on their web site.

Cleanliness, infection control, and hygiene

- The service had an Infection Prevention and Control (IPC) policy that had been read and signed by all staff. Staff we spoke with were able to explain the policy and the role they played in meeting the expected standards. For example, the theatre nurse was able to tell us of hand washing techniques and the personal protective equipment they had to wear.
- We observed staff adhere to IPC policy during our inspection. Staff wore clean scrub uniforms, closed toe shoes and their hair was tied back. During patient treatment, staff wore theatre caps, masks, and non-latex gloves and were bare below the elbows. We observed staff wash their hands at appropriate steps during the patient's treatment and using the 'five moments of hand hygiene' in line with World Health Organisation (WHO) guidance.

Surgery

- We found sanitising gel was not available at the point of care in all clinical rooms, only in the recovery room.
- Staff asked us to change into theatre suits and change our footwear when entering theatres. This is in accordance with the Association of Anaesthetists of Great Britain and Ireland (AAGBI) safety guidance on infection control in anaesthesia.
- An external company conducted an annual IPC audit. We saw the IPC report dated 13 April 2016. There were several recommendations made by the external organisation to improve IPC standards at the service. These included ensuring hand washing gels were wall mounted and the radiator cover in the treatment room was regularly cleaned. During our inspection, we noticed hand gel dispensers were wall mounted and we were shown the daily and weekly cleaning programme, which included the cleaning of the radiator cover.
- We found equipment was visibly clean throughout the department, and staff had a good understanding of responsibilities in relation to cleaning and IPC. We saw cleaning checklists for all areas of the clinic, including weekly cleaning schedules, which were conducted by an external company.
- Sharps bins were in place, dated, signed and off the floor in all areas, we visited. This reflected best practice guidance outlined in the Health and Safety Executive. The Health and Safety (Sharp Instruments in Healthcare) Regulations 2013. Sharps bins are used by clinical staff to safely dispose of used instruments such as, syringes, needles, and glass ampoules.
- We saw that waste was separated and in different coloured bags to signify the different categories of waste. This was in accordance with the Health Technical Memorandum (HTM) 07-01: Safe Management of Health Care Waste and Control of Substance Hazardous to Health (COSHH), health, and safety at work regulations. Waste was kept outside the clinic in a locked outbuilding and collected weekly for disposal.
- There were standard operating procedures (SOP) for IPC, which included; hand hygiene, handling general and clinical waste, needle stick injuries, and reduction of legionella.
- IPC polices were revised and updated annually in line with the recommendations of the external audit company. The practice manager disseminated information regarding amendments to the policy face to face with staff.
- The external company, who helped with clinical advice, phoned through any IPC updates and recommended new SOP, which were shared with staff. The company along with the practice manager ensured all IPC policies were up to date with the latest guidelines.
- The clinic did not have the facilities to sterilise reusable surgical instruments, these were sent to an external company for reprocessing through a service level agreement (SLA). We saw there was a clear procedure and tracking system in place for these instruments following use. Instrument tracking information was kept in the patient file.
- Legionella is a water borne bacteria that can be harmful to people's health. The owners of the building undertook a legionnaire test on a monthly basis and we saw the documentation, which showed the necessary checks, had been made. The water tests for legionnaires disease complied with the Control of Substances Hazardous to Health Regulations 1989; Section 3(2) of the Health and Safety at Work Act 1974.
- During the reporting period there no incidents of MRSA or MSSA and there were no cases of C.diff or E.coli infections.

Environment and equipment

- The clinic was situated on the first floor within the building. There was one treatment room, two recovery rooms and two consultations rooms. The recovery areas and consultation room were spacious and laid out well to ensure the patient was comfortable.
- The treatment room was untidy and cluttered. The room was not streamlined and there were no clear defined areas for clean and dirty equipment. The Department of Health, Health Building Note (HBN) 00-09: Infection control in the built environment, states that clean and dirty areas should be kept separate and the workflow patterns of each area should be clearly defined. Maintaining separate clean treatment and contaminated zones, helps reduce the risk of contamination.
- There were three fridges stored together and an unused fireplace had been boarded up. The ceilings had plastered light fittings and the radiator had a cover with no top on. Sterile gowns were laid on top of an adjacent fridge. Although staff conducted good cross infection techniques, the cluttered working environment hindered best cross infection practices.

- The flooring and walls within the treatment room were HBN00-09 compliant. That is they were impervious and did not allow for any fluid to pass through. The hand washing sinks were deep and had wrist and elbow operated taps.
- There was a planned maintenance schedule in place that listed when equipment was due for servicing. Equipment servicing was managed by the practice manager who arranged for equipment to be serviced by external contractors. We looked at a selection of service records and these were within their service dates.
- Staff told us that all items of equipment were readily available and any faulty equipment was repaired or replaced in a timely manner.
- There was resuscitation equipment in place, which included a defibrillator. We saw daily checks were completed to ensure all equipment was in place and working and no items were out of date.
- The anaesthetist reported all checks were completed on airway equipment but these were not documented.
- We found electrical safety testing stickers on equipment and these were in date.
- There was a daily checklist of equipment stores and cleanliness completed and we noted the last checks had been completed on 20 March 2017.
- Information was kept on The Control of Substances Hazardous to Health (COSHH) in relation to substances used during treatment. Information on how to use the substances/materials and what actions to take for spillage was available for staff to access.
- The clinic building was maintained by an external property owner. In addition, the clinic employed external contractors who maintained the fixtures and fittings including the air-conditioning and water checks. During our inspection, we saw there were SLA agreements for this.
- All disposable items we saw were in date, such as syringes and wound dressings.
- Fire extinguishers were in date and we saw the certificates and service contract to show they had been tested.
- The clinic had risk assessments in place for each room, which provided details of the risk, existing controls in place and actions required. For example, in one of the consultation rooms, a rug was listed as a risk as there was a risk of personal injury from tripping. Therefore, all staff knew they were to accommodate patients into the room and make them aware of the risks of tripping.
- An external company tested the emergency lighting throughout the building every six months.
- The fire alarm system was checked on a quarterly basis. A fire risk assessment was completed for the whole building and we saw this was in date. Actions included installing fire door seals as an extra safety precaution and we saw these had been fitted during our inspection.
- We saw records which showed the lift had been regularly serviced.
- We found there were no daily ambient room temperature checks recorded.

Medicines

- The clinic had an SLA in place for pharmacy support in terms of overseeing medicine management arrangements.
- We found medicines were stored securely and appropriately. Medicines were ordered on an average every four weeks from an external supplier. Medicines requiring cold storage were stored in locked fridges and the temperature was monitored daily. Staff carried out regular expiry and stock checks to ensure medicines were in date.
- Out of date and unused medicines were discarded appropriately and collected by an external supplier.
- The clinic held some emergency medicines (such as adrenaline for anaphylaxis) which were checked regularly and in date. These medicines were stored securely in the resuscitation trolley.
- Controlled drugs (CD) were kept inside and secure in a locked cupboard. CDs are prescription medicines that are subject to stricter and legal controls under The Misuse of Drugs Act 2001.
- The CD register was of an old style, which did not have a section for “supplied, administered, and destroyed”, so this was never recorded. It is regarded as best practice to have a register with these entries included.
- CD stock checks were completed in a separate file (as advised by the Home Office).
- The reconciliation of CD’s were checked on a monthly basis, signed by the consultant, and witnessed by the theatre manager. We saw records for October and November 2016, which showed no discrepancies.
- The CD keys were kept with the surgeon or registered nurse. When the clinic was closed, the keys were stored in a secure key press.
- Staff were aware of the clinics CD and medicine policy. We saw they had been signed and dated.

- Medicines used during surgical procedures and given to patients to take home, were prescribed by the consultant that carried out the surgical procedure.
- The accountable officer was the practice manager, but they had yet to undertake any training with regard to CD.
- The provider told us they had held a home office license and had recently been inspected in January 2017. The inspection had raised no concerns.
- There were risk assessments that demonstrated there were safe processes and management plans in place for patients who had cosmetic surgery with oral and intravenous sedation.
- We saw evidence that the oxygen cylinders had been serviced and were in date. The theatre manager was responsible for monitoring and arranging for delivery. Oxygen cylinders were securely stored in a well ventilated area.

Records

- Patient medical records were paper based with a password protected electronic file.
- We viewed six patient medical records. They were detailed, legible, and covered issues such as medical history, allergies and clinical advice and anaesthetist input. Consent, a patient care plan, and the completed World Health Organisation (WHO) surgical safety checklist were included in these records.
- Staff completed information governance (IG) training as part of their mandatory training. There was a completion for health care records policy, which had been dated and signed by all staff. This provided details on how patient information should be recorded and how any mistakes should be initialled and dated.
- Audits on patient records were completed every three to six months. Checks were completed by the practice manager on random sets of patient notes. The last two audits showed 100% compliance. Such checks included patient consent, risk assessments, and legible patient notes.
- Paper records were locked in a secure cabinet in the practice manager's office, which was locked when not in use.
- We saw and observed in past records that staff kept tracking records of surgical instruments that were used during a procedure, in case this information was needed.

Safeguarding

- Safeguarding was part of mandatory training. The theatre nurse and surgeon were trained to level three in safeguarding children, young people and adults, and the surgeon was the safeguarding lead for the clinic.
- Staff we spoke with had an understanding of safeguarding. Any safeguarding concerns were reported to the consultant or theatre nurse, who escalated these to the necessary local borough safeguarding teams.
- No safeguarding concerns were reported to the CQC during the year up to our visit.
- The service had separate safeguarding policies for children and adults, (even though the service did not treat children) which had been reviewed in February 2017. The polices were not up to date with latest guidelines and did not reference the three key published safeguarding documents. One was the Intercollegiate Document 'Safeguarding children and young people: roles and competences for healthcare staff' that was published by the Royal College of Paediatrics and Child Health in 2014. The second was 'Working together to safeguard Children,' updated in March 2015.
- The policy did not reference the Care Act 2014, which included key changes to information relating to adult safeguarding. The safeguarding policy did not include information on female genital mutilation (FGM) and sexual exploitation or PREVENT strategy, which is a government directive. At the heart ofPREVENTis safeguarding children and adults and providing early intervention to protect and divert people away from being drawn into terrorist activity.

Mandatory training

- Mandatory safety training was outsourced to a training company and staff completed topics such as basic life support, fire training, manual handling, safeguarding, health and safety, information governance, equality and diversity, infection prevention and control, lone working, complaints handling and Care of Substances Hazardous to Health (COSHH).
- All staff had completed mandatory training apart from the receptionist who had just joined the service at the time of our inspection. We saw they were booked to attend training courses relevant to their role.
- Anaesthetists were able to complete training with the centre or with the other establishments, they worked in.

They had to provide evidence of their training if they completed this elsewhere. Records of anaesthetists who worked at the practice showed they were up to date with their mandatory training.

Assessing and responding to patient risk (theatres, ward care and post-operative care)

- Patients had an initial consultation to determine whether they were eligible to receive treatment at the clinic. As part of this process, patients with certain medical conditions were excluded from receiving treatment. For example, patients that were overweight were considered unsuitable for liposuction procedures. This meant the patients that were accepted for treatment were generally fit and healthy with a low risk of developing complications during or after surgical treatment.
- If the provider was concerned about patients' psychological health, they encouraged them to visit their GP and would not go ahead with the surgery.
- Patients undergoing surgical procedures were treated under local anaesthetic or sedation (e.g. Midazolam). General anaesthetic was not used for any procedures carried out at the clinic.
- Patient's risks were assessed and monitored at a pre-assessment consultation, and checked again before treatment. These included risks about mobility, medical history, and examination findings. This ensured they were medically fit to undergo their operation and their condition had not changed since pre assessment.
- The centre used the post anaesthesia care unit system (PACU phase I and II). This system was a recovery room record of the time during which patients emerge from anaesthesia and receive their protective reflexes and motor activity. It is criteria based not time based. Criteria was defined and scored and a progression score of eight was necessary to move onto PACU stage II that allowed for 'home readiness and discharge. We saw baseline observations were completed pre-operatively, during the patient's procedure and post-operatively.
- The WHO (World Health Organisation) surgical safety checklist is a system to safely record and manage each stage of a patient's journey from the ward through to the anaesthetic and operating room to recovery and discharge from the treatment/theatre room. The clinic only used the WHO checklist for patients who had conscious sedation and not for those patients who had local anaesthetic. The WHO checklist should be used for all patients undergoing invasive treatment regardless of what type of anaesthetic procedures are used. We did not observe staff using the WHO checklist during our inspection.
- Patient records we viewed when the WHO checklist had been used showed the checklists were completed appropriately in each case.
- There were emergency buttons located in the recovery rooms and the consultant surgeon and anaesthetist did not leave the premises until the patient was discharged. Therefore, if the patient deteriorated there were readily trained staff to help the patient.
- Emergency services (paramedics and ambulance staff), were able to access the patient in the treatment room if the clinic needed their services.
- We saw documented evidence of venous thromboembolism risk assessment. We saw a patient wearing anti-embolism stockings during their procedure. These tight fitting stockings place mild static pressure on the legs to reduce the possibility of blood from clotting.
- We saw there were a variety of up-to-date standard operating procedures for the management of emergencies, for example massive blood loss and the management of a deteriorating patient. These ensured a standardised evidence based approach to managing emergencies, staff we spoke to confirmed they had access and were aware of the content.
- The consultant also carried out a psychological assessment of the patient, completed at the pre-surgery consultation. This ensured those patients who were psychologically vulnerable were appropriately referred for further assessment.
- The clinic had a service level agreement with a local independent hospital for medical emergencies and poor prolonged post-operative recovery of a patient. For emergency transfer clinical staff would also call 999 to transfer a patient to an NHS hospital. There has been no emergency transfers in the reporting period and no patients had stayed overnight at the clinic.
- The consultant and anaesthetists were immediate and advanced life support trained.

Nursing and support staffing

- The provider told us they did not use any acuity-based staffing tools at the clinic, as there was no variation in dependency or severity of illness in their patient group.

Patients either were seen in an outpatient capacity prior to a cosmetic procedure or had an agreed procedure. This enabled them to plan their required staffing accordingly.

- As the service only operated clinical activity one week per month, the centre employed one full time theatre nurse and used a bank registered theatre nurse or scrub nurse for the one week of clinical duty. Staffing levels were sufficient to meet patient demand. We saw evidence that bank nurses certificates of registration and training had been checked prior to the staff working at the clinic. We were told the service tended to use the same bank nurse, which meant patients, received continuity of care.
- Patient records we reviewed showed evidence that the theatre nurse and anaesthetist were present throughout patient treatment.
- Bank nurses received an induction from the practice manager and theatre nurse when they arrived at the centre.
- The theatre nurse took their required leave during the weeks there was no clinical activity. We were told if the theatre nurse was sick then patient treatment lists might have to be cancelled, but up to the point of our inspection, they had never had to do this. The service was reviewing the option to employ a part time permanent registered nurse to add to their staffing numbers.
- The service supported revalidation for their nursing staff. Revalidation is a process that all nurses and midwifes need to go through in order to renew their registration with the Nursing and Midwifery Council. The practice manager told us nursing staff were able to book any courses that supported their continual professional development as part of their revalidation. The theatre nurse we spoke with said they had recently booked a course on intravenous cannulation.

Medical staffing

- There was one consultant (the provider), who undertook cosmetic procedures. They worked one week per month and were based in another clinic overseas for the remaining period.
- There was one consultant recruited under a practising privileges arrangement who undertook emergency cover for the surgeon.
- The clinic also had recruited three consultant anaesthetists who worked with the NHS, for cosmetic surgery that required conscious sedation, with a practising privileges arrangement.
- The surgeon was available to be contacted out of hours for advice and support to concerned patients who had received treatment at the clinic. The surgeon had practising privileges (authority granted to a physician or dentist by a hospital governing board to provide patient care in the hospital) and access to a larger independent hospital if there was a need to see the patient for more urgent treatment out of hours. However, we were told this had never happened.
- When the surgeon was based overseas, patients were able to contact and get access to the surgeon at their overseas centre. If the patient wanted to be seen, arrangements were made with another consultant who worked at the independent hospital in London. Patients were made aware of these arrangements before they consented to treatment. We were told there had been very few occasions when patients saw the other consultant.

Emergency awareness and training

- There was a fire policy and staff were knowledgeable of the guidance and procedures to follow.
- Staff were trained to respond to an emergency when patients were in the location. Staff had received resuscitation training from an outsourced company.

Are surgery services effective?

Evidence-based care and treatment

- Generally, care and treatment was delivered in line with current legislation and nationally recognised evidence-based guidance. Policies and guidelines were developed in line with the Royal College of Surgeons and the National Institute for Health and Care Excellence (NICE) guidelines. We saw that policies and procedures were in date and staff were able to access these online and in paper form.
- We noted information which demonstrated adherence to the; NICE CG50 Physiological observations. We saw patient physiological assessments had been recorded in pre-assessment and patient care plans.

- The provider took account of professional standards for cosmetic surgery (2016). For example, cosmetic pre-assessment took place.
- The provider did not participate in national audits, but a local audit programme was in place, which included measuring patient outcomes on a quarterly basis. The clinic audited patient unplanned readmissions, unplanned transfers, adverse clinical incidents, and post-operative infections. Other three monthly audits included complaints monitoring, IPC, and patient survey.
- We saw in the patient records we reviewed, completed venous thromboembolism (VTE) assessments in accordance with NICE clinical guideline 92 'reducing the risk of venous thromboembolism (deep vein thrombosis and pulmonary embolism) in patients admitted to surgery.
- Liposuction procedures were documented on a 'VASER LipoSelection' tracking sheet, which contained information about the amplitude setting and laser used for each area of liposuction.

Pain relief

- The provider prescribed analgesia for all cosmetic patients as part of their procedure. Staff recorded pain scores to determine the level of patient pain and to see if the level of analgesia given was effective.
- Pain relief was prescribed by the anaesthetist or consultant and was recorded on the patient's medication records.

Nutrition and hydration

- Most procedures were under local anaesthetic, so patients could eat.
- The provider had water available at the clinic, and hot drinks were provided for patient comfort. Light snacks and food was booked and collected in advance of the patient's treatment.

Patient outcomes

- The service did not collect any Q-PROMS information from patients. Q-PROMS are patient report outcome measures, which describe the level of patient satisfaction with certain operations. These are recommendations from The Royal College of Surgeons (RCS) for providers to routinely collect and report performance reported outcomes measures (PROMS) for all patients receiving procedures such as breast augmentation and liposuction.
- However, the clinic had processes to monitor patient outcomes on a quarterly basis. Patient deaths, unplanned readmissions, returns to theatre, transfers, and adverse clinical incidents were audited and outcomes discussed at the medical advisory committee (MAC) meetings. The clinic also audited patient post-operative infections through reviewing the patient four to six weeks after their procedure, and a further review six months after treatment. These reviews were recorded in the patient's notes. They were seen by the consultant who treated them. The patient was checked to ensure post-operative wounds were healed and the theatre nurse contacted any patients who did not attend for follow up discussions. We saw from audits the service had not had any adverse outcomes.
- 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). However, the provider was aware of what was expected and was at an early stage of implementation.
- Between October 2015 and September 2016 there had been no reported cases of unplanned patient readmissions, transfers, returns to theatre, adverse clinical incidents reported.

Competent staff

- Newly appointed staff underwent an induction process and their competency was assessed prior to working unsupervised. Theatre staff underwent competency based induction training and we saw records, which showed the consulting surgeon, assessed their competency.
- Appraisals were conducted annually. The anaesthetist we spoke with told us they had received their annual appraisal. The receptionist and theatre nurse were newly appointed and had yet to receive their appraisal. We saw evidence of the surgeon and anaesthetists appraisals, which had taken place.
- Consultants working at the service were employed under practising privileges. The Medical Advisory

Committee (MAC) reviewed practising privileges every two years. This included a review of appraisals and scope of practice and checks for any reported incidents related to the individual consultant.

- We viewed four sets of staff records, which included the surgeon who owned the practice and three anaesthetists. The records showed evidence that their professional registration, indemnity insurance, disclosure and barring service (DBS) checks, fitness to practice and training (e.g. life support training) were current and in place.
- The service had appointed a Responsible Officer whose role included overseeing revalidation and appraisal processes.
- The service was supportive of staff development and training. Staff told us they were able to book additional courses to mandatory training. For example intravenous cannula training.
- The provider contacted us after our inspection, to inform us that one of the anaesthetists with practising privileges had failed their advance life support course. By mutual agreement, the staff member no longer practiced at the clinic.
- The responsible officer, who was a registered consultant, gave clinical advice and oversaw the monitoring and management of incidents for the lead consultant who owned the service.

Multidisciplinary working

- We observed medical and nursing staff working effectively as a multidisciplinary team at the clinic.
- The service had a range of external relationships with other companies to provide services to it. These included pharmacy, water testing, pathology, medical devices, infection control, clinical waste, decontamination services, haematology, fire alarms, and occupational health. These relationships were underpinned with service level agreements.

Access to information

- The provider told us the clinic computer database was password secured and only those who required access had passwords to the system.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Consent to care and treatment was obtained in line with legislation and guidance. All consent forms were signed and dated in the patients' notes we reviewed. Staff had the appropriate skills and knowledge to seek verbal informed consent and written consent before providing care and treatment to patients.
- We reviewed nine sets of medical records and saw there were effective consent processes and patients received sufficient information to make decisions about their treatment. For example, patients had at least two weeks between being assessed and given information about risks, benefits, expected outcomes, and signing the consent form. This meant patients were provided with a two-week cooling off period to allow them time to ask any further questions or change their minds.
- Although nursing staff we spoke with had an understanding of the Mental Capacity Act 2005, this was not part of their mandatory training.
- The consultant consented patients. The clinic was able to use the services of local practices with specialist doctors in psychology, if they felt the patient required further assessments.
- A cooling-off period was observed for patients undergoing cosmetic surgery procedures. This was in line with cosmetic surgery guidelines.

Are surgery services caring?

Compassionate care

- We saw that staff were caring and compassionate in interactions with patients. Staff treated patients with kindness, dignity, and respect. Staff interacted with patients in a positive, professional, and informative manner.
- We observed nursing staff collecting patients from the waiting room, shaking hands and introducing themselves prior to consultation.
- The two patients we spoke with said the staff were very friendly, kind, and considerate.
- We viewed two patient surveys, which had been conducted in March and July 2016. The surveys were small in the fact that a total of 13 patient's responses were received. However, the responses showed, patients were satisfied with the care they had received. One patient said they had a fantastic experience and other patients said they had received good aftercare and the procedure went smoothly.

Surgery

Understanding and involvement of patients and those close to them

- Staff involved patients involved in their care, and given time to discuss procedures.
- Staff introduced themselves by name to the patient.
- A copy of the clinics patient guide, which contained details of the services provided by the establishment, was made available for all patients.
- We spoke to a patient who described the initial consultation, investigation and was then told the treatment options. The patient said that staff encouraged them think before making a decision about treatment. This is in line with best practice allowing the patient time to consider all options.

Emotional support

- Counselling was available for all patients accessing the service through a referral system to an independent councillor.
- We observed a procedure and saw that the nurse who was present reassured the patient throughout the treatment.

Are surgery services responsive?

Service planning and delivery to meet the needs of local people

- Patients could access the service either through a recommendation by a GP, through word of mouth, or through an internet search or in response to marketing. The clinic used social media as part of its marketing strategy. The clinic did not do any NHS work and did not receive referrals from the NHS.
- The provider generally undertook cosmetic surgery, outpatient consultations, and treatments one week a month. Other times were available by arrangement. None of the treatments required an overnight stay.
- All patient consultations, pre-assessments, and minor treatments were carried out at the clinic. Breast augmentation was carried out at a larger independent hospital, where extra facilities and equipment were available for the patient procedure.

Access and flow

- Pre- admission checks and assessments were undertaken and when completed the patient changed and waited for their treatment. Staff then escorted patients to the treatment room. The majority of patients walked to the treatment room. After surgery, staff cared for patients in the recovery room.
- During our inspection, the treatment lists ran on time. The inspection did not highlight any concerns relating to the admission, or discharge of patients from the clinic.
- Patients were provided with post-operative care instructions to take home once they were discharged. They were given prescribed pain medication and a discharge summary with emergency contact details.
- All patients were contacted within 24 hours of their surgery, by the theatre nurse to review how they were recovering. Patients would then be reviewed in a follow up appointment to ensure their wound was healing and to discuss any concerns relating to their treatment plan.
- The clinic did not carry out any unplanned surgery. If patients had any concerns out of hours, they were provided with a contact number for the consultant. In an emergency, the patient was directed to an independent hospital or emergency services were called. For non-emergency issues, the consultant or nurse would review the patient at an agreed arranged time.
- The provider reported that no procedures had been cancelled for a non-clinical reason in the last 12 months.

Meeting people's individual needs

- Information for patients about procedures undertaken at the clinic was on display and easy to understand. These included postoperative information. The clinic also had a website with details about clinical procedures, which were clearly explained.
- The clinic only provided cosmetic services for private fee-paying adult patients over the age of 18 years.
- Patients were given a telephone number for contact with the service, that could be used seven days a week 24 hours a day if they had any post-operative concerns following procedures.
- The clinic had access and toilet facilities for wheelchair users and call-bells were in operation.
- The clinic had a lift, which was suitable for people who used wheelchairs.
- Professional telephone translation services were available to those patients that required assistance. An additional Arabic translator was available through their services at their clinic based in Dubai if required.

- Refreshments such as tea, coffee, water, biscuits, and a light snack were available for patients post procedure.
- Patient's appointment times were extended if they required more time to ask questions.
- If the clinic could not provide treatment for patients with special requirements, for example bariatric patients,they were referred to the appropriate services.

Learning from complaints and concerns

- The clinic had a documented complaints process, whereby formal discussions were encouraged to resolve any issues. These were undertaken by the clinic owner or practice manager.
- All complaints received a written acknowledgment within two working days of the complaint and a written response within 20 days. If further investigation required longer than 20 days the patient would be told. A full response was provided within five days of a full conclusion being reached.
- The clinic had received one complaint in 2016. We saw the monitoring of the complaint. Monitoring included a description of the complaint, the stage of complaint and action taken and the outcome of the complaint. The clinic has received a further five complaints during 2016, but these related botox treatments which we do not regulate. We saw complaints were dealt with by the clinic owner through face-to-face conversations, e-mail, and skype. Patients were apologised to and refunded in full if they were still unhappy.
- Complaints were reviewed at the quarterly clinical governance and MAC meetings.
- Patient surveys were completed following minor surgery, all responses were audited, and outcomes monitored through the quarterly clinical governance and MAC meetings.
- If a patient was not satisfied with the conclusion of a complaint, they had the option of contacting an independent arbitration service.

Are surgery services well-led?

Leadership / culture of service related to this core service

- Staff who worked at the service told us they enjoyed working at the clinic, and everyone got on well with each other.
- There was clear leadership. Staff knew their reporting responsibilities and the role they played within the service.
- Regular staff meetings were not held due to the size of the service. The practice manager and consulting surgeon had regular contact with the nurse and receptionist. The theatre nurse told us they were able to contact and speak to either one of the managers if they needed to.

Vision and strategy for this core service

- We were provided with a copy of the clinics statement of purpose: "Our service consists of dedicated and professional practitioners and staff. We strive to be acknowledged by our patients, suppliers, and regulators as the leader in our sector. This will be achieved by ensuring that we recruit and train highly professional staff whose ambitions are to exceed patient expectations.
- The clinics aims were to: "To understand and exceed the expectation of our patients. To both motivate and invest in our team and acknowledge their value. To encourage all the team members to participate in achieving our aims and objectives".
- The clinics objectives were to: "Maintain the highest professional and ethical standards, to respond to the needs of our patients, practitioners, and staff and to encourage innovation, ambition, enterprise, and continuous improvement".
- Staff we spoke with were aware of the clinics aims and objectives and said they worked in practice.

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

- The clinic held meetings through which governance issues were addressed. These meetings included the Medical Advisory Committee (MAC) meetings.
- The MAC met quarterly and reviewed practising privileges, clinical governance, adverse events, infection control, patient feedback, and finances. There was regular contact between managers and the MAC chair and he reported a good working relationship. We viewed two meeting minutes and found all clinical and patient topics had been discussed with actions listed if required.
- There was no risk register at the clinic. However, the provider had undertaken risk assessments for the clinic;

for example, we saw risk assessments on anaphylactic shock, diathermy risks, and sharps risks. The risk assessments gave clear instructions to staff on what could go wrong and the control measures in place to reduce or minimise the risk. For example, with the sharps risk assessment, clear instructions included measures staff needed to take to avoid a sharps injury, such as ensuring they did not overfill the sharps bin and the actions they should take, if they had a sharps injury.

- The provider had an audit schedule in place. The audits were more a review of practice, to identify if any changes of practice were needed. The audits were not measured against national standards.
- Whist the provider did seek feedback from patients regarding their care, they did not perform quality measurements such as collecting patient reported outcomes (Q-PROMS) information from patients, as recommended by the Royal College of Surgeons (RCS). Patient satisfaction with the outcomes of cosmetic surgery pre- and post-operatively, allows for a patient's own measurement of their health and health-related quality of life, and how this has been changed by the surgical intervention.

Public and staff engagement (local and service level if this is the main core service)

- All patients were asked to complete a patient feedback questionnaire about their experience at the clinic. The provider reviewed the responses at the MAC meetings. There was a comments and suggestion book in the patient waiting area.
- Due to the small size of the service, there were no regular team meetings arranged. They were arranged on an ad hoc basis, if there were any urgent issues to discuss.
- The clinic did not carry out any staff surveys due to the small size for the service. Staff told us they were able to feedback on any input into the running of the service, but there was no formal meeting where feedback was discussed.

Innovation, improvement, and sustainability (local and service level if this is the main core service)

- We found staff wanted to learn, develop, and improve their skills and were given time, resources, and encouragement to do so. Staff were encouraged to identify areas of learning or courses to attend to advance their skills.

Outstanding practice and areas for improvement

Areas for improvement

Action the provider SHOULD take to improve

- Make sure the treatment room is decluttered and streamlined to allow for best infection prevention and control practices.
- The World Health Organisation (WHO) surgical safety checklist should be used for all patients undergoing minor surgical procedures.
- The provider needs to have 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).
- The safeguarding policy needs to be updated to reflect national guidelines, to include female genital mutilation (FGM) and sexual exploitation.
- Include The Mental Capacity Act 2005 as part of mandatory training.
- Make sure the practice manager has received the relevant training for their role as responsible officer for controlled drugs.
- Anaesthetists, conducting daily checks on airway equipment need to ensure these checks are recorded.
- Ambient room temperature checks need to be monitored on a daily basis.