Ziering London Clinic

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

Ratings

Overall rating for this location	**Requires improvement**
Are services safe?	**Requires improvement**
Are services effective?	**Requires improvement**
Are services caring?	**Good**
Are services responsive?	**Good**
Are services well-led?	**Requires improvement**

Overall summary

Ziering London Clinic is operated by Chiron Hospitals Ltd. The service has three overnight beds. Facilities include one main theatre, two clinic rooms used for hair transplant operations, consulting rooms, a two-bedded recovery area and a three- bedded ward.

The service provides cosmetic surgery such as breast enlargement and hair transplants, as well as non-surgical interventions.

We inspected this service using our comprehensive inspection methodology. The service was inspected once before in February and March 2018. We carried out an unannounced inspection on 12 June 2019 to see if the provider made the improvements we required them to make at the last inspection.

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? Where we have a legal duty to do so we rate services' performance against each key question as outstanding, good, requires improvement or inadequate.

Summary of findings

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 rate

We did not rate this service last time. We rated it this time as **Requires improvement** overall.

We found the following issues that the service provider needs to improve:

- The service provided mandatory training in key skills to all staff but did not make sure everyone completed it.
- Staff understood how to recognise and report abuse. Staff had received training on safeguarding adults but it was out of date at the time of inspection. The safeguarding policy did not reflect the requirements of the Care Act 2014 (Chapter 14) statutory guidance.
- The centre did not control infection risk well. Though staff used some equipment and control measures to protect patients, themselves and others from infection, they did always not keep equipment and the premises visibly clean. The provider did not have effective systems in place for maintenance of facilities, premises and equipment to keep people safe. However, staff managed clinical waste adequately.
- Managers regularly reviewed staffing levels and skill mix, and gave bank and agency staff a full induction. However, the provider was unable to provide assurance that they were always compliant with(Association for Perioperative Practice (AfPP) guidance as they did not audit this. All staff had out of date basic life support training.
- The service did not use systems and processes to safely record and store medicines.
- The service did not manage patient safety incidents well. Staff recognised incidents and near misses but did not always report them or grade them appropriately. Managers investigated incidents but there was no robust system to share learning from incidents with staff. The service did not use monitoring results well to improve safety. Staff collected safety information, but this was not shared with staff, patients and visitors.
- A safer surgical checklist based on the World Health Organisation (WHO) guidance was used for cosmetic procedures only and the service did not use the WHO checklist for hair transplant procedures. Following inspection, the provider informed us that this had now been implemented for hair transplant procedures and provided a template they intended to use for this purpose going forward.
- The service did not consistently provide care and treatment based on national guidance and evidence-based practice. Some policies were not fit for purpose, and some practice was not in line with current best practice guidance. Staff did not always monitor the effectiveness of care and treatment. Since the last inspection, the provider had not sufficiently improved and widened audit activity undertaken to make improvements and achieve good outcomes for patients.
- The service did not always have adequate measures in place to make staff were competent for their roles. Managers appraised most staff's work performance. However, we were not assured of the quality of these appraisals, and no clinical supervision meetings were taking place at the time of inspection. The provider did not follow their own policy on the review of practising privileges as they did not have a functioning medical advisory committee. They did not monitor every surgeon's scope of practice or performance adequately.
- Managers in the service did not have the right skills and abilities to run a service providing high-quality sustainable care. Staff did not always feel supported by their managers and there had been frequent changes at the level of registered manager. The provider did not promote a universally positive culture that supported and valued all staff.
- Leaders did not ensure effective governance processes operated throughout the service. Staff at all levels were clear about their roles and accountabilities but did not have regular opportunities to meet, discuss and learn from the performance of the service. The centre lacked a robust risk management system and demonstrated limited engagement with staff regarding improving the service, as well as lacking a robust approach to quality improvement.

Summary of findings

However, we also found the following areas of good practice:

- 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 completed and updated risk assessments for each patient and removed or minimised risks where possible. Staff identified and quickly acted upon patients at risk of deterioration.
- Managers ensured that actions from patient safety alerts were implemented and monitored.
- Staff assessed and monitored patients regularly to see if they were in pain and gave pain relief in a timely way. They gave additional pain relief to ease pain. Staff gave patients enough food and drink to meet their needs and improve their health. Generally, doctors, nurses and other healthcare professionals worked together as a team to benefit patients. They supported each other to provide good care. Key services were available six days a week. Staff supported patients to make informed decisions about their care and treatment. They followed national guidance to gain patients' consent.
- The service had a vision for what it wanted to achieve and a strategy to turn it into action. The centre collected information to support some of its activities.

We told the provider that it must take some actions to comply with the regulations and that it should make other improvements, even though a regulation had not been breached, to help the service improve. We issued the provider with two requirement notices and a warning notice that affected the Ziering London Clinic. Details are at the end of the report.

Following this inspection, we told the provider that it must take some actions to comply with the regulations and that it should make other improvements, even though a regulation had not been breached, to help the service improve. We also issued the provider with a warning notice under section 29A of the Health and Social Care Act 2008 and two requirement notices that affected the Ziering London Clinic. Details are at the end of the report.

Nigel Acheson

Deputy Chief Inspector of Hospitals (London and South)

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Surgery	**Requires improvement** 	Cosmetic surgery was the only activity carried out in the service. We rated overall this service as requires improvement because safe, effective and well-led required improvement. We rated caring and responsive as good.

Summary of findings

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Ziering London Clinic

Services we looked at: Surgery

Summary of this inspection

Background to Ziering London Clinic

Ziering London Clinic is operated by Chiron Hospitals Ltd. The service opened in 2014, providing hair transplants, cosmetic surgery and non-surgical cosmetic interventions. In January 2017, the clinic began functioning as a cosmetic surgery provider, providing operations such as breast enlargement, hair transplant and liposuction. It is a private clinic in London. The clinic accepts referrals from GPs, lead referrals from third party companies and self-referrals from patients living in London and internationally. The service does not provide services to NHS-funded patients or patients under the age of 18.

At the time of the inspection, a new manager had recently been appointed and their application for registered manager with CQC had been submitted and was being processed.

Our inspection team

The team that inspected the service comprised a CQC lead inspector, one other CQC inspector, and a specialist advisor with expertise in theatre nursing. The inspection team was overseen by Terri Salt, interim Head of Hospital Inspection.

Information about Ziering London Clinic

The clinic provides cosmetic surgery and is registered to provide the following regulated activities:

• Surgical Procedures

• Treatment of disease, disorder or injury.

During the inspection, we visited the whole clinic, including the reception, waiting areas, theatre, two-bedded post anaesthesia care unit (PACU), the ward and consultation rooms We spoke with 10 staff including registered nurses, health care assistants, reception staff, medical staff, operating department practitioners, and senior managers. We spoke with one patient and one relative. During our inspection, we reviewed seven sets of patient records.

The service was inspected once before in February and March 2018. There were no special reviews or investigations of the hospital ongoing by the CQC at any time during the 12 months before this inspection. This inspection found that the service was not meeting all standards of quality and safety it was inspected against.

Activity (May 2018 – April 2019):

- There were 2,190 patient episodes. Of these, 1104 were outpatient attendances, 1,062 were day cases and 24 were inpatient episodes of care recorded at the clinic. All were privately funded.
- The most common procedures carried out were: breast enlargement (775), mastopexy/augmented mastopexy (204), liposuction (25), gastric bands/ balloons (24), rhinoplasty (20), abdominoplasty (19), otoplasty (8), breast reduction (5), facial and neck (4) and gynaecomastia (2).

There were 17 doctors working at the clinic under practising privileges. The service employed four registered nurses, two healthcare assistants and two receptionists, as well as having its own bank staff. There was an accountable officer for controlled drugs (CDs).

Track record on safety (May 2018 - April 2019):

- No never events
- 30 incidents: 22 clinical and eight non-clinical incidents.
- No serious injuries

Summary of this inspection

- No incidences of hospital acquired Meticillin-resistant Staphylococcus aureus (MRSA)
- No incidences of hospital acquired Meticillin-sensitive staphylococcus aureus (MSSA)
- No incidences of hospital acquired Clostridium difficile (C.diff)
- No incidences of hospital acquired E-Coli
- 63 complaints

Services provided at the hospital under service level agreement:

Clinical and general waste collection

Confidential waste collection

Cleaning service

Fire alarm & lighting servicing

Fire extinguisher checks

Portable appliance testing

Air conditioning

Pest control

Gas boiler maintenance

Legionella risk assessment

Water cooler maintenance

Fixed electrical testing

Laboratory testing

Equipment servicing

Private ambulance services

Blood specimen testing

Supply of linen and provision of laundry

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?

Requires improvement 

We have not rated safe for this service before. We rated safe as **Requires improvement** because:

- The service provided mandatory training in key skills to all staff but did not make sure everyone completed it.
- Staff understood how to recognise and report abuse. Staff had received training on safeguarding adults, but it was out of date. The safeguarding policy did not reflect the requirements of the Care Act 2014 (Chapter 14) statutory guidance.
- The centre did not control infection risk well. The service used systems to identify and prevent surgical site infections. Though staff used some equipment and control measures to protect patients, themselves and others from infection, they did not keep equipment and the premises visibly clean.
- The provider did not have effective systems in place for maintenance of facilities, premises and equipment to keep people safe. Staff managed clinical waste adequately.
- Managers regularly reviewed staffing levels and skill mix, and gave bank and agency staff a full induction. However, the provider was unable to provide assurance that they were always compliant with(Association for Perioperative Practice (AfPP) guidance as they did not audit this. All staff had out of date basic life support training.
- The service did not use systems and processes to safely record and store medicines.
- A safer surgical checklist based on the World Health Organisation (WHO) guidance was used for cosmetic procedures only and the service did not use the WHO checklist for hair transplant procedures. Following inspection, the provider informed us that this had now been implemented for hair transplant procedures and provided a template they intended to use for this purpose going forward.
- The service did not manage patient safety incidents well. Staff recognised incidents and near misses but did not report them, or grade them appropriately. Managers investigated incidents but
- The service did not use monitoring results well to improve safety. Staff collected safety information, but this was not shared with staff, patients and visitors.

However, we also found the following areas of good practice:

Summary of this inspection

- Managers ensured that actions from patient safety alerts were implemented and monitored.
- 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.
- 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.

Are services effective?

Requires improvement

We have not rated effective for this service before. We rated effective as **Requires improvement** because:

- The service did not consistently provide care and treatment based on national guidance and evidence-based practice. Some policies were not fit for purpose, and some practice was not in line with current best practice guidance.
- Staff did not always monitor the effectiveness of care and treatment. Since the last inspection, the provider had not sufficiently improved and widened audit activity undertaken to make improvements and achieve good outcomes for patients.
- Although the service conducted a fasting audit, they did not provide evidence of any action plans or actions taken as a result of collating this information.
- The service did not always have adequate measures in place to make staff were competent for their roles. Managers appraised most staff's work performance. However, we were not assured of the quality of these appraisals, and no clinical supervision meetings were taking place at the time of inspection. The provider did not follow their own policy on the review of practising privileges as they did not have a functioning medical advisory committee. They did not monitor every surgeon's scope of practice or performance adequately.

However, we also found the following areas of good practice:

- Staff assessed and monitored patients regularly to see if they were in pain, and gave pain relief in a timely way. They gave additional pain relief to ease pain.
- Staff gave patients enough food and drink to meet their needs and improve their health.
- Generally, doctors, nurses and other healthcare professionals worked together as a team to benefit patients. They supported each other to provide good care.
- Key services were available six days a week to support timely patient care.

Summary of this inspection

- Staff supported patients to make informed decisions about their care and treatment. They followed national guidance to gain patients' consent.

Are services caring?

Good

We have not rated caring for this service before. We rated caring as **Good** because:

- Staff treated patients with compassion and kindness, respected their privacy and dignity, and took account of their individual needs.
- Staff provided emotional support to patients, families and carers to minimise their distress. They understood patients' personal, cultural and religious needs.
- Staff supported and involved patients, families and carers to understand their condition and make decisions about their care and treatment.

Are services responsive?

Good

We have not rated responsive for this service before. We rated responsive as **Good** because:

- The service planned and provided care in a way that met the needs of their patient population.
- The service was inclusive and took account of patients' individual needs and preferences. Staff made reasonable adjustments to help patients access services.
- People could access the service when they needed it and usually received care promptly.
- It was easy for people to give feedback and raise concerns about care received. The service treated concerns and complaints seriously and investigated them.

However:

- The clinic did not audit waiting times for consultation or surgery. Theatre lists were not always organised sufficiently in advance.

Are services well-led?

Requires improvement

We have not rated well-led for this service before. We rated well-led as **Requires improvement** because:

- Managers in the service did not have the right skills and abilities to run a service providing high-quality sustainable care. Staff did not always feel supported by their managers and there had been frequent changes at the level of registered manager.

Summary of this inspection

- The provider did not promote a universally positive culture that supported and valued all staff.

Detailed findings from this inspection

Overview of ratings

Our ratings for this location are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Surgery	Requires improvement	Requires improvement	Good	Good	Requires improvement	Requires improvement
Overall	Requires improvement	Requires improvement	Good	Good	Requires improvement	Requires improvement

Requires improvement

Surgery

Safe	Requires improvement
Effective	Requires improvement
Caring	Good
Responsive	Good
Well-led	Requires improvement

Are surgery services safe?

Requires improvement

The main service provided by Ziering Clinic London was cosmetic surgery.

We have not rated safe for this service before. We rated it this time as **requires improvement.**

Mandatory training

The service provided mandatory training in key skills to all staff but did not make sure everyone completed it.

- There was mandatory training in place for staff who worked at the clinic. Training included infection control, information governance, fire safety, food hygiene, basic life support and safeguarding for children (level one and two) and safeguarding for vulnerable adults (level one and two). The provider informed us that the next training sessions were due to be completed in September and October 2019. However, the training certificates submitted showed that the certificate was valid for one year and all surgical staff had completed this training in April 2018. This meant that the mandatory training of all surgical staff employed by the clinic was not in date at the time of inspection.
- The hair technicians were employed by the clinic and were expected to complete mandatory training modules. Following inspection, evidence submitted to us showed that all hair technicians had up-to-date training.
- Doctors with practising privileges at the hospital were required to provide annual assurance of mandatory training completion. We saw evidence of this in the files we checked.
- There was a 'sepsis consideration and management policy', dated December 2017. The provider told us that sepsis was covered as part of their mandatory training. We saw evidence of in-house sepsis awareness training sessions provided to all relevant staff.

Safeguarding

Staff understood how to recognise and report abuse. Staff had received training on safeguarding adults, but it was out of date. The safeguarding policy did not reflect the requirements of the Care Act 2014 (Chapter 14) statutory guidance.

- The clinic did not treat anyone under the age of 18. They had a policy for safeguarding patients from abuse, updated in June 2017. However, the safeguarding policy did not reflect the requirements of the Care Act 2014 (Chapter 14) statutory guidance, or detail procedures which offered us assurance that the provider had a safeguarding system in place that would identify, respond and manage safeguarding allegations in a way that would safeguard people from harm.
- A separate female genital mutilation (FGM) policy was in place, which was in date and comprehensive.
- The manager informed us that safeguarding was part of the clinic's mandatory training. We reviewed files of eleven staff and all had undertaken safeguarding vulnerable adult and safeguarding children level one and two training, but this was out of date and staff were booked to attend in October 2019.

- The new clinic manager was the safeguarding lead for the service and had completed safeguarding vulnerable adult level three training.
- Staff we spoke with demonstrated an awareness of safeguarding procedures and how to recognise if someone was at risk or had been exposed to abuse. Staff told us they had never had to raise a safeguarding concern that required escalation but were aware of how they would do so.
- We observed that appropriate safeguarding referral contact details were displayed in clinic and treatment rooms and staff could direct us to them. Between May 2018 and April 2019, the clinic did not report any safeguarding concerns to the local authority and no safeguarding notifications were recorded by the CQC.
- Senior staff told us that they ensured professional registration, fitness to practice, and validation of qualification checks were undertaken for all staff. All staff files we reviewed had relevant Disclosure and Barring Service (DBS) checks in place.

Cleanliness, infection control and hygiene

The centre did not control infection risk well. The service used systems to identify and prevent surgical site infections. Though staff used some equipment and control measures to protect patients, themselves and others from infection, they did not keep equipment and the premises visibly clean.

- At the last inspection, we found that the service did not always take all necessary measures to control infection risk well. We noted some areas were not always fully clean and staff did not always take all appropriate measures to prevent the spread of infection. At the time of this inspection, we found that the provider had not made significant improvements to adequately control the risk of infection.
- On the day of this inspection, in the main theatre, we found visible dust and sticky pink residue on the main storage trolley, as well as two other storage trolleys with visible dust in the storage cupboard. We also found visible blood on diathermy foot pedals (a machine for cutting of tissue during surgical procedures). A remnant of what appeared to be human tissue (fat) was also visible on the main storage trolley. The operating trolley arm supports had remnants of sticky tape present. These issues presented an infection control risk. Following inspection, the provider informed us that trolleys had been removed and new trolleys had been ordered.
- We saw completed daily cleaning checklists for April, May and June 2019, which senior staff told us were completed by theatre staff. We found discrepancies in the cleaning checklist, as it stated no checks were done as the service was closed for six days in April and for seven days in May 2019. This conflicted with the closed days submitted by the provider, which stated the clinic was open on these same days. We were therefore not assured that staff were carrying out the daily theatre cleaning every day or documenting this correctly.
- The manager informed us that in addition to theatre staff cleaning the theatre, external cleaners undertook daily cleaning. We saw evidence of the June checklist completed by the external cleaners. However, this list did not include the theatres. On the day of inspection, the manager was not clear if the theatres were cleaned by external cleaners or not. Following the inspection, the provider confirmed that the main theatre was cleaned by health care assistants, whilst the external cleaners cleaned the rest of the building.
- The provider informed us that the last deep cleaning of the main theatre was undertaken in January 2019 and next was booked for October 2019. Following inspection, the provider informed us that additional deep cleaning was carried out on 12 July 2019.
- We found that daily cleaning checklists were completed intermittently. There were no checks completed for several areas and days when the provider told us the clinic was open. For example, the daily check of the staff toilet was not documented for four days in May and one day in April 2019; the middle clinical room checklist was not completed for two days in June and five days in May 2019; the admission room checklist was not completed for one day in June and April 2019, and the recovery room checklist was not completed for one day in June and 17 days in May 2019.
- Between May 2018 and April 2019, the provider reported 16 surgical site infections (SSIs). There were 984 breast procedures performed in the same period. Of these 16 SSIs, 12 were related to breast procedures (1.2%).
- There was an annual infection prevention control (IPC) work programme. We noted that the annual programme was reviewed and monitored quarterly by the clinic director but did not cover any of the additional concerns

we found on the day of inspection. The provider informed us the annual IPC work programme was designed to capture the need of the business as a whole and that any locally identified issues would be recorded in the IPC environmental audit. However, this audit was not provided when we previously asked for details of any IPC audits that had been conducted.

- We saw that various environmental and infection control concerns were on the provider's risk register and there were plans to address these. For example, in quarter two there were plans to replace the chairs in reception and repair paintwork throughout the building, including damaged door frames to reduce IPC risk. However, not all concerns we identified during the inspection were listed on the provider's risk register.
- There were dispensers with hand sanitising gel situated in appropriate places around the unit, including the main entrance to the unit and inside clinical rooms. The seven-step guidance for effective hand washing was displayed above hand washbasins. Hand washbasins were equipped with soap and disposable towels.
- Adequate supplies of personal protective equipment (PPE) including gloves and aprons, were available. We observed that all staff would change into blue or black scrubs style uniform and adhered to 'bare below elbows' (BBE) dress code. We observed that doctors and clinical staff adhered to this at all times.
- The clinic carried out a monthly hand hygiene audit. Results of the February, March and April 2019 audits showed that all three staff observed were all compliant.
- Between May 2018 and April 2019, the clinic had no reported cases of meticillin resistant staphylococcus aureus (MRSA). MRSA is a bacterium that can be present on the skin and can cause serious infection. The department also reported no cases of MSSA (meticillin susceptible staphylococcus aureus - a type of bacterium that can live on the skin and develop into an infection, or even blood poisoning) and Clostridium difficile (a bacterium that can infect the bowel and cause diarrhoea, most commonly affecting people who have been recently treated with antibiotics).

Environment and equipment

The provider did not have effective systems in place for maintenance of facilities, premises and equipment to keep people safe. Staff managed clinical waste adequately.

- All clinical areas and the main theatre were on ground floor and there was step-free access. Except for the main theatre room, all clinical areas we observed were suitable for their intended use. We found the environment in the main theatre did not meet expected standards. For example, the flooring below the scrub sink had visible stains and there were cracks on floor joints. We found rust on trolleys within the main theatre and the instrument trolley had rusty wheels. In addition, the storage trolley adjacent to sink had dust and visible rust on the top and on the wheels. Following inspection, the provider informed us that trolleys had been removed and new trolleys had been ordered.
- On the day of inspection, the temperature in the main theatre was below 16 degrees Celsius. This was not compliant with health building notice (HBN) 26 for facilities for surgical procedures. We raised this as a concern and as a result, the manager cancelled the remaining breast augmentation procedures booked for the day. We were informed in the afternoon that the temperature had increased, and the remaining procedures booked for the day went ahead as planned. We saw that the servicing and update of the air conditioning system was on the provider's risk register. Following inspection, evidence submitted to us showed that engineers attended the clinic on 13 June 2019 and had resolved this issue relating to low temperature in the operating theatre. We saw that provider's 'general work programme 2019' showed that the theatre's thermometer gauge for the air handling system would be obsolete from end of 2019. The provider was considering installing a new hand-held system as a result.
- The clinic had the relevant emergency resuscitation equipment in recovery. An additional defibrillator was available in the reception area. We saw that defibrillator was checked regularly. However, we found that resuscitation trolley checks were done intermittently. For example, resuscitation trolley daily checks were not completed or documented on 16, 20, and 21 May or 10, 14, 15, 17 and 24 April 2019. We also found that emergency drugs contents checklist did not match with the contents of the box itself. Therefore, the provider was not ensuring that staff would have access to the equipment or drugs needed in an emergency.
- Piped oxygen was not used within the clinic. At the last inspection, there was no evidence of regular checks of oxygen cylinders. At this inspection, we noted that there

were sufficient supplies of oxygen cylinders and there was evidence that regular checks had been carried out. However, we found that the oxygen cylinders within the patient admission room and the hair transplant room were free standing. There were also several medical gas cylinders that were stored in a cupboard on different shelves that were not secured and thus posed a safety risk. Following inspection, evidence was submitted that demonstrated oxygen cylinders had been secured to the wall and medical gas storage had been improved within the cupboard.

- Staff informed us that the provider was slow to act on issues relating to building amenities. For example, one of the patient toilets was out of order for several weeks and the only hand wash sink in the ward was blocked on the day of inspection. No actions had been taken by the provider to fix these issues. Following inspection, the provider informed us that both these issues had been resolved.
- We checked three fire extinguishers that were serviced annually. However, we found two free-standing fire extinguishers (which were not secured to a wall) stored within the storage area and had not been serviced. Following inspection, the provider submitted evidence that all 10 fire extinguishers were serviced on 10 July 2019.
- All portable equipment we checked had been recently serviced and labelled to indicate the next review date. All equipment was serviced annually by an external company.
- All sterile items utilised in the clinic for pre and post-operative care were single use. Reusable instruments were used for liposuction. These were decontaminated and sterilised off-site by an external company under a service level agreement (SLA). Staff told us that there were no issues with this arrangement and processes were in line with national guidance, such as the Department of Health Technical Memorandum on decontamination.
- Clinical waste disposal was provided through an SLA with an external provider. We observed safe systems for managing waste and clinical specimens during the course of inspection.
- We observed that sharps management complied with Health and Safety (Sharp Instruments in Healthcare) Regulations 2013. Sharps containers within the clinic were dated and signed when assembled, not overfilled and temporarily closed when not in use.
- We were unable to check the environment of the hair transplant treatment room on the day of inspection as there was a procedure going on and the patient did not consent to be observed.
- At the last inspection, we found that there were no locked doors between the reception of the clinic and the operating theatre, which may have presented a security risk. At this inspection, we found that although there was still no lock on the doors, the provider had risk assessed this and deemed it was not necessary.
- A legionella risk assessment had been carried out (legionella is a term for a particular bacterium which can contaminate water systems in buildings) and there were no actions to follow up from this.
- The provider informed us that relevant control of substances hazardous to health (COSHH) risk assessment had been carried out. This ensured that flammable substances within the clinic were kept locked and stored safely.

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. However, the clinic did not use the WHO checklist for hair transplant procedures at the time of inspection.

- There was an admission policy in place. Staff we spoke with told us that they would not accept under 18 years old, patients with major medical issues (such as cancer) or mental health issues and patients with a body mass index (BMI) of 38 or over. However, in regard to BMI, this was not recorded in either the pre-admission criteria policy or surgery contraindications/preoperative considerations document provided to us, which stated patients should have a maximum BMI of 35 and 30, respectively.
- Consultations for procedures were completed face to face, with the lead clinician assessing and examining the patient and explaining their treatment options, the risks and the expected outcome of treatment. All patients were asked to complete a medical history and health questionnaire before consultations or procedures.
- Surgical procedures were performed under local anaesthetic or total intravenous anaesthesia (TIVA), which is used for maintenance of general anaesthesia by intravenous infusion, without the use of inhalation

agents. The anaesthetist was required to remain with the patient until the patient was awake and orientated after each procedure where TIVA was used. The anaesthetist was trained in advanced life support (ALS).

- Patients' clinical observations such as pulse, oxygen levels, blood pressure and temperature were monitored in line with National Institute for Health and Care Excellence (NICE) guidance CG50 'Acutely ill-Patients in Hospital.' A scoring system based upon these observations known as a national early warning score (NEWS) was used to identify patients whose condition was at risk of deteriorating. Patient notes we examined contained guidance for staff on the NEWS scoring system, and detailed the actions required if the score indicated deterioration. Staff we spoke with were familiar with using the NEWS tool and how to escalate concerns. Following inspection, a NEWS audit tool template was submitted, which the senior staff at the clinic told us they were planning to use in future.
- We saw evidence within patient notes of risk assessments relevant to the patient's needs having been carried out. Between May 2018 to April 2019, 98% of patients had been assessed for the risk of venous thromboembolism (VTE). Most patients did not stay overnight at the service and did not require pressure ulcer risk assessment.
- Theatre staff used a safer surgical checklist based on the World Health Organisation (WHO) guidance. The surgical safety checklist for patients was intended for use throughout the perioperative journey, to prevent or avoid serious patient harm. By following the checklist, health care professionals can minimize the most common and avoidable risks endangering the lives and well-being of surgical patients. The provider completed monthly audit of WHO checklist. Between January and April 2019, the compliance was between 98% and 100%. All seven patient records we examined also contained completed WHO checklists. However, on the day of inspection, we followed a patient through their procedure and saw the WHO checklist was not completed effectively. We saw that the operating department practitioner (ODP) was not present at the time of the initial brief, as it had taken place in the recovery area. At the 'time out' stage, silent focus was not observed, as the radio was playing, and the surgeon was busy positioning lights and had to be prompted to respond. We observed that 'sign in' and 'sign out' stages were not completed as part of an interactive process as intended. This increased the potential risk of errors and adverse events.
- We found that hair transplant surgeons were not using the WHO checklist at all. Following inspection, the provider informed us that this had now been implemented for hair transplant procedures and provided a template they intended to use for this purpose going forward.
- On the day of inspection, a theatre list was running, and we saw that staffing levels complied with Association for Perioperative Practice (AfPP) guidance, which stated that scheduled operating lists required a minimum of two scrub practitioners, one circulating staff member, and one registered anaesthetic assistant practitioner. We were informed that the theatre scrub nurse would at times perform a dual role for major procedures, which was not in line with the provider's standard operating procedure (SOP) for staffing the theatre. Following inspection, the provider informed us that for any major procedures, a surgical first assistant (SFA) was required. An SFA was used these for major surgery such as bariatrics. If the surgeon requested an assistant, this was provided in addition to a scrub nurse. However, senior leaders were unable to provide assurance that they were always compliant with AfPP guidance as they did not audit this.
- We observed that a patient was given cold fluids during an operation. The clinic was not following current clinical best practice guidance on the management of inadvertent perioperative hypothermia in adults. Following inspection, the provider reported that a fluid warming machine was available, but staff did not use it on instruction of the surgeon. Further, they told us that patient temperature was monitored throughout each procedure and there had been no cases of intraoperative hypothermia. The provider informed us that they had reminded all staff of the correct procedure and they had also purchased a fluid warming cupboard.
- There was a two-bedded recovery area, staffed by one recovery nurse and an HCA. This was not in line with association of anaesthetics of Great Britain and Ireland (AAGBI) staffing for a post anaesthesia care unit (PACU), which states that a PACU should have one-to-one care. The provider told us that they had trialled having two recovery nurses present on days of theatre lists but found this to be unnecessary. This was due to the short

duration of operations undertaken and the staggering of theatre lists, meaning there was only ever one patient requiring immediate one-to-one care by a nurse. This was the case on the day of inspection, although some of the cases on the theatre list were cancelled, so we did not observe the recovery area at a time of normal operating capacity. On the day of inspection, the leaders were unable to provide assurance that they were always compliant with AAGBI guidance as they did not audit this. Following inspection, a snap shot audit of over five days in July was submitted to us, which showed that the flow of patient between theatre, recovery and ward meant that there was only one patient at a time in recovery and there was one-to-one care.

- After each operation, the patient was moved to the PACU or recovery area for at least 90 minutes, before being stepped down to a ward area (for up to four hours), before being discharged. The provider's discharge policy stated that patients must wait a period of at least 60 minutes post-procedure after minor operations and for at least three hours following TIVA. The policy stated that each patient must leave the premises with a chaperone, unless agreed beforehand, with the patient signing a disclaimer. We observed that on the day of inspection, one patient had to wait little longer in the day ward as they were waiting for a friend to pick them up. We were assured that patients were discharged with an escort in line with the clinic's policy. This was an improvement since the last inspection.
- Patients were able to contact staff at the clinic for support at any time. They were given a telephone number to call following their procedure, which was manned by a member of clinic staff 24 hours a day, seven days a week.
- Overnight stays were facilitated for those not fit or ready for discharge, those who elected to stay overnight, or for patients from further afield. The service confirmed that overnight stays were rare, with only 24 patients staying overnight between May 2018 and April 2019. Patients staying overnight were cared for by a nurse and resident medical officer (RMO). The RMO was trained in ALS.
- The clinic did not provide high dependency or intensive care. There were emergency crash alarms available in the recovery areas. In an emergency situation, the standard 999 system was used to transfer the patient to an NHS hospital. The clinic also had a contract with a neighbouring NHS trust to transfer patients for critical care facilities. The clinic had arrangements with two local private ambulance companies for less urgent transfers. In the year leading up to our inspection, there had been no such unplanned transfers to another hospital. A staff rota of the on-call system was in place for any unplanned returns to theatre.
- Pre-operative assessment included testing patient's blood values and haemoglobin levels, sent to an external laboratory. Operations were not performed if blood results were outside of normal range. The clinic had a service level agreement (SLA) with a private company for fast turnaround of blood sampling. At the time of inspection, no blood transfusion was available at the clinic. They told us that patients were assessed prior to surgery and no operations would be performed on those at high risk of blood loss. Senior staff informed us they were in talks with the same company who sampled blood to store universal blood for use in an emergency on site, but this could not be obtained until staff had received further training. No further evidence of this was provided. All patients had preoperative blood tests in line with National Institute for Health and Care Excellence (NICE) guidance.
- The provider told us that staff were encouraged to monitor signs of infection and sepsis during the procedure and before discharge, as well as monitoring for symptoms as part of the wound care process post-surgery.
- There was formal psychological assessment of patients in all the patient records we looked at. It is a requirement of the Royal College of Surgeons that the consultation identifies any patients who are psychologically vulnerable and they are appropriately referred for assessment. The provider informed us that all patients were screened pre-operatively and those with any existing mental health concerns were referred back to their GP for more information and support before any procedure was considered.
- There were appropriate building indemnity arrangements in place to cover all potential liabilities.

Nursing and support staffing

Managers regularly reviewed staffing levels and skill mix, and gave bank and agency staff a full induction. However, the provider was unable to provide assurance that they were always compliant with(Association for Perioperative Practice (AfPP) guidance as they did not audit this. All staff had out of date basic life support training.

- At the time of inspection, the clinic directly employed one full-time equivalent (FTE) registered manager and one FTE receptionist, who shared front of house and administrative duties. There were also two FTE non-clinical surgical advisors. The surgical advisors' role was to talk to patients about the company, costs and anything administrative, before they saw the operating surgeon.
- Clinically, they also employed one FTE theatre coordinator and one FTE healthcare assistant (HCA), who worked between the theatre and recovery area.
- As of 1 April 2019, the clinic reported they had one filled FTE post for inpatient nurses, achieving a 100% fill rate against the planned establishment of three FTE nurses. There were three filled inpatient HCA posts, against an establishment of three FTE posts. For theatre nurses, two FTE posts had been filled, against an establishment of 2.5, whereas 1.5 FTE establishment theatre operating department practitioner (ODP) posts had been filled, against an establishment of 1.5. There were four FTE hair technicians, against an establishment of four.
- Between May 2018 and April 2019, the clinic had an average vacancy rate of 33% for ODPs and HCAs, 50% for registered nurses and 20% for theatre nurses.
- The clinic reported that there were no unfilled shifts between May 2018 and April 2019. In the same period, the clinic had an average monthly usage rate of 15% for bank nursing staff, 20% for bank HCA staff and 25% for bank ODP staff. The average figures for agency staff usage were 25% for bank nurses and 30% for bank HCAs. No agency ODP staff were used. The clinic manager informed that they always used same agencies who would usually send the same staff to assist with continuity of care. No hair technician shifts were filled by bank or agency staff.
- The recovery nurse was immediate life support (ILS) trained and was supported by an ALS trained anaesthetist covering the theatre list for the day. All staff had received basic life support training; however, this was not in date at the time of inspection.
- In the case of an elective overnight stay, an agency nurse would be used. In the case of an emergency overnight stay, the nursing and operating department staff who had taken part in that day's theatre list remained on call to return to the theatre in case of emergency.
- We observed the nursing handover of patients between theatre and recovery and found it to be comprehensive and clear.
- All surgical days at the location were planned in advance to ensure that the registered nurse was on duty and available.

Medical staffing

The service had enough medical staff.

- Consultants who worked at the clinic were required to maintain current practicing privileges in line with the local practising privileges policy to be eligible to work on site. The granting of practising privileges is an established process whereby a medical practitioner is granted permission to work within an independent hospital. Medical staff with practising privileges had their appraisals and revalidation undertaken by their respective NHS trusts or an independent appraiser. There was a responsible officer who worked for the provider organisation who completed appraisals for those doctors without a substantive NHS post.
- At the time of our inspection, there were 17 consultants with practising privileges at the clinic. One anaesthetist and one surgeon would work the entire theatre list on any given day. These medical staff were clinically responsible for the patients under their care and were required to review their patients following the operation. We were told that all operating staff would remain at the clinic or at a nearby hotel until the patient had left the premises. In the event of an overnight stay, a regular resident medical officer (RMO) was used via an agency, working 9pm until 8am.
- The amount of follow-up consultations would depend on the procedure. Patients had access to their assigned patient coordinator before, during, and after their procedures. Surgical advisors at the clinic called the patient 48 hours after the procedure to check in with them and confirm the follow-up appointment dates. Staff were automatically prompted to make follow-up appointments on the electronic system.

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.

- The clinic used electronic and paper records for patient information. All paper records were scanned and stored electronically. All record containing patient information were stored in a locked filling cupboard, and electronic records were password protected.
- Information was shared with GPs if patients gave their consent. Patients received a discharge letter after surgery that they could share with their GP.
- We reviewed seven patient records and found them to be complete, comprehensive and legible. We found minor inconsistencies in discharge documentation. A monthly records audit was part of the service's audit programme. The audit of February, March and April 2019 highlighted minor issues, such as no copy of patient identification being added to the file, surgeon follow up notes not being included and patients not having signed to indicate they were given patient information.
- However, evidence of action taken to improve practice was limited.
- The records included the procedure carried out and details of any implants used. Staff recorded the serial number of the implant in the patient's records and patients signed a consent form relating to the implant registry.
- A theatre register was kept, with details of all surgical procedures carried out in the theatre. All entries were clear and legible.

Medicines

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

- There was a 'medicine management policy', dated November 2018. The policy clearly described obtaining, prescribing, recording, handling, storage and security, dispensing, safe administration and disposal of the medicines held at the clinic. However, we found that medicines were not managed according to the provider's own policy.
- There was a service level agreement (SLA) in place with a local pharmacy for the supply of medicines.
- The clinic had obtained a controlled drug (CD) license from the Home Office in October 2017. We were informed that the new clinic manager would apply to be the new control drug accountable officer (CDAO). CDs were stored in a locked cupboard and policy stated they should be checked daily by two nurses. We checked the CDs and found an expired CD in the CD cupboard. We checked the records and found that CD checks were done intermittently, which contradicted the provider's own policy. No checks had taken place on 5 June or 30 May, despite the clinic being open. This increased the risk around incorrect use or loss of CDs.
- We were concerned that large stock of CDs was kept in theatre CD cupboard. The company director was unclear as to why these large stocks were kept in the theatre. We found that the risk of over/under supply of stock and medicines was on the provider's risk register. Following inspection, the provider informed us that the large stocks were kept due to national shortage of CDs. However, we were not assured an appropriate risk assessment had been carried out to mitigate the risk of theft or misuse of these drugs.
- On the day of inspection, there was a delay in starting the first case on the theatre list as there was no propofol in stock. Propofol is a common drug used in procedural sedation. This further highlighted medication stock control issues at the clinic.
- Medication fridge temperatures were monitored daily. We checked the records and found that there was no record of any checks between 6 and 23 May and 1 and 9 June 2019. We spot checked the medicines stored within the fridge and found one tube of high viscosity dermabond in a tray with no expiry date or package and one prefilled syringe of rDNA vaccine wrapped in cling film. Following inspection, the provider informed us that the vaccine was left over from an occupational health visit; it was used as a hepatitis B booster for staff. They told us that the syringe had now been disposed of.
- We found that there was no pharmaceutical waste bin within the building to discard medicines or CDs. The new clinic manager was aware of the procedure regarding the safe disposal of control drugs and informed us that an appropriate bin would be ordered.
- There was an antibiotic prescribing policy in place which stated: 'One Health only provide antibiotics for true infections. NICE guidance CG 74 states that an antibiotic should be prescribed where surgical site infections are suspected, with consideration of local resistance patterns and the results of microbiological tests when choosing an antibiotic. However, we found that all patients were given a broad-spectrum antibiotic following surgery, which was not in line with local policy or national guidance. The clinic had not reviewed or audited this practice since their last inspection.

- Medicines were stored securely in locked cupboards and keys were held by the registered nurse on duty. We saw evidence that drugs were checked daily to ensure that they were in date. All the ambient non-controlled medicines we checked were in date.
- The clinic carried out a monthly medicines management audit. We saw evidence of a medicines management audit completed between January to April 2019, in which all checks were completed and no concerns were found. However, we were not assured that these audits were carried out effectively as none of the issues we highlighted on the day of inspection were identified by these.

Incidents

The service did not manage patient safety incidents well. Staff recognised incidents and near misses but did not always report them, or grade them appropriately. Managers usually investigated incidents but there was no robust system to share learning from incidents with staff. Managers ensured that actions from patient safety alerts were implemented and monitored.

- The clinic did not report any never events between May 2018 and April 2019. Never events are serious incidents that are entirely preventable as guidance or safety recommendations providing strong systemic protective barriers are available at a national level and should have been implemented by all healthcare providers.
- No serious incidents (SIs) were reported between May 2018 and April 2019.
- Between May 2018 and April 2019, the clinic reported 30 incidents. Out of these 30, 22 were clinical incidents and eight non-clinical incidents. Out of these 22 clinical incidents, five resulted in 'no harm' and five resulted in 'minor' harm, five resulted in 'moderate' harm and one resulted in 'major' harm. Level of harm was not recorded in the other seven incidents. Clinical incident themes included changes in implant size, returns to theatre, post-operative complications and surgery plans being changed at short notice. Following inspection, information submitted to us contradicted the level of harm recorded on the actual incident forms. The provider informed us that there were no incidents that had resulted in 'moderate' or 'major' harm. We were therefore not assured that staff reported incidents appropriately and if level of harm was correctly documented.
- The clinic had a policy in place to guide staff on how to report any incidents. We saw evidence that incidents were reported using paper forms, which were supplemented by an additional form that graded incidents by severity and likelihood of harm. The clinic manager informed us that issues the inspection team picked up on the day of inspection had been reported as incidents. However, only one incident regarding theatre temperature was logged as an incident. Although actions were taken to address other issues highlighted on the day of inspection, these were not actually logged on the incident forms.
- Staff we spoke with were aware of how they would report incidents. The clinic manager informed us that learning from incidents was shared with staff verbally, in meetings and via email. However, we reviewed minutes of September and November 2018 clinical governance meetings and saw that incidents were briefly discussed in the November meeting only. Staff told us that there hadn't been any governance or staff meeting for five months. Staff we spoke with said that they were not encouraged to report incidents. Staff were unable to tell us if there had been any learning or change in practice as a result of an incident. We were therefore not assured that there was an open reporting culture and that there was any shared learning from incidents.
- 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. This means providers must be open and honest with service users and other 'relevant persons' (people acting lawfully on behalf of service users) when things go wrong with care and treatment, giving them reasonable support, truthful information and a written apology. The provider told us there were no reported incidents which met this threshold. However, the provider supplied contradictory evidence around level of harm relating to incidents, so it was unclear if DoC was triggered in six incidents of 'moderate' and 'major' harm. We were therefore not assured that the provider was meeting this requirement.
- The clinic had systems in place for receiving, disseminating and acting on patient safety alerts from

the Medicines and Healthcare Regulatory Agency (MHRA). We saw evidence where alerts were forwarded to relevant staff for information or in order to take appropriate actions.

Safety Thermometer (or equivalent)

The service did not use monitoring results well to improve safety. Staff collected safety information, but this was not shared with staff, patients and visitors.

- The clinic, unlike NHS trusts, was not required to use the national safety thermometer to monitor areas such as venous thromboembolism (VTE). However, services are required to have equivalent systems in place. The clinic reported no incidences of VTE in the reporting period. As patients rarely stayed overnight, pressure ulcers were not likely to occur.

Are surgery services effective?

Requires improvement

We have not rated effective for this service before. We rated it this time as **requires improvement.**

Evidence-based care and treatment

The service did not consistently provide care and treatment based on national guidance and evidence-based practice. Some policies were not fit for purpose, and some practice was not in line with current best practice guidance.

- We saw minutes from quarterly clinical governance meetings which referenced review of policies briefly, but these were not discussed in any detail. Some referenced appropriate National Institute for Health and Care Excellence (NICE) and Royal College guidelines, but not all policies reviewed referenced current best practice guidance or were fit for purpose, including the safeguarding policy. We found the same at the time of the previous inspection, so were not satisfied that sufficient governance processes had been implemented. There were no specific NICE guidelines related to hair transplant available at the time of inspection.
- We were not satisfied that current best practice guidance was being followed in practice. For example, on the day of inspection, fluid was not being warmed before being given intraoperatively to patients, in line with NICE CG65: Hypothermia: prevention and management in adults having surgery.
- The clinic had not specifically audited their compliance with the Royal College of Surgeon's professional standards for cosmetic surgery. The clinic conducted some local audits relating to infection control, documentation, fasting and surgical site infection. However, evidence of actions taken as a result of these audits was limited. The provider submitted data to the Private Healthcare Information Network (PHIN).

Nutrition and hydration

Staff gave patients enough food and drink to meet their needs and improve their health. Although the service conducted a fasting audit, they did not provide evidence of any action plans or actions taken as a result of collating this information.

- Patients were screened to ensure they were not at risk of malnutrition. A tool based on the MUST (malnutrition universal screening tool) was used to identify the risk level of each patient and this was documented in each set of notes we reviewed.
- Records we checked on the day of inspection showed checks were made to ensure patients had adhered to fasting times before surgery went ahead. The service conducted a fasting audit to ensure that all patients followed The Association of Anaesthetists of Great Britain and Ireland (AAGBI) best practice guidance on fasting prior to surgery. This found that out of 67 patients between February and April 2019, one did not comply with these guidelines. In the 2018 audit, 76 out of 205 patients were not documented as compliant with best practice guidelines in relation to fasting. The service did not provide an action plan or evidence of any actions taken as a result of these findings.
- The clinic provided water, tea and coffee to all patients. They also had an arrangement with a local café, which allowed them to provide a range of meals to patients staying for a longer period to recover and overnight stays.
- Nausea and vomiting were managed, with patients prescribed anti-sickness medication if required. We saw that nurses regularly checked that patients did not feel sick, both in practice and in patient records.

Pain relief

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

- The numeric rating scale (NRS) was used in the clinic, with patients asked to score their pain from zero to 10 each time their vital signs were taken. In this scale, zero meant no pain and 10 was extreme pain. We observed staff asking patients about their pain and administering pain relief as necessary. The seven sets of medical notes we reviewed showed that patients had been given regular pain relief after their procedures.
- Due to the type of anaesthesia used, additional pain relief was required post-procedure. It was usual for patients to be discharged home with up to seven days of tramadol (a strong painkiller used to treat moderate to severe pain).
- The service told us that they conducted a pain audit but were unable to provide any evidence of this, or any actions taken as a result. We were told that patient feedback was sought specifically in relation to pain in the survey given to them, but could not see this evidenced in the data provided.

Patient outcomes

Staff did not always monitor the effectiveness of care and treatment. Since the last inspection, the provider had not sufficiently improved and widened audit activity undertaken to make improvements and achieve good outcomes for patients.

- In the reporting period May 2018 to April 2019, there were 2,190 episodes of care recorded at the clinic. Of these, 1104 were outpatient attendances and 1,086 were inpatient or day cases. In this time, there were 18 unplanned returns to theatre. These were due to issues such as post-operative haematomas, investigation of infection and suturing. Although the service collected this data, there was no evidence that they used it meaningfully to drive improvement.
- The clinic was supplying national data to the Private Healthcare Information Network (PHIN). At the time of the last inspection, the service told it was in the process of preparing to collect data in relation to Quality Patient Reported Outcome Measures (Q-PROMS), which involved restructuring some of the documentation in use, due to be completed by March 2018. At the time of this inspection, the provider could still not demonstrate this had taken place. We were not provided with any collated information or indication of how many patients had completed Q-PROMS, or any details of how this was being used to improve the service. The Royal College of Surgeons has requested providers of cosmetic surgery to submit Q-PROMs for cosmetic surgery procedures such as liposuction, rhinoplasty and breast augmentation. Q-PROMs are distinct from more general measures of satisfaction and experience, being procedure-specific, validated, and constructed to reduce bias effects. The data gathered from the use of Q-PROMs can be used in a variety of ways to empower patients, inform decision making and, where relevant, support quality improvement.
- Some patients came from other places in the country. Any issues after operations would be followed up locally at the provider's clinics in other parts of the country, with a review by a nurse between three and seven days following the procedure. These patients would be booked to
- come back to the London clinic 12 weeks post-procedure. Wound care appointments would be carried out by nursing staff as necessary.
- There had been no instances of sepsis in the 12 months prior to inspection. The provider did not conduct an audit specifically on sepsis management. Staff were encouraged to monitor signs of infection and sepsis during the procedure and before discharge, as well as monitoring for symptoms as part of the wound care process post-surgery. We saw evidence of in-house sepsis awareness training session provided to staff.

Competent staff

The service did not always have adequate measures in place to make sure staff were competent for their roles. Managers appraised most staff's work performance. However, we were not assured of the quality of these appraisals, and no clinical supervision meetings were taking place at the time of inspection. The provider did not follow their own policy on the review of practising privileges as there was no functioning medical advisory committee. They did not monitor every surgeon's scope of practice or performance adequately.

- We were told that all permanent staff had received an appraisal in the last 12 months, but evidence showed that only seven out of 11 staff had been appraised. Staff told us that appraisals did not have an appropriate focus on development needs, but instead tended to

discuss operational issues. We viewed some completed appraisals for 2019 where staff raised the need for continuing professional development and training, but the provider could not always demonstrate any significant actions had been taken as a result. There was no clinical supervision available for staff at the time of inspection, but the newly appointed registered manager informed us that she would organise a clinical supervision system for staff with a surgeon she worked with in the past acting as a clinical supervisor. This did not follow the provider's own training and development policy, which stated there would be 'regular supervisions at least bi-monthly' and a 'programme of in-house training events and discussions held regularly to which all staff must attend.' Following inspection, evidence was provided that indicated supervision sessions had taken place with staff at the end of June 2019.

- The clinic worked with consultants under a practising privileges arrangement. The granting of practising privileges is an established process whereby a medical practitioner is granted permission to work within an independent service. The provider's policy stated that practising privileges of all practitioners would be reviewed every year by the medical advisory committee. However, there remained no functioning medical advisory committee at the time of inspection, with practising privileges being reviewed by a senior member of staff. Although we found all practising privileges documentation we checked to be up to date, including GMC registration checks, evidence of appraisal and validation, this method of reviewing practising privileges did not follow the provider's own policy.
- The provider informed us that surgeons only worked within their scope of practice and operated completely within their area of known practice and ability, but there was limited evidence of this. Each surgeon kept a log book of their operations, which they used as part of their appraisal and revalidation process. At the time of the last inspection, we were told that each surgeon would be submitting data annually, beginning in March 2018, relating to total number of all operations they had carried out, complaints, revision rate, returns to theatre, surgical site infection rates and general compliance and performance. However, prior to inspection, the provider only provided this information from 2017. Following inspection, the provider collated performance data in relation to revision rate for the surgeon who performed the bulk of operations (82%) in 2018. There had been a total of 23 revisions, due to patient expectation, scar revision, pocket adjustment, implant replacement following haematomas and infections. No data had been collated in relation to the performance of other surgeons, and performance was not benchmarked in relation to the previous year or other similar providers. They informed us that this was the intention going forward but we were not assured as to how scope of practice or each surgeon's competence was monitored.
- National RCS guidance for patients states: "The surgeon must, as a minimum, be registered with the GMC and be fully insured to carry out the procedure in the UK. The Royal College of Surgeons (RCS) recommend choosing a surgeon who is on the GMC's specialist register in the area of practice relevant to this procedure." At the time of the last inspection, two of the three surgeons carrying out the bulk of the cosmetic surgery procedures did not have specialist registration. The service informed us that future recruitment of surgeons was planned around them having specialist registration. The list of 10 cosmetic surgeons provided at the time of this inspection showed that three were on the specialist register for plastic surgery, three were on the specialist register for general surgery, and the remaining four were not on the specialist register at all. Two of the three surgeons who performed the bulk of the clinic's cosmetic procedures in 2018 were therefore did not have specialist registration.
- All surgeons had current medical indemnity cover.
- We saw evidence of an induction programme which differed in length and content, dependent on clinical role. There was a competency checklist for qualified nurses, with relevant skills in areas such as medication management and intravenous therapy. We also saw separate checklists that needed to be signed off prior to independent practice for areas such as venepuncture and surgical asepsis.
- Hair transplant technicians could assist in procedures under the supervision of the doctor. The doctor carrying out the surgery would lead the procedure; however, the technician was able to insert the hair follicle once the doctor had made the incision. There were no nationally agreed competency requirements for hair technicians, but the provider demonstrated that they provided training to these individuals appropriate to their roles.

Multidisciplinary working

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

- Staff told us that they enjoyed working with their colleagues and were complimentary about the support they received from one another, on the whole, although they noted some issues with communication within the clinic. On inspection, we observed good working relationships between all grades of staff and all professional disciplines, but some problems with communication regarding theatre list revisions and WHO checklist completion between doctors and nursing staff. There were no structured multidisciplinary team (MDT) meetings as such. The provider told us that MDT meetings were part of the WHO checklist, with the MDT discussing the theatre list first thing before surgery commenced.
- The clinic asked every patient for their consent to share post-operative information with their GP. This was to ensure the GP was aware of the procedure and post-operative treatment recommended. We saw from records that GPs were also contacted prior to surgery if the medical history of the patient suggested this was required.

Seven-day services

Key services were available six days a week to support timely patient care.

- The clinic was usually open six days a week. We saw that theatre lists ran on weekends to offer more choice to patients. An on-call system operated for 24 hours after each operating list, which meant the same team would return in the case of emergency.
- Patients were able to contact staff at the clinic for support at any time. They were given a telephone number to call following their procedure, which was manned by a member of clinic staff 24 hours a day, seven days a week.

Health promotion

Staff gave patients advice regarding their procedure.

- On admission, patients were provided with materials they could read that would outline their procedure. On discharge, patients were provided with further information on how to look after themselves post-surgery.

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 to gain patients' consent.

- We saw evidence that patients came in for an initial consultation appointment, where they met with a surgical advisor and the surgeon who would perform their operation. At this appointment, all the risks and benefits of surgery were discussed, as well as all relevant patient history. The Royal College of Surgeons' professional standards for cosmetic surgery states that consent must be obtained in a two-stage process, with a cooling-off period of at least two weeks between the stages to allow the patient to reflect on their decision. All seven records that we reviewed had a clear gap of at least two weeks from consultation to the surgery procedure. However, we did note one logged incident where the cooling off period had not been observed. In this case, the surgeon was asked to write a report on the incident and the provider discussed this with the team. We saw limited evidence that this had taken place. The provider's policy stated that any operation could be postponed free of charge if the patient was unsure about any aspect of their procedure. The patient reconfirmed their intention to go ahead with surgery by completing the consent within their surgical pathway on the day of surgery. We reviewed seven records with completed consent forms for surgical procedures and the sharing of implant information.
- At the time of the last inspection, the provider told us that they were looking into providing consent and capacity training to surgical advisors. Although they did not actively take consent, the provider recognised that their role touched on this aspect of patient care. Following this inspection, the provider told us that they had only recently secured e-learning training in this area, due to our prompting.
- We saw evidence that systems were in place to obtain consent from patients before carrying out treatment. We observed staff gaining consent from patients before providing care such as routine observations. There was a policy in place for consent in relation to use of images for promotion and online.
- Results from monthly consent audits showed that all patients had correct documentation in relation to consent, but that not all consent forms had the same

surgeon sign both consent forms in April 2019. It was unclear whether this was a data collection issue, as this had not presented as an issue in any other preceding months. We asked for an action plan or evidence of actions taken as a result of this audit, but none were provided.

- The clinic did not routinely accept patients for admission that were deemed to lack capacity regarding treatment decisions. However, the provider demonstrated that all staff received mandatory training in the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS).

Are surgery services caring?

Good

We have not rated caring for this service before. We rated it this time as **good.**

Compassionate care

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

- We observed interactions between staff and three patients prior to, during and following a surgical procedure. Staff looked after patients in a kind and compassionate manner. Staff introduced themselves, explained their role and communicated in a clear manner. This ensured that patients understood what was happening and felt able to ask questions. The patient we spoke to on the day of inspection was positive about the care they had received.
- We observed that the privacy of patients was maintained throughout the duration of their procedure. Staff were mindful when speaking to or about patients. Staff made sure patients were covered by blankets or sheets when being transported and made sure doors were closed, especially during intimate examinations.
- Senior staff told us that feedback was often posted online, with this monitored by their digital marketing manager. Patients were also encouraged to give feedback via a patient satisfaction questionnaire. In 2018, the clinic received 214 survey responses from a possible 1106 patients, representing 19.3% of patients. Of these respondents, the majority said they would recommend the clinic as a place to be treated (212 patients). All agreed they were treated with dignity and respect whilst in hospital, and that their privacy was respected.

Emotional support

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

- Staff recognised that many patients were anxious about having surgery and they made sure patients always had enough time to ask questions. We observed positive interactions between patients and clinical staff and different members of staff supporting patients at different stages of their hospital stay. For example, we saw theatre staff reassuring patients and taking their time to explain procedures.
- We saw evidence in care records that mental health screening was part of the pre-operative assessment process, in order to identify psychologically vulnerable patients. The provider informed us that if further information was required at this stage, they would obtain this from the patient's GP. Any concerns indicating vulnerability would mean their procedure would be placed on hold while the service liaised with the patient, their relatives and other health practitioners where appropriate. The service did not provide any formal counselling services to patients at any time, but would refer any patients requiring enhanced support back to their GP. Staff were mindful of the different needs patients may have.
- In the 2018 local patient survey, 69% of patients felt they could always find someone to talk to about their fears whilst in hospital, with the remaining patients reporting they only sometimes felt like this. After leaving hospital, 210 of the 214 respondents felt like they knew who to contact for support and advice if worried after discharge.

Understanding and involvement of patients and those close to them

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

- The clinic offered patients as many consultations as necessary, either with the same surgeon, or an alternative, to ensure patients were happy with the procedure. Any additional consultations were offered free of charge.
- Patient records showed discussion of potential risks and complications of surgery, as well as the benefits and alternatives available. In the 2018 local patient survey, all patients reported feeling involved in their care.
- Patient information was available explaining what to expect on the day of the procedure, and then upon discharge, and who patients could contact if they had any concerns about their recovery.
- Patients were offered the opportunity to have a friend or relative present during consultations, unless safeguarding concerns were raised in relation to this. Patients were required to have a friend or family member to act as a chaperone to help the patient home after discharge.
- As the service provided only cosmetic surgery or hair transplant, all patients were private and self-funding. A discussion around costs took place at the patient's initial consultation and was documented in their records.

Are surgery services responsive?

Good

We have not rated responsive for this service before. We rated it this time as **good.**

Service delivery to meet the needs of the patient population

The service planned and provided care in a way that met the needs of their patient population.

- As the clinic provided private elective cosmetic surgery, admissions were planned in advance at times to suit the patients. The clinic was open six days a week, with approximately 22 theatre days per month at the time of our inspection. This had increased from approximately 10 theatre days a month at the time of our previous inspection.
- The hospital was in central London, with good public transportation links, making it accessible to patients from a wide geographical area.

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.

- The clinic had step-free access and was located on the ground level, enabling disabled access.
- The service offered interpretation services for patients where English was not their first language. When a patient booked in for a consultation, any enhanced needs would be flagged, and an interpreter would be arranged if required, at the cost of the service.
- Patients attending for a consultation were given a copy of information leaflets and procedure guides for the services they were interested in. The clinic informed us that they could provide patient information in any format, such as another language or braille. Information was also available on the company website.
- Following surgery, patients were provided with a contact telephone number for the service. If patients had any concerns following discharge from the hospital, they were encouraged to phone for advice and support.
- Any female patient who required a chaperone to be present could be provided with one or could ask a friend or relative to be present. Details of the chaperone would be recorded in the patient's notes. There was a chaperone policy dated September 2017, which stated this role would usually be performed by someone of the patient's choice, or a registered nurse. There was no record provided of specific training or competency requirements for this role.
- The clinic treated some bariatric patients for weight loss surgery but did not have any specialist trolleys or beds. Senior staff told us that approximately six to eight cases of this surgery had taken place thus far, on patients with a body mass index (BMI) of 38 or less, so no specialist trolleys or beds were required. Any cases where the patient's BMI was found to be higher would be referred elsewhere for surgery. However, we could not see this recorded in either the pre-admission criteria policy or surgery contraindications/preoperative considerations document provided to us, which stated patients should have a maximum BMI of 35 and 30, respectively. In the latter document, if a patient was found to have a BMI in excess of 30, the anaesthetist would have to assess the patient and approve the surgery, with information on the patient's health status being sought from their GP.

- The service did not routinely treat patients with complex needs, as it did not accept patients for admission that were deemed to lack capacity regarding treatment decisions, as it provided elective cosmetic surgery and hair transplant procedures.

Access and flow

People could access the service when they needed it and usually received care promptly. However, the clinic did not audit waiting times for consultation or surgery. Theatre lists were not always organised sufficiently in advance.

- Patients could contact the clinic via email or telephone. There was a team of patient-booking staff based centrally, who responded to any initial patient enquiries. Patients considering surgical procedures would have a face-to-face consultation with a surgical advisor and the relevant surgeon. Following this appointment, subsequent consultations could be offered or the surgery could be booked. The service did not audit patient waiting times for surgery. This was because all procedures were elective, and patients were able to choose their preferred dates.
- Patients for surgery arrived at the clinic before the start of the surgical list and a pre-operative assessment took place with the anaesthetist. A pre-operative checklist was completed and consent was obtained for the procedure, first by the theatre nurse, and then by the anaesthetist.
- Delays to the theatre list could occur, but staff told us that patients were always informed of any delays. The clinic did not monitor average waiting times for theatre, so it was not clear if patients would normally have to wait for longer periods in the waiting area before their procedures. Staff informed us that patients could sometimes be added to the theatre list at the last minute, and we witnessed this taking place on the day of inspection. We also noted that theatre lists often ran late into the day with procedures taking place into the evening.
- If patients had an issue following surgery, they were provided with a phone number to contact a clinician to discuss this. In an emergency, the patient was directed to an acute hospital accident and emergency department. For non-emergency issues, the patient would be reviewed by their surgeon. Any revisions to their surgical outcomes could be arranged as a planned episode of surgery.
- In the 12 months prior to inspection, the clinic reported no procedures had been cancelled for a non-clinical reason. However, on the day of inspection, procedures had to be cancelled due to the temperature in the main theatre being below an acceptable temperature.
- Nurses told us there were not usually delays in the discharge process due to most patients being self-caring and not requiring complex care arrangements. Patients were discharged home with post-operative care instructions, and pre-booked appointments were made for follow-up care either at the main clinic or at a location arranged by the surgeon.
- Patients had access to their assigned patient coordinator before, during, and after their procedures. Surgical advisors at the clinic called the patient 48 hours after the procedure to check in with them and confirm the follow-up appointment dates. Staff were automatically prompted to make follow-up appointments on the electronic system.
- For hair transplant procedures, patients met with an advisor for a face-to-face consultation and hair assessment, with images of the area for transplant taken. The doctor responsible for the procedure then reviewed the patient files and images prior to the day of procedure. The patient met with the doctor prior to the procedure to discuss any concerns.

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 and investigated them.

- A complaints leaflet was available which described the process should a patient want to raise a concern. There was information about how to contact the Independent Sector Complaints Adjudication Service (ISCAS) if patients were unhappy about the outcome of their complaint. At the time of inspection, the provider did not have an up to date copy of ISCAS membership, but we were told this could be provided. Evidence of an email correspondence with ISCAS was provided that demonstrated they were in the process of obtaining this.
- The hospital received 63 complaints between May 2018 and April 2019. The service aimed to acknowledge all

complaints within two working days and provide a full response within 20 working days, which they achieved. Where this timeframe was not possible, then a letter would be sent to the complainant to inform them of the revised schedule. Of these complaints, one had been referred to ISCAS and was partially upheld.

- The most common themes included theatre delays, poor communication and management of patient expectations. The provider told us that it audited complaints on a quarterly basis, but this was not completed in March 2019 according to documentation provided.
- The provider told us that they now called patients five days in advance of a procedure (instead of two) because of a complaint about not allowing enough time to arrange travel. In response to another complaint, communication was now sent standardly via email, so patients were not receiving all information verbally or via post unless requested.
- Complaints information and learning was shared with staff at clinic verbally and via email. The complaints tracker was available for all staff to view so they had visibility of both active and completed complaints. We were told that complaints were discussed at formal meetings, but not all senior staff had knowledge of these meetings. We saw minutes from some wider staff meetings where complaints were discussed.

Are surgery services well-led?

Requires improvement

We have not rated well-led for this service before. We rated it this time as **requires improvement.**

Leadership

Managers in the service did not have the right skills and abilities to run a service providing high-quality sustainable care. Staff did not always feel supported by their managers and there had been frequent changes at the level of registered manager.

- The company director was the nominated individual. The director was supported by head of finance, clinical consultant, marketing executive and a team of clinical and non-clinical staff. The director did not have a clear understanding of either the clinical or governance aspects of the clinic, and told us that the clinical service manager was responsible for the overall day-to-day running of the clinic. However, there had been instability at this level for the five months prior to our inspection, with two candidates being appointed and then dismissed. The provider had recruited a new manager into this post just two weeks prior to inspection, and believed them to be the right person for the role. The new clinic manager was in the process of submitting their application for registered manager for this location.
- Staff informed us that senior leaders who were currently in post were visible and approachable. However, due to instability of the clinic manager's position in past few months there had been limited support available for them. The clinical director left the clinic in February 2019 but returned on a consultancy basis in April 2019. All staff told us they felt assured that things would improve now that the new manager and the clinical director consultant were in place.
- Since joining, the new clinic manager had met with all staff. She informed us that she would be reinstating the monthly meetings with all staff.
- We found that there was no effective medical advisory committee and there was lack of medical leadership.

Vision and strategy

The service had a vision for what it wanted to achieve and a strategy to turn it into action.

- The provider was in the process of changing the company name to 'Curis Healthcare Limited'. The company vision was 'to create a long-term business, which is safe and effective and provides our patients and staff with the assurance of existence'. A strategy in place about how the clinic would achieve this. The service aimed to establish a positive and long-lasting relationship with their patients who would recommend the clinic to friends, family or colleagues.
- Staff across the clinic were broadly aware of the clinic's vision, with knowledge of developments such as the recruitment of more permanent staff. Detailed information on the vision and strategy were not included specifically in staff training or at their induction.

Culture

Requires improvement

Surgery

The provider did not promote a universally positive culture that supported and valued all staff.

- We received mixed feedback from staff in relation to culture. Some staff told us they enjoyed working at the clinic. They spoke positively regarding the management team and they felt able to raise any concerns. However, most staff said that they were not encouraged to raise concerns openly and if they did so, senior managers would not respond to those concerns in a timely fashion. For example, staff told us they had raised environmental issues regarding the temperature in the theatre, the blocked sink in the ward and the blocked patient toilet but no actions had been taken.
- Staff told us there were no opportunities for any additional external training and senior staff did not support them in their professional development. Staff told us that there were no career development opportunities. Following the inspection, the provider told us that some staff had progressed throughout the organisation and provided examples of this.
- Throughout our inspection, we saw evidence of responsible marketing that complied with the guidance contained within the Committee on Advertising Practice's (CAP). We did not see any evidence of irresponsible incentives or 'hard sell' tactics.
- We saw evidence in patient records to show the centre provided patients with a statement which included the terms and conditions of the service and outlined the fees relating to treatment.

Governance

Leaders did not ensure effective governance processes operated throughout the service. Staff at all levels were clear about their roles and accountabilities but did not have regular opportunities to meet, discuss and learn from the performance of the service.

- Although some changes had occurred since the last inspection, there remained a lack of senior oversight in regard to governance processes, with no established platforms for discussion or sharing learning amongst staff at the service. This meant we were not assured that there were adequate processes in place that ensured learning from incidents, complaints or audit findings in order to improve the service.
- The clinic had shown some improvement from the last inspection regarding governance and had introduced a system of various daily checklists and a risk management structure. However, we still found that the centre did not have a robust governance system which regularly reviewed clinical outcomes, incidents or complaints. In addition, although audits were undertaken, there were rarely action plans developed as a result, or any learning shared with staff.
- The staff we spoke with told us that there were staff meetings where aspects of governance such as incidents, risk and learning were discussed, but that these had not occurred since January 2019. Senior leaders told us that there had been staff meetings, however the previous manager did not keep formal records of those. The new clinic manager told us that she intended to restart monthly clinic meetings with all staff. We saw minutes of May 2019 staff meeting held by the new clinic manager.
- After the last inspection, the provider set up a medical advisory committee (MAC). We saw evidence that MAC meetings were held in July, April and October 2018. However, there hadn't been any MAC meetings since then. The nominated individual informed us that they had tried to get surgeons on board, but it was very difficult to get them to attend MAC meetings. Practising privileges were therefore not reviewed at the MAC, as per provider's own policy. We were not assured that there were sufficient governance arrangements in place to monitor any surgeons employed at the clinic.
- There were bi-monthly provider level governance meetings. We saw minutes of these meetings from September, November 2018 and January 2019. We found no governance meetings were held in March and May 2019 as the clinic director left in February 2019. This demonstrated a lack of senior oversight of incidents, complaints, policy changes and other related governance matters. We were informed that these meetings would be reinstated as the new clinic manager was in place.

Managing risks, issues and performance

Leaders did not use systems to manage performance effectively. They did not identify and escalate relevant risks and issues and did not identify actions to reduce their impact. However, they had plans to cope with unexpected events.

- Since the last inspection, the provider had developed an annual governance work programme and risk register. Each risk had a grading depending on the severity of the

risk. Each risk had a nominated lead responsible for review and a target date. However, we found the provider risk register was last reviewed in January 2019. We were not assured that senior staff were monitoring and reviewing risks regularly, as per their own policy.

- The provider had a policy for safeguarding patients from abuse, updated in June 2017. We found that the policy was not fit for purpose and did not reference all current national guidelines. We were not assured that staff knew how to protect patients from potential abuse, or report any concerns appropriately.
- Staff told us that there hadn't been any team meeting for some time (five months) as there had been no permanent manager in place. Staff felt unsupported. We were not clear how incidents, complaints and operational issues were shared with staff.
- Staff informed us that incident reporting was not encouraged. They told us that the provider was not responsive to concerns they raised. This contradicted the provider's own policy and we were not assured that incidents were reported or investigated, so that lessons could be learned and shared.
- The clinic conducted some local audits relating to infection control, documentation, fasting and surgical site infection. However, action plans from these audits were not provided when requested and we were not assured that these were used to improve the quality of the service provided.
- The provider submitted data to the Private Healthcare Information Network (PHIN). At the time of the last inspection, the service told it was in the process of preparing to collect data in relation to Quality Patient Reported Outcome Measures (Q-PROMS), which involved restructuring some of the documentation in use, due to be completed by March 2018. At the time of this inspection, the provider could still not demonstrate this had taken place. We were not provided with any collated information or indication of how many patients had completed Q-PROMS, or any details of how this was being used to improve the service.
- There was an emergency generator as part of the building facilities provided by the premises provider, with a back-up supply which allowed for 30 minutes use to ensure patient safety.
- All employed surgeons performing cosmetic surgery had professional indemnity insurance in place. We saw evidence of this in staff records.

Managing information

The clinic collected information to support its activities.

- There was Information Management, Caldicott Guidance and Data Protection Policy, which referenced appropriate national guidance.
- All initial patient contact was recorded on a computerised system. All notes from the day of treatment were recorded on paper patient notes, which were tailored to each specific treatment. Once treatment was completed these notes were scanned onto the patient record and the hard copy was stored in a locked filling cupboard.
- Patients received a discharge letter with clinical information after surgery. The letter could be shared with the GP if the patient wished to do this.
- All staff had received information governance training. However, this was out of date at the time of inspection.

Engagement

The clinic engaged with patients regarding improving the service. However, there was limited staff engagement.

- Patients and relatives were asked to complete a provider feedback questionnaire about their experience. Patients were also able to provide feedback via the clinic website and email. The clinic told us that they also engaged with the public through their social media channels. Patients were able to add comments to their website page.
- In 2018, the clinic received 214 survey responses from a possible 1106 patients, representing 19.3% of patients. Of these respondents, the majority said they would recommend the clinic as a place to be treated (212 patients).
- We did not receive any completed CQC comment cards from patients. These comment cards were sent to the clinic prior to this inspection and the aim was to receive direct feedback from service users.
- Staff told us that since last inspection, there had been improvement around team meetings but due to frequent changes in clinic manager position, there has been limited formal engagement from the provider for last five months.

Requires improvement

Surgery

- At the last inspection, the clinic was aiming to generate a monthly newsletter for staff, to provide them with company updates and any new policy or legislation information. We found that there was no newsletter produced for staff at the time of this inspection.
- There was no formal mechanism for staff feedback other than team meetings, and there was no staff survey. The provider informed us that a staff survey was conducted in March 2018 but did not have a high level of staff participation and the provider told us this added no value. The business plan for 2019 included some staff engagement, with a plan to move towards conducting staff surveys anonymously.
- At the time of inspection, seven staff had their appraisal with the previous manager and of the remaining four staff, three were booked for these to be conducted in July 2019 with the new clinic manager. However, feedback from staff was that they did not see any value in this appraisal process as not all staff had developmental objectives set.

Learning, continuous improvement and innovation

The centre lacked a robust approach to quality improvement.

- We found the centre lacked reasonable challenge from internal or external sources regarding quality improvement, governance, safety and effectiveness.
- The provider informed that in June 2019, they changed the post-operative garments they recommended to patients. They had implemented the use of adjustable cups and straps for comfort and reduction of post-operative complications such as seroma and haematoma.
- The provider also introduced an implant delivery system for inserting breast implants into the surgical pockets. This was a clear funnel shaped tool that allowed for easier insertion of the breast implants into the chest cavity without over-handling of the prosthesis, reducing the risk of bacterial contamination.

Outstanding practice and areas for improvement

Areas for improvement

Action the provider MUST take to improve

- The provider must ensure that there are effective systems in place to control infection risk well.
- The provider must ensure that there are effective systems to safely record and store medicines, including control drugs and emergency medicines on resuscitation trolley.
- The provider must have effective systems in place for maintenance of facilities, premises and equipment to keep people safe.
- The provider must have systems in place to monitor staff compliance with mandatory training.
- The provider must ensure they are auditing their compliance with AAGBI and AfPP guidance for nursing and theatre staffing.
- The provider must ensure that leaders have effective governance systems in place.
- The provider must ensure that practicing privileges are reviewed as per their policy.
- The provider must review the safeguarding policy to reflect the requirements of the Care Act 2014 (Chapter 14) statutory guidance.
- The provider must ensure that there are regular and effective staff meetings or forums to support staff
- The provider must ensure that there is an open reporting culture in relation to incidents and shared learning from complaints and incidents.
- The provider must ensure that it is meeting requirements under the duty of candour regulation.

Action the provider SHOULD take to improve

- The provider should embed a culture of using the WHO checklist in a meaningful way for all surgical procedures, including hair transplant procedures.
- The provider should have effective systems for disposal of medicines.
- The provider should have a process to review all policies and procedures, so they remain in line with evidence-based practice and national guidance.
- The provider should consider that local audits are conducted meaningfully, with results shared with staff and actions taken because of their findings.
- The provider should appraise all staff regularly, with appropriate focus on continuing professional development for staff.
- The provider should follow national guidelines to make sure patients fasting before surgery are not without food for long periods.
- The provider should follow their local policy on the reviewing of the practising privileges and scope of practice of medical staff.
- The provider should consider requiring future surgeons recruited to the clinic to have specialist registration.
- The provider should amend the admission policy to reflect what senior staff reported on the day of inspection regarding body mass index (BMI) limits for patients treated at the clinic.
- The provider should consider auditing waiting times for consultation and surgery.
- The provider should consider how to ensure that theatre lists are organised sufficiently in advance.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

The table below shows the legal requirements that were not being met. The provider must send CQC a report that says what action they are going to take to meet these requirements.

Regulated activity	Regulation
Surgical procedures Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing **(1) Sufficient numbers of suitably qualified, competent, skilled and experienced persons must be deployed in order to meet the requirements of this Part.**

Regulated activity	Regulation
Surgical procedures Treatment of disease, disorder or injury	Regulation 15 HSCA (RA) Regulations 2014 Premises and equipment **(1) All premises and equipment used by the service provider must be;** **(a)Clean,** **(e)Properly maintained** **Regulation (1) (a),(e)**

This section is primarily information for the provider

Enforcement actions

Action we have told the provider to take

The table below shows the legal requirements that were not being met. The provider must send CQC a report that says what action they are going to take to meet these requirements.

Regulated activity	Regulation
Surgical procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment Regulation 12, Safe care and treatment, of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. 12.(1) Care and treatment must be provided in a safe way for service users. (2) Without limiting paragraph (1), the things which a registered person must do to comply with that paragraph include— (a) assessing the risks to the health and safety of service users of receiving the care or treatment; (b) doing all that is reasonably practicable to mitigate any such risks; (e) ensuring that the equipment used by the service provider for providing care or treatment to a service user is safe for such use and is used in a safe way; (f) the proper and safe management of medicines; (h) assessing the risk of and preventing, detecting and controlling the spread of, infections, including those that are health care associated Regulation 12, (1)(2)(a)(b)(e)(f)(h)

Regulated activity	Regulation
Surgical procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance Regulation 17, (1)(b), Good governance, of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

This section is primarily information for the provider

Enforcement actions

(1) Systems and processes must be established and operated effectively to ensure compliance with the requirements in this part.

(b)assess, monitor and mitigate the risks relating to the health, safety and welfare of service users and others who may be at risk which arise from the carrying on of the regulated activity.

Regulation 17, (1)(b)