Cranley Clinic Limited

Cranley Clinic

Inspection report

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

Ratings

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

Summary of findings

Overall summary

We have not previously rated this service. We rated it as inadequate because:

- The service could not provide evidence staff had sufficient training in key skills, including safeguarding. There was limited evidence the service controlled infection risks and record keeping was insufficient. There was poor management of medicines. There was no audit trail of incidents, lessons learned, or acted on national safety alerts.
- The service did not monitor the effectiveness of care and did not have a system to provide assurance of staff competence. There was no monitoring system for pain relief and evidence of multidisciplinary working was very limited.
- Service planning was sporadic and there were no formal adaptations to facilitate access for patients with reduced mobility, cognitive needs, or language needs.
- The overarching governance system was not fit for purpose. Policies were wholly inappropriate for the care provided and the senior team did not have a grasp of the risks and performance issues in the clinic.
- There was no vision or strategy and staff were unable to clearly describe their roles, responsibilities, and accountabilities.

However:

- Staff treated patients with compassion and kindness, respected their privacy and dignity, took account of their individual needs, and helped them understand their conditions.
- People could access the service when they needed it and did not have to wait too long for treatment.

Following the inspection, we took immediate action to suspend all regulatory activity at the provider for three months. In addition, we placed the provider in Special Measures.

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

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Surgery	Inadequate	We have not previously rated this service. We rated it as inadequate because: • The service could not provide evidence staff had sufficient training in key skills, including safeguarding. • There was limited evidence the service controlled infection risks and record keeping was insufficient. There was no audit trail of incidents, lessons learned, or acted on national safety alerts. • The service did not monitor the effectiveness of care and did not have a system to provide assurance of staff competence. There was no monitoring system for pain relief and evidence of multidisciplinary working was very limited. • Service planning was sporadic and there were no formal adaptations to facilitate access for patients with reduced mobility, cognitive needs, or language needs. • The overarching governance system was not fit for purpose. Policies were wholly inappropriate for the care provided and the senior team did not have a grasp of the risks and performance issues in the clinic. • There was no vision or strategy and staff were unable to clearly describe their roles, responsibilities, and accountabilities. However: • Staff treated patients with compassion and kindness, respected their privacy and dignity, took account of their individual needs, and helped them understand their conditions. • People could access the service when they needed it and did not have to wait too long for treatment.
Services for children & young people	Inadequate	This was our first inspection of the service. We rated it as inadequate because:

Summary of findings

- The service did not have enough staff to care for children and young people and keep them safe. Staff did not have training in key skills such as paediatric life support.
- Managers did not monitor the effectiveness of the service for children and did not make sure staff were competent.
- The service did not consider the individual needs of children and young people.
- The service did not have formal written criteria by which they assessed and accepted children and young people into the service.
- The service did not have formal processes and policies in place to reflect caring for children and young people that referenced national guidance.

However:

- Staff understood how to protect children and young people from abuse.
- Staff assessed risks to children and young people, acted on them and kept good care records.

Services for children and young people is a small proportion of hospital activity. The main regulated service was surgery. Where arrangements were the same, we have reported findings in the surgery section.

Outpatients

Inadequate

We have not previously inspected this service.
This was our first inspection of the service. We rated it as inadequate because:

- The service was unable to evidence staff with appropriate training and qualifications delivered care.
- Managers did not monitor the effectiveness of the service and did not monitor practices were in line national guidance.
- The service did not have appropriate standard operating procedures or policies to ensure care was accessible.
- The service did not have functioning governance and risk management systems in place.

Outpatients is a small proportion of clinic activity. The main regulated service was surgery. Where arrangements were the same, we have reported findings in the surgery section.

Summary of findings

Contents

Summary of this inspection

Background to Cranley Clinic

Cranley Clinic is operated by Cranley Clinic Limited and offers cosmetic surgery, children and young people services, dental services, and dermatology outpatients.

Services are provided over four floors of a converted residential building. Cosmetic surgery procedures take place in a surgical suite. There is a pre-operative consultation room and one dental treatment room. Outpatients services are delivered from consultation rooms.

There is one waiting room for all patients.

Clinical services delivered by other providers take place on site. These do not form part of our inspection or ratings other than consideration of local premises safety procedures.

The provider registered this location in 2018 and we have not previously carried out an inspection.

The service has a registered manager and is registered to provide the following registered activities:

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

The main regulated service provided by this provider was cosmetic surgery. Where our findings on another core service – for example, management arrangements – also apply to other services, we do not repeat the information but cross-refer to the surgery service. We do not regulate or inspect aesthetic treatments.

We rated this service as inadequate because it was not safe, effective, responsive, or well led. We inspected but did not rate caring.

How we carried out this inspection

We carried out an announced inspection of the service on 21 March 2022 and 22 March 2022 using our comprehensive methodology. We inspected surgery which included dentistry, children and young people and outpatients.

The inspection team consisted of four inspectors and two specialist advisors with support from an inspection manager.

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

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

Summary of this inspection

Areas for improvement

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

Action the service MUST take to improve:

- The service must ensure that hazardous waste is managed in accordance with national best practice guidance. (Regulation 12)
- The service must implement and maintain standards of practice to meet the Control of Substances Hazardous to Health (COSHH) Regulation. (Regulation 12)
- The service must ensure sharps waste is managed in accordance with national standards. (Regulation 12).
- The service must ensure infection prevention and control measures are fit for purpose and contribute materially to a safe environment for patients and staff. They must meet the requirements of the National Standards of Healthcare Cleanliness 2021. (Regulation 12).
- The service must ensure clinical areas are sanitised between patients and maintain evidence of this. (Regulation 12).
- The service must ensure it is compliant with NHS England Health Technical Memorandum 01-05 in relation to decontaminating reusable instruments in dental care. (Regulation 12).
- The service must ensure equipment in clinical areas is well maintained, free from corrosion and damage, and safe for use. (Regulation 12).
- The service must ensure emergency resuscitation equipment is immediately accessible by all staff in the building. (Regulation 12).
- The service must implement a quality assurance programme that includes maintenance and servicing for X-ray equipment. (Regulation 12).
- The service must ensure surgeons fully and consistently use the World Health Organisation surgical safety checklist, or an appropriate alternative. (Regulation 12).
- The service must ensure surgeons always follow the standard national cooling off period for surgical treatment. (Regulation 12).
- The service must ensure a named responsible person has oversight of Controlled Drugs brought on site, including their management and disposal. (Regulation 12).
- The service must ensure post-sedation care meets the standards of the Safe Sedation Practice for Healthcare Procedures Standards and Guidance October 2013. (Regulation 12).
- The service must have an effective arrangement to receive and respond to relevant external safety alerts, recalls, inquiries, investigations or reviews. (Regulation 12).
- The service must ensure full compliance with the Ionising Radiations Regulations 2017 (IRR17) in relation to dental treatment. (Regulation 12).
- The service must ensure medicines management processes are fit for purpose and reflect national standards. (Regulation 12, Regulation 17).
- The service must implement improved safety measures for the care of children and young people unless it maintains a policy of declining care for those under 18 years old. (Regulation 12; Regulation 13).
- The service must ensure safeguarding policies, including for chaperones, reflect best practice and that staff are fully versed in them. (Regulation 13).
- The service must ensure that children and young people are protected from harm. (Regulation 13).
- The service must ensure compliance with the Regulatory Reform (Fire Safety) Order 2005 in that premises must be safe with appropriate fire risk prevention measures in place. (Regulation 15).

Summary of this inspection

- The service must ensure services are accessible by patients with additional needs, such as physical access support or language interpretation. (Regulation 15).
- The service must ensure premises are regularly cleaned. This includes all areas of visitor access, including the toilet and lift. (Regulation 15).
- The service should ensure they follow government guidance from the Health and Safety Executive to make practicable modifications to reduce the risk of falls by making simple changes to the design. The design of stairs should be free from trip hazards, such as uneven steps. (Regulation 15).
- The service must ensure that consultant surgeons inviting external first assistants or other staff into theatres be granted either appropriate practicing privileges or other checks as required by schedule 3 of the HSCA 2008 (Regulated Activity) Regulations 2014. (Regulation 17).
- The service must implement effective audit, governance, and risk management systems. These must incorporate effective clinical management, effective management of incidents, and effective management of complaints. (Regulation 17).

Action the service SHOULD take to improve:

- The service should continue to progress with plans to install an airflow system in the surgical suite.
- The service should implement a systematic programme of clinical and internal audit to monitor quality, operational and financial processes, and systems to identify where action should be taken.
- The service should implement processes for clinical governance for reviewing surgical procedures.

Our findings

Overview of ratings

Our ratings for this location are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Surgery	Inadequate	Inadequate	Insufficient evidence to rate	Inadequate	Inadequate	Inadequate
Services for children & young people	Inadequate	Inadequate	Insufficient evidence to rate	Inadequate	Inadequate	Inadequate
Outpatients	Inadequate	Insufficient evidence to rate	Insufficient evidence to rate	Inadequate	Inadequate	Inadequate
Overall	Inadequate	Inadequate	Insufficient evidence to rate	Inadequate	Inadequate	Inadequate

Inadequate

Surgery

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

Are Surgery safe?

Inadequate

We have not previously inspected this service. We rated safe as inadequate.

Mandatory training

The service could not evidence they provided mandatory training in key skills to all staff.

There had limited evidence staff received and kept up-to-date with mandatory training as records were inconsistent. For example, staff told us they were up to date with training but in one record there was a seven-year gap in infection control training. The provider was unable to provide a training tracker or log during our inspection.

After our inspection the registered manager provided a list of mandatory training, which comprised cardiopulmonary resuscitation (CPR), fire safety, health and safety, and infection prevention and control (IPC). All staff were up to date in the mandatory training areas. However, staff included on the log did not delivery regulated activities. Most regulated activity was delivered by consultants working under practising privileges who brought their own nurse or healthcare assistant with them. The provider did not keep a record of the training status of these individuals or of the one contracted surgeon.

The mandatory training did not meet the needs of patients and staff. There was no reference to safeguarding or clinical competencies in the provider's training log.

Clinical staff did not complete training on recognising and responding to patients with mental health needs, learning disabilities, autism and dementia. The service was unable to demonstrate how they would ensure safe care for these patient groups.

The registered manager told us they monitored mandatory training but there was no evidence this took place on a routine basis.

Safeguarding

Staff understood how to protect patients from abuse. The provider could not evidence they provided training to all staff.

Staff did not receive training specific for their role on how to recognise and report abuse. While they could give examples of how to protect patients from harassment and discrimination, staff did not understand the level to which they held safeguarding training and the provider's records were out of date.

Staff could tell us how to identify adults and children at risk of, or suffering, significant harm but there was no policy to support them. The safeguarding policy referred to another London borough, which meant contact and escalation details were inaccurate. There was no documentation of safeguarding discussions, meetings, or referrals.

The service did not keep a record of the patients and clinical staff at any one time. This meant the senior team had no record of people in the building considered to be vulnerable or at risk.

The quality of care and treatment policy detailed the requirement that a nurse be present for all intimate examinations. The policy stated patients could also ask for a relative or friend to be present at the time of the procedure. This was not an appropriate policy because the service allowed surgeons to bring their own nurses, of which there was no audit trail or standardised competence checks. Enabling a relative or friend to be present during a surgical process was a safeguarding risk and the provider had no mitigating actions in place for this.

Policies did not reflect good standards of safeguarding practice. The quality of care and treatment policy noted patients may be accompanied by a third party for language needs or "personal difficulties" and that this person would need to co-sign the consent form and document the nature of their relationship with the patient. There was no standard of inclusion or exclusion to demonstrate how staff would decide if a chaperone was appropriate.

Cleanliness, infection control and hygiene

The service did not control infection risk well. The service had no systems to identify and prevent surgical site infections. Staff could not evidence the use of equipment and control measures to protect patients, themselves and others from infection. Premises and equipment were visibly dirty and damaged in areas.

Clinical areas were dirty and had furnishings and equipment that were tarnished and poorly maintained. The surgical suite had two metal trolleys used to lay out surgical instruments ahead of a procedure. Both trollies were tarnished, stained, and had areas of rust. It was not possible to tell if the trollies were clean or sterile. Staff did not keep cleaning documentation and it was not possible to confirm when the trollies had last been cleaned or if staff had used suitable cleaning products. The metal swab bucket in the surgical suite was rusty and stained and contained debris.

The service could not demonstrate performance for cleanliness. The last documented IPC audit was dated March 2019. After our inspection, the provider sent us evidence of an IPC audit dated 1 March 2022. There were no cleaning schedules posted in clinical or public areas of the building. The registered manager said the cleaning contractor introduced cleaning checklists in January 2022. However, the service did not keep a record of this on site and the manager told us the cleaner kept their own records. This meant the service could not be assured clinical areas were cleaned and sanitised consistently. After our inspection the service sent us the cleaning checklists dating from January 2022 to March 2022. The checklists were not fit for purpose. They listed generic areas for cleaning such as "surfaces cleaned" and "bench tops". The documents did not identify which rooms had been cleaned and made no reference to clinical equipment or areas.

Staff did not use records to identify how well the service prevented infections. The service did not keep a centralised record of surgical site infections.

Inadequate

Surgery

Staff did not consistently follow best practice infection control principles including the use of personal protective equipment (PPE). During one observation in the surgical suite, a chaperone did not adhere to PPE best practice. They wore long sleeves and a wristwatch, neither of which was acceptable practice for a clinical environment.

Policies did not reflect the environment or practice. The general surgery policy noted sinks in the surgical suite were for handwashing procedures only. However, the surgical suite included only one sink, which surgeons used for pre-operative scrub procedures.

There was no assurance staff cleaned equipment after patient contact and labelled equipment to show when it was last cleaned. Staff did not use a marking or labelling system to identify when they had cleaned and disinfected equipment. The service did not have cleaning audits, cleaning inspections or documented evidence of the frequency and depth of cleaning. This meant there was no assurance of standards of infection prevention and control (IPC).

To get from the pre-operative changing room to the surgical suite, patients had to walk down a flight of stairs or use the lift. The lift was operated using a manual cage/gate system. The gate was coated in thick dirt, grime and dust. The carpeted stairs were visibly dirty and in a poor state of repair. Both routes presented an IPC risk to patients.

Environment and equipment

The design, maintenance and use of facilities, premises and equipment did not promote safety in surgical areas. Standards in the dental suite were in line with guidance for non X-ray equipment. Staff did not manage clinical waste well.

The design of the environment did not follow national guidance. There were numerous trip hazards in hallways and on staircases where the carpet was loose, and the floor was uneven. The stairs leading from the ground floor pre-operative room to the surgical suite were worn and frayed.

The surgical suite did not have an air handling unit to filter or exchange air during procedures. Air exchanges help to reduce the risk of airborne infections for patients undergoing invasive treatment and are required under NHS England Health Technical Memorandum (HTM) 03-01 'Specialised ventilation in healthcare premises.' The registered manager told us a new air system was due to be installed in late May 2022 but could not provide detailed information on the specifications.

Staff did not carry out daily safety checks of specialist equipment. There were no documented checks of equipment calibration or safety checks. After our inspection, the provider sent us evidence of electrical safety checks that had taken place in the previous six months.

The service did not have a stock control or rotation system for consumables. There were two expired products in the surgical suite's clinical storage area. These had expired in October 2021 and were stored with in-date products and were intended for use. We previously told the provider to improve its stock rotation system after we found a wide range of expired products in use during an engagement visit in January 2022. While the service had removed the specific expired products we found, this had not included a full stock check or implementation of a new system.

Staff did not manage or dispose of clinical waste safely and was not compliant with the NHS England HTM 07/01 (2013) in relation to the safe management and disposal of healthcare waste. Staff did not empty hazardous waste between surgical procedures, and we found bins contained clinical waste on days when no procedures had taken place.

Inadequate

Surgery

The main hazardous waste bin was lockable and could be secured to prevent unauthorised access. However, the key was tied to the bin, which meant there was no controlled access.

The service was not fully compliant with HTM 07/01 and the Health and Safety Executive Health and Safety (Sharps Instruments in Healthcare) Regulations 2013 in relation to sharps waste. For example, staff did not routinely close the lid aperture of the sharps bin in the surgical operating suite.

The service did not have protocols or policies to help staff adhere to the Control of Substances Hazardous to Health (COSHH) Regulations and practice did not keep people safe. There was no dedicated storage or chemicals subject to COSHH. On both days of our inspection we found staff stored a hazardous chemical on the floor next to the hazardous waste bin in a fire escape route.

There was no tracing system in place for surgical instruments, theatre trays, or consumables. This meant the service could not trace specific items of equipment to individual procedures, which is a national safety standard.

The building was multi-purpose and was shared by another clinical service provider and private residents. There was no coordinated fire and evacuation policy. In the event of a fire alarm there was no named fire warden in place and no system that would guide a coordinated evacuation. Staff told us the registered manager was the fire warden but there was no alternative if they were off site.

The service did not complete a fire test log or fire safety audits. The last fire safety inspection took place in 2017 and found significant safety risks. The service had not acted on any of the risks. On the first floor of the building, staff used a rubber wedge to force an automatic fire door to stay open. This meant the door would not close in the event of a fire. The fire service had noted this in their 2017 report although staff had not acted. Two fire extinguishers had labels indicating their annual service was over two years late. After our inspection the service provided evidence the fire extinguishers had been serviced.

The registered manager carried out an annual evacuation drill. The most recent took place in December 2021. While the manager documented drills, they did not include information on evacuation times or whether all staff were included, such as those visiting temporarily to carry out clinical treatment.

The practice did not have arrangements to ensure the safety of the X-ray equipment. The required radiation protection information was unavailable. There was no radiation protection file. A Radiation Protection Advisor (RPA) had not been appointed. The X-ray equipment had not been serviced and maintained according to manufacturer's requirements. Local rules for use of X-rays were not in place. The provider had not completed the required registration with the Health and Safety Executive (HSE). After our inspection the registered manager provided evidence that an RPA had been appointed.

The service ensured equipment for the sterilisation of dental instruments was safe to use and maintained and serviced according to manufacturers' instructions. The practice ensured the facilities were maintained in accordance with regulations.

Assessing and responding to patient risk

Staff did not complete risk assessments for each patient to remove or minimise risks. There was no system in place to manage patients at risk of deterioration. The system for patients to contact a clinician to discuss complications or concerns was not fit for purpose.

Inadequate

Surgery

Staff did not use a nationally recognised tool to identify deteriorating patients. There was no standard operating procedure or service level agreement for the care of patients whose needs exceeded the abilities of the surgical team and clinic.

Staff did not use risk assessments for specific issues. Surgeons did not complete risk assessments for venous thromboembolism (VTE) in advance of surgical procedures, which was not in line with NICE guidance. In addition, in the records we checked there was no evidence of a pre-operative safety checklist. Staff did not consistently use the World Health Organisation (WHO) surgical safety checklist or a suitable alternative. We looked at two records, one of which had a completed checklist and the other did not. The service did not audit compliance with the WHO standards and could not provide evidence this was a requirement for surgeons acting under practicing privileges.

After our inspection the provider sent us three completed patient surgery checklists from the previous six months. The records were inconsistently completed. The surgeon had not documented consent and it was not clear when the checklists had been completed as they contained dates for different areas of care, such as a prescription issued four months before a procedure. The surgery checklist template included a space for medical history, which the surgeon had completed in two out of three cases, but there was no information relating to risk management.

An automatic external defibrillator (AED) and an emergency grab bag were located in the cupboard of a locked clinical room on the first floor. This was the only emergency equipment in the building for this service and was signposted only on the entrance to the clinical room. Staff used the room for laser aesthetic treatments and kept the door locked when not in use. There was no immediate way for staff to gain access to the equipment.

Surgeons took the AED into the surgical suite when carrying out a procedure. However, staff did not use a tracking system to monitor the location of the equipment, which meant there was no way to locate it quickly. The registered manager told us they had ordered a second AED and second emergency grab bag.

The crash bag included airway equipment and rescue medicine. Staff had introduced a weekly safety check of stock. This was up to date, but we were not assured of the accuracy of the process. This was because the bag contained a pack of Aspirin marked as containing 28 tablets. Staff had confirmed the contents on a safety checklist but 50% of the labelled contents were missing.

The surgical suite was not temperature controlled and there was no air conditioning, heating equipment or a thermometer.

The service had no access to mental health liaison or specialist support services. If a surgeon believed a patient needed a psychological assessment, they recommended the patient seek this themselves and did provide a formal referral.

The service did not have suitable post-operative care policies. In one patient record staff had noted, “No-one to accompany patient – will stay at clinic.” In this case a non-clinical member of staff had accompanied the patient to a hotel on the instruction of the surgeon and remained with them for one hour. This meant staff undertook procedures that would normally require a chaperone for 24 hours afterwards without adequate post-operative monitoring.

Staffing

The service could not evidence it had enough staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment. Care was pre-planned and staffing levels and skill mix arranged in advance.

Inadequate

Surgery

One surgeon worked for the service under a contract. They held valid General Medical Council (GMC) registration with a licence to practice and were entered on the specialist register.

Other surgeons, consultants, and nurses worked under practising privilege arrangements. The provider did not have a clear record of the doctors who worked on site. The service did not keep a coherent record of the doctors, surgeons, and nurses working under practising privileges. The registered manager told us one anaesthetist carried out all sedation for surgical procedures. This did not match the information provided on the service's website and the anaesthetist noted on clinical records was not named in any clinical documentation.

One registered nurse worked in the service. They held valid Nursing and Midwifery Council (NMC) registration.

Documented evidence of Disclosure Barring Service (DBS) checks were inconsistent. The most recent DBS for one surgeon was dated November 2018, over three years before our inspection. We spoke with the registered manager who told us the policy was to reapply for a new DBS every three years. After our inspection they told us they had applied for updates for each clinician associated with the service.

Two cosmetic dermatologist consultants carried out surgical pre-assessments. We were unable to confirm if they help appropriate specialist training.

Consultants and surgeons worked under a practising privileges arrangement. The practising privileges policy noted each individual underwent a review every two years and that they only carried out procedures declared on their practising privileges declaration. However, none of the doctors practising on site had this information completed and the service was unable to demonstrate a record of who was currently authorised to deliver care and treatment on site.

The dental team was fully staffed. There were plans in place to expand the team with an additional dentist due to start soon.

Records

Staff kept inconsistent records of patients' care and treatment. Records were not always clear, up-to-date, or stored securely. Staff did not record all cosmetic implants on the Breast and Cosmetic Implant Registry (BCIR).

Patient notes were inconsistent in completion and contents and varied between surgeons. In one instance a patient underwent a six-hour procedure. However, there was no record of a documented medical history and the surgeon had undertaken procedures that differed from the signed consent form. There was no documentary evidence the surgeon had discussed this with the patient.

Staff did not consistently, and fully complete treatment checklists and information documented did not always match the procedures that took place.

Staff did not consistently log or document post-surgical outcome letters, referrals, summaries, or follow-up treatments. In one patient record staff had documented a return to the clinic for an ultrasound of a complication but had not documented consent or details of care delivered.

Records management was noted on the risk register as a key risk. The service was in the process of digitising paper records to improve security and storage and had experienced challenges with the contracted service. The registered manager told us they had resolved the issues, but the risk register did not reflect this, and we could not establish an accurate level of risk.

Inadequate

Surgery

The service did not use the BCIR, a national tool to help trace patients who have received implants that later have a safety risk or recall.

Dental care records we saw were complete, legible, were kept securely and complied with General Data Protection Regulation requirements.

Medicines

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

Staff did not store and manage medicines safely. Staff used a locked medicines cupboard to store medicines securely. However, documentation was inaccurate and incomplete. Staff had dated the first day of use of the medicine logbook as 17 March 2022 but the first documented use of medicine in the book was dated 16 days prior to this. In another entry staff had documented a clinical procedure in the medicines book.

There was no stock control system in place for medicines. The medicines cupboard contained paracetamol that expired in November 2021. Surgeons carried their own medicines for procedures and the service did not have oversight of these.

The provider maintained a policy that no Controlled Drugs (CDs) were kept on site. However, the anaesthetist, who worked in the service under practising privileges, carried their own CDs. The provider did not have assurance that the CDs were fit for use and safely managed on site. There was no policy to guide the disposal of CDs on site.

Surgical safety documentation was not fit for purpose in relation to the safe use of medicines. Documentation did not include patient allergies or a clear description of medical history and the patient's current medicines. This meant we were not assured doctors had considered possible interactions with medicines used during surgery, and for medicines reconciliation should the patient require inpatient treatment after their procedure.

The service had documented evidence of temperature checks of the medicine's fridge from January 2022 onwards. However, there was no documentation or policy that established the safe temperature range of the fridge and staff were unable to provide this information. This meant temperature recording to did not provide assurance of safe storage.

Surgeons noted they prescribed postoperative antibiotics however here was no evidence of compliance with antimicrobial prescribing standards. Clinical staff told us they followed an antimicrobial policy although there was no documented evidence of audits, checks, or benchmarking.

Incidents

The service could not demonstrate how they managed patient safety incidents. There was limited evidence staff recognised and reported incidents and near misses. The service did not investigate incidents or share lessons learned with the whole team. There was no evidence when things went wrong, staff apologised and gave patients honest information and suitable support. There was limited assurance that actions from patient safety alerts were implemented and monitored.

Most staff who delivered care under regulated activities were not contracted or employed by the service. The provider had no system in place that provided evidence of appropriate incident reporting. Non-clinical staff employed by the service included administration and coordination staff, said they understood the incident reporting policy.

There were no incidents in the previous 12 months, including in the dental service. Surgeons who worked in the service under practising privileges had not reported any incidents in the same period.

Inadequate

Surgery

Are Surgery effective?

Inadequate

We have not previously inspected this service. We rated effective as inadequate.

Evidence-based care and treatment

The service had no benchmarks, audits, or standard operating procedures to provide care and treatment based on national guidance and evidence-based practice in surgery. The service could not demonstrate if they met cosmetic surgery standards published by the Royal College of Surgeons.

Staff did not follow national best practice guidance, including that issued by the National Institute for Health and Care Excellence (NICE). For example, surgeons did not carry out warming in the surgical suite in line with NICE clinical guidance 65 to reduce the risk of perioperative normothermia. They did not use equipment such as flatiron boots to reduce the risk of venous thromboembolism (VTE) during lengthy procedures.

Policies were inconsistent and were not all accurate, relevant, and fit for purpose.

The general surgery policy was dated March 2022 and did not reflect the procedures undertaken. The policy noted no sterile procedures were undertaken and that surgical procedures were too short to risk deep vein thrombosis (DVT). Neither of these statements were accurate. Surgeons undertook intensive surgical procedures that lasted up to six hours and that required sterile conditions. The policy included inaccurate information about handwashing facilities in the surgical operation room. We asked the registered manager about this and they told us the policy was not in use and had been replaced. The service was unable to explain why this policy had been recently updated and could not provide an alternative.

The service did not have standard operating procedures for sedation and staff told us individual consultants held these individually. The governance lead had issued a post-sedation chaperone policy in March 2022. The service had a post-sedation escort policy. This was undated and was identical to the chaperone policy. Neither policy followed best practice guidance issued by the Royal College of Anaesthetists (RCoA). The RCoA requires post-sedation care thresholds to be based on the level of sedation given. The service's chaperone policy-based thresholds of care on the length of time the patient underwent treatment. This meant the service did not have assurance post-sedation care was effective.

The service had systems to keep dental professionals up to date with current evidence-based practice. We saw the provision of dental implants was in accordance with national guidance.

Nutrition and hydration

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

The service required patients to fast for six hours before a procedure and to have only clear fluids in the two hours before. However, there was no documented evidence surgeons checked this and no audits in place to provide assurance.

The service provided catering for patients if they booked in advance for after their procedure. Staff told us this was offered on an individual basis and patients could choose from a range of local caterers and menus.

Inadequate

Surgery

The dental service provided preventive care and supported patients to ensure better oral health.

Pain relief

There was no evidence to provide assurance that staff assessed and monitored patients regularly to see if they were in pain and gave pain relief in a timely way.

Staff did not include pain assessments or pain medicine in their surgical notes. While pain relief was available on site, the stock for the surgical suite had expired in November 2021.

Patient outcomes

Staff did not monitor the effectiveness of care and treatment.

The service did not monitor patient outcomes. There was no system for auditing, reporting, or benchmarking.

During an observation of care the surgeon asked the patient about their expected outcomes. They asked why the patient wanted to undergo surgery and discussed in detail what they wanted from the procedure. The surgeon was open and honest about the likelihood of success and made clear results may not be as expected.

Staff did not monitor or track instances of patients who returned to theatre (RTT) or the reasons for them. We found two instances of RTT by looking at a random sample of patient notes. Staff had not carried out reviews of either patient and there was no documented reason for either RTT. This meant the service was not assured clinical treatment was carried out safely and consistently because there was no auditing process for patient outcomes.

The service had not implemented the NHS England National Safety Standards for Invasive Procedures (NatSSIPs) or the Local Safety Standards for Invasive Procedures (LocSSIPs). Both were introduced nationally in 2015 to drive improvements and cross-provider learning in surgical services. The provider had no equivalent system in place to monitor outcomes.

We saw evidence dentists justified, graded and reported on the radiographs they took. The service did not carry out six-monthly radiography audits in line with current guidance and legislation.

Competent staff

The service did not have a system to make sure staff were competent for their roles. Managers did not appraise staff's work performance or hold supervision meetings with them to provide support and development.

Staff did not undergo annual appraisals. The last documented annual appraisal for the registered nurse was in 2015. There was no record of an appraisal for the contracted surgeon. The provider did not keep an up to date record of appraisals for consultants working under practising privileges.

There was no evidence permanent staff had undertaken developmental opportunities or continuing professional development.

Newly appointed dental staff had a structured induction and clinical staff completed continuing professional development required for their registration with the General Dental Council.

Multidisciplinary working

There was no evidence of multidisciplinary working to provide good care.

Inadequate

Surgery

Surgeons treated patients independently of wider care pathways and the provider did not keep a record of patient details. Staff did not hold multidisciplinary meetings and there was no evidence they liaised with other professionals to coordinate care and treatment.

Seven-day services

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

Surgeons provided treatment on demand at times to meet the requests of patients.

The service had an out of hours phone system if patients had an urgent query after their procedure. However, this involved the patient leaving a voicemail and a member of staff picking this up then calling back.

Health promotion

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

The service had relevant information promoting healthy lifestyles that complemented aesthetic treatments, which are not regulated. However, this information was on display throughout the service and could be accessed by anyone.

Staff assessed each patient's medical history when assessing them for surgery although did not document how they provided support for any individual needs to live a healthier lifestyle.

The dental service provided preventive care and supported patients to ensure better oral health.

Consent and Mental Capacity Act

We were not assured staff supported patients to make informed decisions about their care and treatment. They did not consistently follow national guidance to ensured patients gave consent in a two-stage process with a cooling off period of at least 14 days between stages.

Staff did not consistently or clearly record consent in patients' records. In two surgical records, consent documentation did not match the procedures undertaken and there were discrepancies between the dates assessments took place and the dates consent was documented. In two patient records surgeons had not documented consent for follow-up procedures.

In two instances patients had signed consent forms and there was no evidence of a witness signature.

Staff did not always adhere to a 14 day cooling off period following the first stage of consent. We found some surgical procedures took place 10 days after consent.

Staff did not have documented training in the Mental Health Act, Mental Capacity Act 2005 and the Children Acts 1989 and 2004.

The service did not monitor or audit consent processes, which meant there was no assurance of consistency or compliance with best practice standards.

Dental staff were up to date with continuing professional development requirements in consent and the Mental Capacity Act.

Inadequate

Surgery

Are Surgery caring?

Insufficient evidence to rate

We have not previously inspected this service. We are unable to rate caring as we could not gather enough evidence.

Compassionate care

We did not speak to any patients during our inspection. Staff told us how they would provide compassionate care but most individuals who delivered care under a regulated activity did not work for the provider and did not provide formal patient feedback.

Patients who completed feedback cards said staff treated them well and with kindness. On one comment card a patient noted, "The service is exceptional." Another patient noted, "[staff] made me feel very special."

One patient noted, "Friendly but lacks privacy – other staff do not knock before entering, they come in and out."

Understanding and involvement of patients and those close to them

Staff made sure patients and those close to them understood their care and treatment. We observed a pre-operative consultation with a surgeon. They were open and honest with the patient and established their expectations of cosmetic surgery. The surgeon explained the risks, benefits, and alternatives of the treatment. They asked the patient how they would cope with the results if they did not exactly match their expectations and ensured the patient understood this had to be the right decision for them.

Patients and their families could give feedback on the service and their treatment and staff supported them to do this. There were comments cards and a comments box in the waiting room and staff encouraged patients to provide feedback.

Patients mostly gave positive feedback about the service. Patients commented on the time doctors gave to address their concerns. One patient noted the doctor had, …"offered his reasoned expertise and practical solutions." Another patient noted, "I found great reassurance from my consultant." While most comments were positive, staff did not document follow-up action where patients noted a problem. For example, one patient noted, "One [staff]…was brusque and unhelpful and made me feel like a nuisance."

Are Surgery responsive?

Inadequate

We have not previously inspected this service. We rated responsive as inadequate.

Meeting people's individual needs

The service was not inclusive and did not take account of patients' individual needs and preferences. There was no system for referring patients for psychological assessment before starting treatment, if necessary.

Inadequate

Surgery

There were no systems in place to help staff make sure patients living with mental health problems, learning disabilities and dementia, received the necessary care to meet all their needs. The nature of care provided meant it was unlikely a patient living with dementia would present in the clinic. However, staff did not have formal training or policies to help them in such an event.

During our observations, a surgeon considered a patient's psychological needs and suggested they undergo an assessment before proceeding with surgery. There was no formal referral system in place for this and the patient was required to access support themselves.

Patient records and care information leaflets were not accessible by people with communication or language needs. The service did not have an agreement with an interpretation service and staff said they relied on friends or relatives to translate for patients.

The provider had an access policy that noted the premises were accessible by patients or visitors with reduced mobility, including those who used a wheelchair. This was inaccurate. The clinic did not have step-free access from the street to the entrance and the lift was not wheelchair accessible. The lift did not serve the toilet used by patients and visitors, which required navigating stairs.

Access and flow

The service could not provide evidence that people could access the service when they needed it.

The cosmetic surgeon referred their own patients to the clinic and reviewed requests from other consultants and patients who self-referred. Clinics ran on demand to meet patient requests.

The service did not keep a record of when patients had their appointments or procedures cancelled. After our inspection the provider sent us tracking information from February 2022. This noted a provider-implemented cancellation rate of 16%. However, it was not possible to identify which cancellations related to regulated activities, why the cancellations had taken place, or the action the provider took afterwards.

Each individual surgeon managed discharges for their own patients. The service did not have an overarching discharge policy. The registered manager told us each doctor monitored patients vital signs and blood sugar before they were discharged. However, there was no evidence this took place in the patient records we looked at.

The service had a patient selection criteria that detailed exclusion criteria for surgical procedures. The policy was in date and due for review in January 2023. It stated six potential reasons patients would not be accepted for surgery. Two clinical exclusion criteria referred to those known to have tested positive for Creutzfeldt-Jakob disease (CJD) or those suspected of being infected. CJD is a type of brain disease and we could not establish why this was the service's main clinical exclusion criteria for cosmetic surgery. Other exclusion criteria included those unable to give consent or those with an identified cardiac or respiratory condition that would place them at risk. The policy did not identify how clinicians decided if patients were suitable candidates for surgery.

Learning from complaints and concerns

It was easy for people to give feedback and raise concerns about care received. It was not evident the service treated concerns and complaints seriously, investigated them and shared lessons learned with all staff. The service had an unsuitable system for referring unresolved complaints for independent review.

Inadequate

Surgery

The service had a complaints policy in place. This detailed how the registered manager would investigate and resolve complaints but did not include suitable information for independent escalation or review. For example, the policy directed complainants to contact CQC if they were unhappy with the outcome of an investigation. The address for CQC in the policy was out of date and CQC's role does not include complaint resolution or arbitration.

The service documented one complaint in the previous 12 months that may have been related to regulated activity. However, staff made very brief notes that meant it was not possible to fully understand the situation. The patient alleged the surgeon had damaged their lip during a procedure and said the surgeon had carried out a procedure to which they had not consented. Staff did not document an investigation or outcome and noted only that the patient was partially refunded.

Are Surgery well-led?

Inadequate

We have not previously inspected this service. We rated well-led as inadequate.

Leadership

Leaders did not have the skills and abilities to run the service. They failed to understand and manage the priorities and issues the service faced. However, they were visible and approachable in the service for patients and staff.

We were not assured of the abilities of the senior team. There were gaps in understanding of governance, operational safety, and the measures needed for safe clinical practice. Leaders could not evidence they understood challenges to quality and sustainability. They had not acted substantively to address quality issues.

The service did not have a leadership strategy or development programme and there were no contingencies in place for absence by the registered manager. There was no structure to clinical leadership and if the registered manager was off site there was no designated lead.

The service did not have a system to ensure staff and those working under practising privileges were supported with performance, met and trained together, and had access to human factors training to underpin the delivery of safe care. This would usually be included in work to follow the National Safety Standards for Invasive Procedures (NatSSIPs) but the service did not take part.

Staff told us they felt supported by the registered manager. They said he was readily available and visible in the service.

Vision and Strategy

The service did not have a vision for what it wanted to achieve or a strategy to turn it into action. It was unclear who the key stakeholders were.

The service did not have a clear vision or set of values. There was no sustainability programme in place.

Staff, stakeholders, and those working under practising privileges rarely met as a group and there was no cohesive communication strategy in place.

Inadequate

Surgery

Culture

Staff felt respected, supported and valued. The fragmented nature of staffing in the service meant there was a lack of cohesion and communication between staff.

A number of professionals worked in the clinic on an ad-hoc, limited, or temporary basis. There was an overall lack of understanding of, or adherence to, national standards and guidance. This included the Royal College of Surgeons professional standards for cosmetic surgery.

Cosmetic surgery services are required to follow guidance from the Advertising Standards Authority, under the Committee of Advertising Practice Ltd, to ensure marketing is not misleading and is responsible and accurate. The service did not carry out any auditing or benchmarking to provide assurance they met these standards.

There were no mechanisms for providing staff at every level with development and high-quality appraisals. There was no evidence of career development conversations although staff told us they enjoyed working for the provider and most individuals had worked there for several years.

There was no structure or system to promote diversity and equality and the service did not have a strategy to ensure it was meeting the requirements of the Equality Act (2010).

The dentist was unaware of local audit procedures or of their requirements. This reflected the wider culture in which it was unclear where accountability and responsibility lay for specific tasks. The provider did not have a clear system for disseminating information to clinical staff and there was no evidence of regular, consistent communication with the various professionals in the service.

There were cooperative, supportive and appreciative relationships amongst staff. Conflict or challenge was very rare and administration staff worked collaboratively together. There was very limited evidence this occurred amongst clinical staff as most individuals were not permanent employees and there was no structure for communication or collaborative working.

Governance

Leaders did not operate functioning governance processes.

Governance processes were significantly lacking for surgical and medical processes and there was no clinical governance group or committee. The service did not have a clinical audit programme, did not have an established system of multidisciplinary communication, and had no system in place to ensure polices and standard operating procedures were fit for purpose. However, governance processes for the dental service were better. The lead dentist managed the service with an established governance system that included some safety mechanisms, although these were not integrated with the provider.

The service reviewed cosmetic surgery services in an ad-hoc manner without a structure or governance framework to guide improvements or monitor performance.

The service did not govern and manage arrangements with partners and third-party providers effectively. There was limited evidence of coordinated interaction or focus on patient-centred care.

Inadequate

Surgery

The service did not keep up to date evidence of consultants' indemnity insurance to practice. One consultant's indemnity insurance certificate expired in April 2019. The service documented a request to the consultant to update their details over three months' later but there was no documented follow-up.

The team had implemented clinical staff meetings one week before our inspection. Minutes from the meeting indicated staff discussed a fire inspection due in April 2022.

General clinical and operating polices were in place and the provider had started to review and update them. However, we were not assured the service had enough expertise or access to appropriate guidance to ensure policies were fit for purpose. For example, the governance lead had issued a policy in March 2022 to guide staff in reporting faulty medical devices. The policy referred to an agency that ceased operating 19 years previously and included inaccurate contact details. The practising privileges policy relating to consultants and surgeons referred individuals to a doctor for advice who told us they had left the clinic in 2019. Such examples meant we were not assured the service and registered manager had adequate, functioning governance systems in place.

Management of risk, issues and performance

There was no system to manage performance effectively.

The service did not have comprehensive assurance systems and there were no processes to monitor cosmetic surgery services.

The registered manager used a risk register to track risks and mitigation in place. This included risks caused by inadequate fire prevention measures and challenges in carrying out repair work to the building. The register reflected the lack of oversight of which clinical staff were on site at any given time and the procedures they were undertaking. The register noted individual doctors carried their own medicines, which were not documented or recorded by the service, and that an "overflow of people" could occur when the service was being used clinically and for promotional filming. Mitigation for these risks was brief and limited in detail.

The service last risk assessed the workplace for staff in 2017. This included workspace assessments for safety. Staff had documented problems with broken equipment, uncomfortable workspaces, and the inability to control the temperature. The provider had not documented action taken from the assessments and there was no recent update.

The service did not have system for continuous improvement in infection prevention and control. There were no surveillance systems in place and no evidence of multi-agency working.

The 'Responding to Alert and Hazard Notices and Adverse Clinical Incidents' policy noted "hazard or alert letters" would be received in the clinic by the registered nurse. It was unclear which national alert system(s) the service subscribed to or how alerts were applied to practice. The policy referred to a now disbanded government department, the Medical Devices Agency, and out of date contact details to report defective medical devices. The policy was dated March 2022 but referred to an agency and escalation process that expired in 2003. This meant we were not assured the service had appropriate access to escalation processes for faulty medical devices. After our inspection the service sent us the latest published weekly summary of Field Safety Notices (FSNs), which are issued by medical device manufacturers when a change in practice or use is needed to maintain safety. However, there was no associated action log or review to identify if any of the FSNs applied to this service.

Information Management

The information systems were not managed securely.

Inadequate

Surgery

There was a records and information management policy in place dated March 2022. The policy stated an operating logbook of all procedures was maintained on site. However, staff did not maintain a logbook or register of surgical procedures undertaken.

Staff did not maintain the security of information systems. Computers were not always password protected when not in use and there was no time out facility that locked them after a period of inactivity.

The service did not have a holistic understanding of performance that included people's views with information on quality, operations, and finance. There were no associated processes to measure improvement or baselines assurance.

The service did not have systems to monitor quality and sustainability. There were no performance measures and no reporting system for operational or patient outcomes.

Engagement

There was limited evidence leaders and staff actively and openly engaged with patients and each other.

Staff told us they felt well informed by the registered manager and had regular opportunities to meet.

The service sought feedback from patients, which was generally positive. However, there was no evidence of action taken when patients noted poor quality care, including a lack of privacy and being rushed by a consultant. The service documented refunds as a first line of resolution and there was no documented evidence of investigations or work towards improved practices.

It was unclear whether external partners were engaged in the service. There was no evidence stakeholders were involved in the running of the service or its strategy or sustainability.

There was no evidence the practice gathered feedback from dental staff through meetings and informal discussions. The dentist told us they worked one day a week and often missed team meetings. They were unable to tell us how they were updated about things in the practice.

Learning, continuous improvement and innovation

The service could not demonstrate processes for continuous learning, improvement and innovation. The service did not participate in accreditation schemes and did not check if surgeons working under practising privileges were compliant with the Royal College of Surgeons cosmetic surgery certification requirements.

The service did not have standardised improvement tools or methods although the registered manager rewarded performance and commitment amongst the administration team.

The dental service did not have appropriate quality assurance processes to encourage learning and continuous improvement. The dental service had not undertaken audits of radiographs and infection prevention and control in accordance with current guidance and legislation. We discussed this with the principal dentist. They were aware of the required audits and could not explain why they had not been completed.

Inadequate

Services for children & young people

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

Are Services for children & young people safe?

Inadequate

This was the first inspection of the service. We rated safe as inadequate.

Mandatory training

The service did not provide mandatory training in paediatric care to staff who required it.

Staff were not trained in paediatric life support.

Mandatory training did not include any specific additional clinical training in paediatrics. For example, nursing staff had not received additional training to ensure they were competent to care for children and young people.

See information under this sub-heading in the surgery section of this report.

Safeguarding

Staff had training on how to recognise and report abuse, but this training was not at the right level for all staff.

The registered manager told us they were the level four named professional for safeguarding children, however they were unable to provide evidence to show they had undertaken level four training. We only saw their level three child safeguarding certificate.

The child safeguarding policy was not fit for purpose. It did not stipulate what level of training staff who worked with children required, and it did not state the name of the safeguarding lead in the service or to contact them if staff had any safeguarding concerns.

See information under this sub-heading in the surgery section of this report.

Environment and equipment

Inadequate

Services for children & young people

The design, maintenance and use of facilities, premises and equipment did not keep young people safe.

The service did not have suitable facilities to help them to safely care for children and young people. The service did not have a separate waiting area for children and young people.

See information under this sub-heading in the surgery section of this report.

Assessing and responding to patient risk

Staff completed and updated risk assessments for each child and young person however there were no policies and procedures to support this.

Staff carried out a risk assessment for children and young people using the service. However, staff did not use a nationally recognised tool to identify children or young people at risk of deterioration and escalate them appropriately. The service did not have a standard operating procedure for the management of a deteriorating child.

See information under this sub-heading in the surgery section of this report.

Nurse staffing

The service did not have nursing staff with the right qualifications, skills, training and experience to keep children, young people and their families safe from avoidable harm and to provide the right care and treatment.

The service had nursing and support staff but none of them had paediatric training.

See information under this sub-heading in the surgery section of this report.

Records

Staff kept detailed records of children and young people's care and treatment. Records were clear, up-to-date, and easily available to all staff providing care. However, they were not stored securely.

We reviewed six records for children and young people. Patient notes were comprehensive, and staff could access them easily.

Electronic patient records were not stored securely. We found computers were left unlocked and had no timeout or password protection.

See information under this sub-heading in the surgery section of this report.

Inadequate

Services for children & young people

Are Services for children & young people effective?

Inadequate

This was the first inspection of the service. We rated effective as inadequate.

Evidence-based care and treatment

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

Staff did not have access to up-to-date policies to plan and deliver high quality care according to best practice and national guidance for children and young people.

See information under this sub-heading in the surgery section of this report.

Competent staff

The service did not make sure staff were competent for their roles.

The service did not have access to paediatric trained nurses or support staff in line with national guidance.

Health promotion

Staff gave children, young people and their families practical support and advice to lead healthier lives.

We saw a book on acne which was given to patients and included information on health promotion exercise, and lifestyle.

See information under this sub-heading in the surgery section of this report.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

Staff supported children, young people and their families to make informed decisions about their care and treatment.

Staff made sure children, young people and their families consented to treatment based on all the information available.

Staff clearly recorded consent in the children and young people's records. There was no specific assessment for consent such as Gillick competency. All patients under the age of 18 were accompanied by a parent or carer.

See information under this sub-heading in the surgery section of this report.

Are Services for children & young people caring?

Inadequate

Services for children & young people

Insufficient evidence to rate

This was the first inspection of the service. There was insufficient evidence to rate caring.

No children or young people were being treated by the service at the time of our inspection.

See information under this heading in the surgery section of this report.

Are Services for children & young people responsive?

Inadequate

This was the first inspection of the service. We rated responsive as inadequate.

For learning from complaints and concerns, please see the surgery section of this report.

Service delivery to meet the needs of local people

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

The service was not designed to provide care to meet the needs of children and young people. For example, they did not have a separate waiting area for children and young people which meant they mixed with adults while waiting. The registered manager told us they were aware of the limited provision for children and young people and had made the decision to no longer see under 18s at the clinic.

See information under this heading in the surgery section of this report.

Meeting people's individual needs

The service did not take into account of children, young people and their families' individual needs and preferences.

The service was not designed to meet the individual needs of children, young people and their families. For example, there were no specific times set for children and young people to access appointments. The service had not considered in policies and procedures how the needs of adults and children and young people were different**.**

See information under this heading in the surgery section of this report.

Access and flow

The service did not have formal written criteria by which they assessed and accepted children and young people into the service.

Inadequate

Services for children & young people

Staff told us that consultants only saw children on an ad hoc basis and that they were usually the children of their regular patients. Records showed 30 children had been seen in the 12 months prior to inspection and their ages ranged from seven to 17. One child had undergone surgery.

See information under this heading in the surgery section of this report.

Are Services for children & young people well-led?

Inadequate

This was the first inspection of the service. We rated well-led as inadequate.

Leadership

Leaders did not have the skills and abilities to run the service for children and young people.

Leaders had not taken into account how the services needed to be adapted to care for children and young people. However, the registered manager told us they recognised this and had decided to stop seeing children at the clinic.

Vision and Strategy

The service did not have a vision and strategy that included children and young people, and planned to stop seeing children and young people at the clinic.

Governance

The governance structure for the service did not take into consideration children and young people.

The service did not have policies and procedures in place to support the care for children and young people.

See information under this sub-heading in the surgery section of this report.

Management of risk, issues and performance

The service did not have oversight of risks, issues and performance related to children and young people.

The registered manager did not have oversight of how many children and what age ranges were seen at the clinic. They told us they never saw children for surgery, however, records showed that one child had undergone surgery at the clinic in 2021 and this surgery resulted in an infection and a reversal of the procedure. There was no record of any incident investigation or learning from this.

Inadequate

Services for children & young people

The registered manager told us they were aware that the service did not meet the requirements for children, and they had decided to stop seeing children at the clinic from the day of our inspection. However, we were not assured that consultants working at the clinic would be aware of or adhere to this decision, as some staff we spoke with were not aware of it. We were not assured the registered manager would be aware of whether consultants were seeing children or not as they did not have oversight of those seen in the past 12 months.

See information under this sub-heading in the surgery section of this report.

Inadequate

Outpatients

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

Are Outpatients safe?

Inadequate

We have not previously inspected this service. We rated safe as inadequate.

Cleanliness, infection control and hygiene

The service was unable to demonstrate how it controlled infection risk. Staff kept equipment and the premises visibly clean.

Clinical areas were clean and had suitable furnishings which were clean and well-maintained. Staff did not keep cleaning records that demonstrated which areas of the service had been cleaned and sanitised. This meant there was no audit or record of performance for cleanliness.

The service did not use a labelling system in consulting rooms to show when equipment had been cleaned and sanitised for use. Staff used clinical rooms interchangeably and there was no system in place to check cleaning had been completed before use.

Environment and equipment

The design, maintenance and use of clinical facilities kept people safe but the service did not manage premise safety well. Staff did not manage clinical waste well.

Clinical rooms were well equipped and had suitable equipment for outpatient consultations. The service was compliant with the Department of Health and Social Care (DHSC) Health Building Note (HBN) 00/09 in relation to clinical environment design. Consultation rooms had two designated areas, one for clinical assessment and treatment, and an administration area. Rooms had vinyl flooring, which was fully compliant with DHSC HBN 00/10 in relation to infection control in the clinical environment

Please see our surgery report for full details of hazardous waste management.

Staffing

Inadequate

Outpatients

The service could not evidence it had enough staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment. Care was pre-planned.

The registered manager told us two dermatology consultants provided services in the clinic. However, our checks indicated one doctor was registered with the General Medical Council as a GP. The service did not hold evidence of specialist training in dermatology. After our inspection, the provider submitted evidence of two doctors with specialist training in dermatology.

Doctors led outpatient consultations without nurse or other clinical support and arranged them in advance with patients to meet demand.

Records

Staff kept inconsistent records of patients' care and treatment. Records were not always clear, up-to-date, or stored securely.

The service had recently digitised patient records, which were readily available on the computer system. This system was not secured, and staff did not routinely lock computer screens when unattended.

We were not assured notes were comprehensive, contemporaneous, and fully reflective of consultations. The service did not keep a record of outpatient consultations and so it was not possible to cross-reference appointments with specific patient records.

Are Outpatients effective?

Insufficient evidence to rate

We do not currently rate effective for outpatients.

For pain relief, multidisciplinary working, seven-day services, health promotion, and consent, please see the surgery report.

Evidence-based care and treatment

The service had no benchmarks, audits, or standard operating procedures to provide care and treatment based on national guidance and evidence-based practice.

Policies were readily available but did not consistently reflect best practice and national guidance. The service did not keep evidence staff read policies and understood them, such as an approved signature list with defined time to read the policies.

The service did not have an audit programme and could not provide evidence of how it assessed or benchmarked standards of care with appropriate organisations, such as the Royal College of Physicians.

Inadequate

Outpatients

Patient outcomes

Staff did not monitor the effectiveness of care and treatment.

Staff offered outpatient appointments typically as standalone appointments, or as a precursor to future surgery. They did not use defined care pathways and the service was unable to provide evidence care was provided in line with national guidance, such as from the British Association of Dermatologists' Getting It Right First Time (GIRFT) report.

The service did not keep information or data that enabled them to identify and monitor patient outcomes. This meant there was no process to assess if treatment met patients' needs or if steps could be taken to improve outcomes.

Competent staff

The service did not have a system to make sure staff were competent for their roles. Managers did not appraise staff's work performance or hold supervision meetings with them to provide support and development.

There were discrepancies in the information kept by the provider regarding the staff available for consultations.

Are Outpatients caring?

Insufficient evidence to rate

We have not rated caring for outpatients.

Please see the surgery report.

Are Outpatients responsive?

Inadequate

We have not previously inspected this service. We rated responsive as inadequate.

For complaints, please see the surgery report.

Service delivery to meet the needs of people

The service planned and provided care on demand. It could not demonstrate how it also worked with others in the wider system and organisations to plan care.

The service did not monitor repeat appointments and there was no standard system in place to identify if doctors referred patients to other or more appropriate services.

Inadequate

Outpatients

The service had a service level agreement with a United Kingdom Accreditation Service (UKAS)-accredited laboratory for blood samples and staff arranged courier collection as needed.

Facilities and premises were not accessible to everyone. The provider's access policy noted consultation rooms were accessible by wheelchair. However, there was no step free access from the street to the ground floor, where the most accessible room was located. The only toilet available for patient and visitor use could only be accessed by stairs.

Staff said they would refer patients in need of mental health support to appropriate services although there was no policy or standard operating procedure for this process.

The service did not keep a record of missed appointments and did not document if they contacted patients who did not attend. After our inspection, the provider submitted information relating to six missed appointments in February 2022. However, the service did not track if any of the appointments related to regulated activities and staff did not document evidence they followed up with each patient.

Meeting people's individual needs

The service could not evidence how they were inclusive or took account of patients' individual needs and preferences. Staff could not make reasonable adjustments to help patients access services. They did not coordinate care with other services and providers.

The service did not provide staff with training in delivering care to patients living with mental health problems, learning disabilities, or dementia. There were no communication resources or service adaptations to meet needs relating to these conditions.

The service did not have a policy on meeting the information and communication needs of patients with a disability or sensory loss. This meant there was limited guidance at hand to help staff deliver care.

Information was not available in other languages and the service did not hold a contract with an interpretation or signing service. Policies directed staff to rely on relatives or friends accompanying patients to provide language support. This was not an acceptable solution because it presented a safety and safeguarding risk.

Access and flow

People could access the service when they needed it.

Outpatient clinics were consultant led and planned in advance to meet demand.

Patient feedback was mostly positive about the service although two individuals noted in feedback forms that doctors had rushed them through appointments. The service did not maintain a record of such issues and there was no evidence the registered manager had addressed them with the clinical team.

The service did not monitor cancelled appointments.

Are Outpatients well-led?

Inadequate

Outpatients

Inadequate

We have not previously inspected this service. We rated well-led as inadequate.

Governance

Leaders did not operate functioning governance processes.

The outpatients service did not have a cohesive clinical governance or operational structure. It was unclear who was providing outpatient services and the provider did not maintain a clear understanding of the roles, accountabilities, and qualifications of doctors.

For our detailed findings on governance, please refer to the surgery report.

Management of risk, issues and performance

There was no system to manage performance effectively.

The service had a risk register in place that included areas that impacted outpatients, such as risks in a programme to digitise patient records. Risks relating to the premises, such as deficiencies in fire safety measures, were relevant to each core service. For our detailed findings on risk, please refer to the surgery report.

The service did not monitor or manage issues and performance with outpatient services and there was no system in place to help staff understand if the service was running well or needed improvement.

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
Diagnostic and screening procedures Surgical procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment • There were not adequate systems in place to assess the risk's to people's heath and safety during their care or treatment, • The provider did not make sure that staff had the qualifications, competence, skills and experience to keep people safe, • The provider did not ensure the premises and equipment was safe for use, • The provider did not ensure medicines were managed and administered appropriately. • There were not effective processes and policies in place to manage and prevent the control and spread of infection.

Regulated activity	Regulation
Diagnostic and screening procedures Surgical procedures Treatment of disease, disorder or injury	Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment • The provider must ensure safeguarding policies, including for chaperones, reflect best practice and that staff are fully versed in them. • The service must ensure that children and young people are protected from harm.

Regulated activity	Regulation
Diagnostic and screening procedures Surgical procedures Treatment of disease, disorder or injury	Regulation 15 HSCA (RA) Regulations 2014 Premises and equipment

This section is primarily information for the provider

Enforcement actions

- The provider did not have appropriate fire risk prevention measures in place.
- The service's premises were not always clean or suitable for the intended purpose.
- The service's premises did not always follow the government guidance from the Health and Safety Executive to make practicable modifications to reduce the risk of falls by making simple changes to the design. The design of stairs should be free from trip hazards, such as uneven steps.

Regulated activity	Regulation
Diagnostic and screening procedures Surgical procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance • The provider did not ensure that consultant surgeons inviting external first assistants or other staff into theatres were granted either appropriate practicing privileges or other checks as required by schedule 3 of the HSCA 2008 (Regulated Activity) Regulations 2014. • The provider did not have effective audit, governance, and risk management systems. This includes: effective clinical management, effective management of incidents, and effective management of complaints.