CC Kat Aesthetics Ltd

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

Mental Health Act responsibilities and Mental Capacity Act and Deprivation of Liberty Safeguards

We include our assessment of the provider's compliance with the Mental Capacity Act and, where relevant, Mental Health Act in our overall inspection of the service.

We do not give a rating for Mental Capacity Act or Mental Health Act, however we do use our findings to determine the overall rating for the service.

Further information about findings in relation to the Mental Capacity Act and Mental Health Act can be found later in this report.

Summary of findings

Overall summary

CC Kat is operated by CC Kat Aesthetics Ltd. The service has no overnight or day beds. Facilities include one operating theatre and outpatient facilities.

The service provides surgery and outpatients services. We inspected both services.

We inspected this service using our comprehensive inspection methodology. We carried out the announced part of the inspection on 8 and 15 August 2017.

To get to the heart of patients' experiences of care and treatment, we ask the same five questions of all services: are they safe, effective, caring, responsive to people's needs, and well-led? Where we have a legal duty to do so we rate services' performance against each key question as outstanding, good, requires improvement or inadequate.

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

We regulate cosmetic surgery services but we do not currently have a legal duty to **rate** them when they are provided as a single specialty service. We highlight good practice and issues that service providers need to improve and take regulatory action as necessary.

The main service provided by this clinic was cosmetic surgery. Where our findings on surgery – for example, management arrangements – also apply to outpatients, we do not repeat the information but cross-refer to the surgery core service.

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

- There was no formalised safety procedure or instrument and swab count during surgical procedures. The provider did not follow national safety procedures such as the World Health Organisation checklist to ensure people were protected from avoidable harm in theatre.
- There was limited measurement and monitoring of safety performance. The provider did not use a clinical dashboard to review safety. Safety was only monitored through any complications of surgery.
- There was no evidence to show that staff were trained and qualified to an acceptable level to keep people safe, this included an absence of safeguarding training.
- There was no mandatory training programme in place and the provider did not keep mandatory training staff records.
- There were no systems or triggers in place to conform to Duty of Candour. People may not have always been told and may not have received an apology when things went wrong.
- When things went wrong, there was no evidence that suggested reviews and investigations were sufficiently thorough and there were no necessary improvements recorded.
- There were minimal systems in place for incident reporting and those that were in place were not always reliable or appropriate.
- Processes for ensuring good cleanliness, infection control and hygiene were not fit for purpose and were not in line with current guidance and best practice.
- Staff did not identify, assess, manage or monitor for risk, the potential hazards of space restriction within the clinic.
- The risks associated with anticipated events and emergency situations were not fully recognised, assessed or managed.
- The approach to assessing and managing day-to-day risks to patients was not fit for purpose.
- The provider did not provide care in line with 2014 Laser Radiation Guidance.
- Equipment and maintenance checks were not carried out regularly and COSHH records were not updated since 2006. Medicines were not stored appropriately and some were out of date.
- There was insufficient assurance systems in place to demonstrate that people received effective care.
- There was very limited monitoring of people's outcomes of care and treatment.
- The provider was not developing a readiness to collect Patient Reported Outcomes Measures that the Royal College of Surgery (RCS) has deemed as particularly important in cosmetic surgery, despite the clinic undertaking procedures that would apply.

Summary of findings

- There was no local audit programme, national benchmarking or participation in peer review or national audit programmes.
- There was a lack of assurance that people received care from staff who had the skills or experience that is needed to deliver effective care. There were gaps in management and supporting arrangements for staff such as regular appraisal, supervision and professional development.
- There were few policies in place to support staff and those that were contained irrelevant and out of date guidance and legislation.
- The waiting area did not always allow for patient privacy and confidentiality to be maintained.
- There was no evidence to show that waiting times, delays and cancellations were minimal and managed appropriately. There was no formal arrangement for managing patient flow and the provider did not assess or monitor cancellations. The provider however assured us these issues are practically irrelevant in private aesthetic practices as all patients had individual appointments.
- The service did not accommodate unplanned surgery. If patients were in need of unplanned surgery, they were directed to the local NHS service.
- The complaints procedure was out of date and did not make reference to relevant legislation such as the Duty of Candour.
- There was a reduction in the ability for the provider to learn from complaints due to stage three independent reviews not being part of the provider's complaint process.
- Governance and assurance systems and processes were not robust, fallen into neglect or completely absent from the service.
- There was no effective system for identifying, capturing and managing issues and risks at team, directorate and organisation level.
- There were no formal processes in place to review key items or government arrangements. The only items the provider reviewed were complaints and complications of surgery.
- There did not appear to be a set of values or a strategy in place.
- Leaders were not always clear about their roles and their accountability.
- Systems in place to maintain and service equipment were not robust with much of the available documentation out of date.
- There were no arrangements in place to formally address the Fit and Proper Persons requirement for persons 'directing' the service.
- Leaders did not have the necessary knowledge of current relevant legislation and regulation requirements needed to provide a safe and effective service. This included conforming to the 2014 Laser Radiation Guidance and the Control of Artificial Optical Radiation at Work Regulations 2010.
- There were missed opportunities for analysing patient feedback. The system in place was not fit for purpose and had a low uptake. Patients did not know about the process for giving feedback and the provider did not conduct any patient surveys.

We found the following areas of good practice:

- All areas of the clinic and theatres were clean and regularly maintained. Staff adhered to infection, prevention and control policies and procedures.
- Consultants were undertaking pre-assessments and there was evidence of risk assessments and pre-operative risk assessments in patient records.
- The clinic was appropriately staffed by a qualified doctor and a qualified nurse. These were supported by support and administration staff.
- Staff managed people's pain relief effectively.
- Staff could access information needed to assess, plan and deliver care to people in a timely way. People understand and had a copy of the information that was shared about them.
- Staff worked collaboratively to understand and meet the needs of people who used services.
- Detailed information about a patient's procedure was shared with the patient and other relevant healthcare professionals with the patient's consent.
- There was evidence that consent to care and treatment was in line with legislation and guidance. People were supported to make decisions.
- People were offered flexibility, choice and continuity of care and this was reflected in the services provided.
- The needs of people were taken into account when planning and delivering services.
- Care and treatment was coordinated with other providers.

Summary of findings

- People could access care in a timely way at a pace that suited them.
- The provider took an ethical and moral approach to treatment; declining to carry out procedures where the cost to the patient would exceed the likely benefit or fail to meet their expectations.
- The provider responded to complaints in a timely way.
- Staff supported people who used services, treated them with dignity and respect, and involved them as partners in their care.
- People who used services were communicated with and received information in a way they understood.
- Staff gave sufficient information to people who used services to allow informed decision making and enabling people to become active partners in their care and treatment.
- Feedback from patients we spoke with was positive. They said staff treated them with compassion and respected their privacy and confidentiality.
- Staff encouraged patients to seek counselling for emotional support when they refused to treat for medical or ethical reasons.
- There was a clear vision that was person-centred.
- Staff felt well supported by leaders.

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 five requirement notice(s) that affected surgery and outpatients. Details are at the end of the report.

Heidi Smoult

Deputy Chief Inspector of Hospitals (Central Region)

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Surgery		We regulate cosmetic surgery but do not currently have the legal duty to rate them, where services are provided as an independent healthcare single speciality service. Surgery was the main activity of the clinic. Where our findings on surgery also apply to other services, we do not repeat the information but cross-refer to the surgery section. The service was a small single speciality service that consisted of a small team of staff that worked across both surgery and outpatients services.
Outpatients and diagnostic imaging		Please refer to detailed information provided throughout the report within the surgery core service section.

Summary of findings

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Summary of this inspection

Background to CC Kat Aesthetics Ltd

We regulate cosmetic surgery but do not currently have the legal duty to rate them, where services are provided as an independent healthcare single speciality service.

Surgery was the main activity of the clinic. Where our findings on surgery also apply to other services, we do not repeat the information but cross-refer to the surgery section.

The service was a small single speciality service that consisted of a small team of staff that worked across both surgery and outpatients services.

The clinic offers on-site services ranging from skincare consultation, skin treatments, injectable aesthetic treatments, laser treatments to a full range of aesthetic surgeries under local anaesthesia. Assessment for cosmetic surgeries are also conducted at the clinic with the surgeries (requiring general anaesthesia or sedation) carried out at three private hospitals around the Midlands. From June 2017, a consultant dermatologist was joining on a regular basis to provide a dermatology service along with hair transplant surgery.

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 management. The inspection team was overseen by Tim Cooper, Head of Hospital Inspection.

Why we carried out this inspection

We carried out this inspection as part of our programme of comprehensive inspections of independent health care services.

How we carried out this inspection

During the inspection, we visited both premises that comprise the clinic including the theatre and outpatients consultation rooms. We spoke with six staff including; registered nurses, reception staff, medical staff and the manager. We spoke with six patients. During our inspection, we reviewed six sets of patient records and staff files.

Information about CC Kat Aesthetics Ltd

CC Kat Aesthetics provides cosmetic plastic surgery to people aged 18 years and over. No overnight beds are provided at the clinic.

It is registered to provide surgical procedures and treatment of disease, disorder and injury. The manager is registered with us to provide these services. The clinic has had a registered manager in post since 2010.

We have inspected this location twice since 2013. We made two compliance actions/requirement notices at the

Summary of this inspection

last inspection concerning safeguarding procedures and information about the records and checks relating to the fitness of workers. At this inspection we found the provider had complied with these.

CC Kat Aesthetics is operated by CC Kat Aesthetics Ltd. The service opened in 2008. It is a private clinic in Birmingham. The clinic primarily serves the City of Birmingham.

The main service is cosmetic surgery. There were no inpatient and day case episodes of care at the clinic between April 2016 and March 2017. There were approximately 250 outpatient total attendances during that period; all of which were funded through non-NHS means. Ninety-six percent were adults 18 to 74 years and 4% were adults aged over 75 years.

The clinic is set out over the ground floors of two buildings adjacent to each other on a small junction in the Ladywood area of the City. It has a small car park a few hundred yards away.

The clinic has one theatre and two consulting/treatment rooms and is registered to provide the following regulated activities:

- Surgical procedures
- Treatment of disease, disorder or injury

There were no special reviews or investigations of the clinic ongoing by the CQC at any time during the 12 months before this inspection. The service has been inspected twice and the most recent inspection took place in February 2014, which found that the service was not meeting all standards of quality and safety it was inspected against.

From April 2014 to March 2015 the most frequent procedure was Botulinum toxic injection (267) and dermal filler injection (214); these are not regulated activities. Theatre treatments were carried out at the clinic under local anaesthesia only (no sedation). These were excision of lesions (16); mini facelift (53) and vaser liposuction (6). No patients stayed overnight at the clinic.

There were 250 outpatient attendances in the reporting period (April 2016 to March 2017); all of which were funded through non-NHS means.

One surgeon worked at the clinic under practising privileges. The clinic employed one registered nurse and two reception staff.

Track record on safety:

- Nil Never events
- Clinical incidents 0 no harm, 0 low harm, 0 moderate harm, 0 severe harm, 0 death
- 0 serious injuries
- 0 complaints
- 0 infections

No services accredited by a national body.

No services provided at the clinic under service level agreement.

Summary of this inspection

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?

We do not currently have a legal duty to rate cosmetic surgery services, where these services are provided as an independent healthcare single speciality service.

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

- There was a disregard of national safety procedures to ensure people were protected from avoidable harm in theatre.
- There was no formalised safety procedure or instrument and swab count during surgical procedures.
- The provider did not provide care in line with 2014 Laser Radiation Guidance.
- There was limited measurement and monitoring of safety performance. The provider did not use a clinical dashboard to review safety. Safety was only monitored through complications of surgery.
- There was no evidence to show that staff were trained and qualified to an acceptable level to keep people safe.
- There was no mandatory training programme in place and the provider did not keep mandatory training staff records.
- There were no systems or triggers in place to conform to duty of candour. People may not have always been told and may not have received an apology when things went wrong.
- When things went wrong, there was no evidence that suggested reviews and investigations were sufficiently thorough and there were no necessary improvements recorded.
- There were minimal systems in place for incident reporting and those that were in place were not always reliable or appropriate.
- Processes for ensuring good cleanliness, infection control and hygiene were not fit for purpose and were not in line with current guidance and best practice.
- Staff did not identify, assess, manage or monitor for risk, the potential hazards of space restriction within the clinic.
- The risks associated with anticipated events and emergency situations were not fully recognised, assessed or managed.
- The approach to assessing and managing day-to-day risks to people who used services was not fit for purpose.
- Equipment and maintenance checks were not carried out regularly, COSHH records were not updated since 2006 and medicines were not stored appropriately and were out of date.

However, we found areas where the provider performed well:

Summary of this inspection

- All areas of the clinic and theatres visited were visibly clean and regularly maintained. Staff adhered to infection, prevention and control policies and procedures.
- There was a good track record of safety.
- Consultants were undertaking pre-assessments and there was evidence of risk assessments and pre-operative risk assessments in patient records.
- Staffing levels and skill mix were appropriate for the clinic setting.

Are services effective?

We do not currently have a legal duty to rate cosmetic surgery services, where these services are provided as an independent healthcare single speciality service.

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

- There was insufficient assurance in place to demonstrate that people received effective care.
- There was very limited monitoring of people's outcomes of care and treatment.
- The provider was not developing a readiness to collect Patient Reported Outcomes Measures that the Royal College of Surgeons as deemed as particularly important in cosmetic surgery, despite the clinic undertaking procedures that would apply.
- There was no local audit programme, national benchmarking or participation in peer review or national audit programmes.
- There was a lack of assurance that people received care from staff who had the skills or experience that is needed to deliver effective care. There were gaps in management and supporting arrangements for staff such as regular appraisal, supervision and professional development.
- There were few policies in place to support staff and those that were contained irrelevant and out of date guidance and legislation.

However, there were areas where the provider were performing well:

- Staff managed people's pain relief effectively.
- Staff could access information needed to assess, plan and deliver care to people in a timely way. People understand and had a copy of the information that was shared about them.
- Staff worked collaboratively to understand and meet the needs of people who used services.

Summary of this inspection

- Detailed information about a patient's procedure was shared with the patient and other relevant healthcare professionals with the patient's consent.
- There was evidence that consent to care and treatment was in line with legislation and guidance. People were supported to make decisions.

Are services caring?

We do not currently have a legal duty to rate cosmetic surgery services, where these services are provided as an independent healthcare single speciality service.

We found areas where the provider was performing well:

- Staff supported people who used services, treated them with dignity and respect, and involved them as partners in their care.
- People who used services were communicated with and received information in a way they understood.
- Staff gave sufficient information to people who used services to allow informed decision making and enabling people to become active partners in their care and treatment.
- Feedback from patients we spoke with was positive. They said staff treated them with compassion and respected their privacy and confidentiality.
- Staff encouraged patients to seek counselling for emotional support when they refused treated for medical or ethical reasons.

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

- The waiting area did not always allow for patient privacy and confidentiality to be maintained.

Are services responsive?

We do not currently have a legal duty to rate cosmetic surgery services, where these services are provided as an independent healthcare single speciality service.

We found areas where the service performed well:

- People were offered flexibility, choice and continuity of care and this was reflected in the services provided.
- The needs of people were taken into account when planning and delivering services.
- Care and treatment was coordinated with other providers.
- People could access care in a timely way at a pace that suited them.

Summary of this inspection

- The provider took an ethical and moral approach to treatment, declining to carry out procedures where the cost to the patient would exceed the likely benefit or fail to meet their expectations.
- The provider responded to complaints in a timely way and in detail.

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

- There was no evidence to show that waiting times, delays and cancellations were minimal and managed appropriately. There was no formal arrangement for managing patient flow and the provider did not assess or monitor cancellations. However the provider assured us these issues are practically irrelevant in private aesthetic practices**.**
- The service did not accommodate unplanned surgery. If patients were in need of unplanned surgery, they were directed to the local NHS service.
- The complaints procedure was out of date and did not refer to relevant legislation such as the duty of candour.
- There was a reduction in the ability for the provider to learn from complaints due to stage three independent reviews not being part of the provider's complaint process.

Are services well-led?

We do not currently have a legal duty to rate cosmetic surgery services, where these services are provided as an independent healthcare single speciality service.

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

- Governance and assurance systems and processes were not robust, fallen into neglect or completely absent from the service.
- There was no effective system for identifying, capturing and managing issues and risks at team, directorate and organisation level.
- There were no formal processes in place to review key items or government arrangements. The only items the provider reviewed were complaints and complications.
- There did not appear to be a set of values or a strategy in place.
- Leaders were not always clear about their roles and their accountability.
- Systems in place to maintain and service equipment were not robust with much of the available documentation out of date.

Summary of this inspection

- There were no arrangements in place to formally address the Fit and Proper Persons requirement for persons 'directing' the service.
- Leaders did not have the necessary knowledge of current relevant legislation and regulation requirements needed to provide a safe and effective service. This included conforming to the 2014 Laser Radiation Guidance and the Control of Artificial Optical Radiation at Work Regulations 2010.
- There were missed opportunities for analysing patient feedback. The system in place was not fit for purpose and had a low uptake. Patients did not know about the process for giving feedback and the provider did not conduct any patient surveys.

However, there were areas where the provider was performing well:

- There was a clear vision that was person-centred.
- Staff felt well supported by leaders.

Detailed findings from this inspection

Surgery

Safe	
Effective	
Caring	
Responsive	
Well-led	

Are surgery services safe?

The main service provided by this clinic was cosmetic surgery. Where our findings on cosmetic surgery for example, management arrangements – also apply to outpatient's services, we do not repeat the information but cross-refer to the surgery section.

We regulate cosmetic surgery services but we do not currently have a legal duty to rate them when they are provided as a single specialty service.

Incidents

- 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.
- The provider reported no never events and confirmed to us no never events took place at the service between April 2016 and March 2017. The provider reported and confirmed no infections such as MRSA, MSSA, E-coli or C.diff for the same period. There were no serious injuries and no patient deaths at the service.
- There were minimal systems in place for incident reporting. They comprised a critical incidents form, a complaints log and the complications log. We noted the complaints and complications logs were kept up to date.
- The manager told us any incidents would be discussed among the team in their regular meetings. Staff we spoke with confirmed this and although there were no minutes kept, we saw meeting agendas and follow up action e-mails between the manager and staff team that addressed issues such as complications and complaints.
- Only one critical incident was recorded and this was in 2014. The manager and lead nurse confirmed no further incidents had occurred.
- From April 2016 to July 2017, the provider had recorded two complications for treatment carried out at this location. Both were about haematoma post mini face lift procedures. There was no outcome recorded against these records although action was recorded as taken for responsive treatment.
- There was no trigger for applying the Duty of Candour. There was no system or trigger for making required notifications to the CQC, although those complications would not have met the threshold for a trigger. The Duty of Candour 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.

Clinical Quality Dashboard or equivalent (how does the service monitor safety and use results)

- The NHS safety thermometer `system of recording` is only available to providers of NHS funded care. Non-NHS funded providers may have a similar system in place in order to monitor and measure the same types of harms.
- The manager told us the service did not use a clinical dashboard or equivalent. Safety was monitored through the complications record log and the complaints log and discussion at team meetings.

Cleanliness, infection control and hygiene

- The provider had updated its policy in May 2017 on good visibly cleaning practice in clinical areas.
- We noted all areas of the clinic were clean and there were regularly maintained and up to date cleaning schedules including for the treatment rooms.

Surgery

- However, the theatre did not have a dedicated dirty utility; the original identified space within the building contained a washing machine and a table-top steriliser.
- A theatre scrub nurse explained the process for decontamination of reusable medical devices (instruments). They used the theatre sink at the end of the day and then the theatre sink was cleaned down.
- We saw evidence of up to date audits of sterilisation track and trace processes. Staff acknowledged the process for decontamination was a work around for the minor instrumentation used. This was not in line with national good practice guidance. There was no written process in place for this or any assessment undertaken for mitigating the risk of infection.
- The provider did not record surgical site infection rates separately from complications. There had been two complications (these did not relate to surgical site infections) at the clinic during 2016/17 reporting period and these had been managed by treatment at the clinic.
- Nurses and doctors followed the provider's policy for using personal protective clothing (PPE) such as aprons and gloves. They were arms bare below the elbow in keeping with good practice, and wore appropriate theatre scrubs and footwear for surgical procedures.
- Clinical staff cleansed their hands in between patients to reduce risk of infection. There was an up to date hand hygiene policy in place and wash basins were properly stocked with soap and towels.
- However, we noted there were no alcohol gel dispensers or effective hand cleansing information on display. When we returned for the second day of inspection the provider had acquired some laminated posters for wash basin areas.

Environment and equipment

- The clinic was set out over two sites that were adjacent to each other with a minor side road running between them. No other services or businesses used the premises. The manager agreed both sites were restricted for space.
- With the exception of administrative work station cable and wires, the potential hazards of this space restriction were not identified, assessed, managed and monitored for risk. For example, our movement was restricted by two pieces of equipment therefore presenting as a hazard.
- The service was set out over two buildings and the theatre was situated in one building with consultation rooms and the main reception area in the other building.
- The clinic kept one defibrillator kit on site and this was in the reception area of the building in which the theatre was situated. This was a standard public issue kit that could be used by any person. Beauty therapy staff told us nursing staff were responsible for checking this equipment. However, nursing staff told us they were not sure and could not demonstrate how often they checked this equipment.
- There was a procedure in place, including a risk assessment that confirmed the equipment could be reached and returned to the other building if necessary within four minutes. However, this included staff crossing the road between the buildings near a junction. This had not been specifically addressed in the assessment in calculating the time it could take to safely fetch it.
- The theatre contained appropriate equipment, including to enable patient monitoring. There was a system in place for checking equipment.
- The service kept a folder containing information about the equipment and maintenance agreements in place. However, we found there were no records of 2016/2017 agreements, or for any 2017 service level agreements in place.
- There were no up to date records for equipment maintenance or water quality test records, the last water quality test on record was in 2015. The sharps contract for clinical waste disposal was dated 2014.
- The Control of Substances Hazardous to Health Regulations 2002 COSSH records, with the exception of one product, had not been updated or reviewed since 2006.

Medicines

Surgery was the main service and medicines information also relates to other services.

- Medications were stored in a locked cabinet in a room at the rear of the reception area; this area was restricted to members of the public. There was a drug fridge within this cupboard, which contained medication requiring to be stored at 5 degrees celsius (c) or less.

- Medication stored outside of the fridge should be maintained at 25 degrees celsius or less. There was no system in place to regularly check the room temperature.

Records

- The consultant surgeon did not transport patient notes off the premises.
- We noted from patients' records that surgery pre-assessments were undertaken by the consultant surgeon. These included risk assessments.
- There was a detailed theatre list displayed that had been created by the consultant surgeon and contained detailed information about the proposed surgery for each patient.
- There was no theatre register available to review and staff confirmed that they did not keep a theatre log for surgical procedures.
- Pre-operative assessments were recorded in each set of the patient records we reviewed.
- The provider reported no patients were seen in the period April 2016 to March 2017 without all their relevant medical records being available.
- The manager told us the service did not use any 'apps' or other digital facilities for patients. The IT system was protected by firewalls and antivirus software. The provider was in the process of moving to a cloud based IT solution to further enhance security. All electronically stored patient notes were backed up and password protected.

Safeguarding

- There were no safeguarding concerns reported to CQC in the reporting period (April 2016 to March 2017) and the provider confirmed none had been raised within or about the service.
- The registered manager was on record as the location lead for safeguarding. We made a requirement at our last inspection in 2014 that the provider must have a safeguarding children and safeguarding adults policy and procedure available to staff, and that it included contact numbers to the local authority and adult safeguarding board. The provider sent us an action plan of how it intended to comply.
- The registered manager was the only person who had received safeguarding training for both adults and children. Other staff had received no training. The manager told us following the inspection that they would procure this training for all staff, at the appropriate level.
- When we visited we found it was a clinical nurse specialist who managed this and reported to the registered manager. The file containing safeguarding information, policy, procedure and local authority contacts was in the keeping of the nurse and the registered manager could not locate it for us. We found it ourselves as the nurse was in theatre at the time.

Mandatory training

- The provider kept no mandatory staff training records and told us there was no programme of mandatory training for staff, such as hygiene and control of infection, and fire safety. The clinical nurse specialist did keep up to date with basic life support training.

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

- We observed surgical procedures taking place. The theatre team did not demonstrate use of World Health Organisation (WHO) checklist and use of Five Steps to Safer Surgery procedure and the initial swab and instrument count. Following the inspection the provider gave us evidence that this was now in use.
- There was no formal process in place, and the provider had no policy for this.
- We asked staff about this, they told us they did not complete WHO check lists as patients and the theatre list were discussed during a team meeting prior to surgery. This discussion included any important information needed about the surgery.
- We noted that a theatre scrub nurse did not undertake a swab or needle check on closing of first side or on completion of the surgery at either skin closure or at the end of the procedure.
- The consultant surgeon acknowledged there was no justification for this lack of safe procedure in the theatre and acknowledged it was routine in their work at other services. They said they would ensure that a safer surgery checklist was implemented at the clinic immediately.
- Aftercare information was given to patients as part of the consent document and pre-operative letter. This

included information about the out of hours' service operated by the consultant and manager at the clinic and the stand in arrangement through an independent hospital.
- There were no service level agreements in place for emergency transfer of patients to acute local services. The manager was a registered medical practitioner and was always on-site when the clinic was open including surgery list days.
- Patients would be stabilised and taken to acute emergency services by paramedics through the 999 service if necessary. There had been no transfers made to acute services in the reporting period 2016/17.
- The resuscitation policy was in use for the automated external defibrillator (AED) that could be used by anyone if necessary and a 999 call. The first aider identified staff on the team that had received training in use of AEDs and annually updated basic life support training.
- The theatre team consisted of the surgeon, a scrub nurse and a runner. Two members of staff were present to support the surgeon. A registered nurse (RGN) acted as a scrub nurse and a beauty therapist acted the theatre runner.
- We observed vital signs monitoring was in place and records made during the surgery. There was no 'early warning score' (EWS) system in place to pathway a response to any deterioration in a patient's condition.
- The manager told us if the RGN was not available or on holiday then the surgery would be undertaken at a local private hospital.
- There was a small recovery room adjacent to the theatre where patients were monitored.
- The provider kept a record of surgical complications and these were discussed at team meetings. Six were listed for the period 2016/2017 to the date of our inspection visit. Two of these were from mini facelift procedures that took place at the clinic both involving haematoma. The others were from procedures undertaken through the provider's clinic services at local independent hospitals.
- The manager told us there were no formal systems in place for access / referral for appropriate psychological assessment if necessary. Clinic staff 'tried' to encourage patients to self-refer when they had been declined the treatment they wanted.
- We noted from patient records the consultant surgeon provided very detailed letters to any other professionals involved in the patient's care for other issues, including risk assessments for the proposed procedure. This could include the patient's GP if they wished.

Nursing and support staffing

- Surgery was supported by a clinical nurse specialist who was the RGN that worked at the service. Non-clinical staff undertook supporting roles in theatre.
- Staff confirmed that the clinic did not use agency or bank staff. Surgical services relied heavily on the provider's small clinical team, which was led by the consultant surgeon. The provider's policy was to arrange for the surgery to take place elsewhere if the whole team was not available at the clinic.

Medical staffing

- The service was owned, run and staffed by a consultant surgeon and a registered medical practitioner. The consultant surgeon undertook all the surgical procedures.
- Out of hours' cover was within an agreement with a local independent hospital, which provided a named stand in consultant.

Emergency awareness and training

- There was a fire safety risk assessment in place but it did not address the specifics of the buildings the service was using. There were no fire evacuation tests or evacuation plans. Staff had not undertaken any emergency awareness training.
- The clinic was set out over the ground floors of two buildings adjacent to each other on a small junction.
- Both clinic buildings were protected by secure access arrangements. There was no telephone line contact between the buildings but we saw a walkie-talkie system in place and staff told us this assured their safety and enabled contact in any emergency.
- There was no specific major incident plan or procedures in place for loss of power or utility.

Are surgery services effective?

We regulate cosmetic surgery services but we do not currently have a legal duty to **rate** them when they are provided as a single specialty service.

Surgery

Evidence-based care and treatment

- There were few policies available to staff to consult and none that reflected any professional guidance that could be based on NICE/Royal College guidelines. Neither the registered manager nor clinical nurse specialist were aware of Royal College of Surgeons (RCS) guidelines and referred us to the consultant surgeon.
- There was no policy, procedure, pathway or audit in place for sepsis.
- Due to the small size of the service the provider undertook no formal audit activity or benchmarking national or local services provided at this location.
- Staff told us patient theatre lists were discussed at the team meeting prior to surgery day. These meetings discussed each patient's needs and surgical assessment outcomes. These meetings were not minuted so we could not review any.

Pain relief

- We noted pre-operative assessments for post-operative pain relief on patient's records.
- We observed constant communication between the patient and surgeon and scrub nurse about comfort during the surgical procedure. Patients we spoke with told us their pain was well managed.

Patient outcomes

- We found complaints and dissatisfaction were the only measure of the effectiveness of the procedure used by the provider.
- The provider told us, "Performance in aesthetic medicine is difficult to measure objectively. Outcomes are measured by patient satisfaction. We try to get patient feedback wherever possible but the best reflection of satisfaction is probably in terms of repeat customers and word of mouth recommendation."
- The Royal College of Surgeons advises recording the patient outcome (patient reported outcome measures PROM's) is particularly important within cosmetic surgery, where the whole purpose of treatment is to address patient-related concerns, as opposed to addressing injury or disease.
- A PROM is a series of questions that patients are asked in order to gauge their views on their own health. They are the patient's own assessment of their health and health-related quality of life. Collection of PROMS enables quality improvement and participation in national bench marking.
- The provider was not developing a readiness to collect PROMS although they apply to blepharoplasty (eyelid surgery) and rhytidectomy (face-lift) and these procedures were carried out at the clinic.
- The provider did not participate in any national clinical outcome audits but did contribute to the BAAPS annual audit of number and types of procedures undertaken and returns to surgery.
- We saw a copy of the audit submitted to BAAPS by the consultant for 2016. It showed the number of operations carried out during April 2016 and March 2017, broken down by type of procedure and gender. The number of complications per procedure and gender were also reported.
- Complications and patient complaints were recorded and the manager told us this was how patient outcomes and follow up on long-term results were assessed. This was not a robust system to effectively gauge clinical outcomes for patients.
- We saw the records of complications for procedures carried out at the clinic during April 2016 to July 2017. Two were recorded for that period and both concerned haematoma post mini face-lift surgery.
- The provider told us the surgery carried out at the clinic was done under local anaesthesia and were minor procedures and therefore an unplanned return virtually never occurs.
- We noted unplanned return rates were not recorded except as surgical complications.

Competent staff

- The consultant surgeon was a member of the (BAAPS). All BAAPS Members are trained Plastic Surgeons on the General Medical Council specialist register. They were also a member of the British Association of Plastic, Reconstructive and Aesthetic Surgeons (BAPRAS). The manager and the secretarial staff confirmed there were systems in place to capture data for the consultant surgeon's annual appraisal.
- The manager told us the clinic held bi-monthly team meetings and a fortnightly routine meeting. These offered opportunities for group supervision and group support.

- On an individual basis, the provider operated an open door policy with staff and staff confirmed this. Individual appraisal and feedback had recently been changed from twice yearly to annually.
- The clinical nurse specialist was an aesthetics nurse, an advanced scrub practitioner and had undertaken nurse revalidation during 2017.

Multidisciplinary working

- We noted from patient records the consultant surgeon provided very detailed letters to any other professionals involved in the patient's care for other issues, including risk assessments for the proposed procedure. This could include the patient's GP if they wished.
- The provider held weekly meetings for the whole staff group. These were a forum for day-to-day business matters and troubleshooting, for example hospital listing clashes. The manager kept no records of these meeting but we saw some examples of follow on action correspondence with staff through e-mail.
- The provider did not work with any psychiatric services. It declined to provide treatment to any prospective patient it believed could not realistically benefit from surgical procedures.

Access to information

- Discharge information was provided to the patient to share with their GP.
- Clinical staff had access to patient paper records and on electronic systems. Paper records were locked away in cabinets and electronic records were password protected.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- We noted from patient records and observation of treatment that the consultant cosmetic surgeon explained the consent process to each patient. There was a very detailed and lengthy consent document in place that the patient was provided at the initial consultation stage.
- This explained treatment outcomes and complications and was designed to inform patients fully in order to support their expectations of the surgery outcome. The surgeon told us they did not book any patient for surgery unless the patient returned a signed copy of this consent.
- The consultant surgeon wrote a lengthy letter to patients following the initial consultation that explained the surgery in detail to ensure the patient had full information of the procedure that they were electing to have undertaken.
- The provider's policy was that no surgical procedure would be booked for a patient until at least two weeks after their initial consultation. This gave patient's time to reconsider.
- There were no arrangements in place to formally address mental capacity. The owner, who was a doctor, had practised psychiatry within the NHS earlier in their career. They told us the clinic did not see patients with compromised capacity and would advise patients to discuss surgery first with their GP.
- The provider had a 2017 policy and procedure in place to support consent to treatment. There was also a consent policy in place dated 2014 due for review in 2018 that included capacity. However, we noted the supporting legislation set out was the Incapacity (Scotland) Act 2000 and this was not helpful for staff working in England.

Are surgery services caring?

We regulate cosmetic surgery services but we do not currently have a legal duty to **rate** them when they are provided as a single specialty service.

Compassionate care

- We observed a patient in theatre undergoing surgery by local anaesthetic. All the staff present were very courteous and respectful towards the patient.
- The surgeon and other theatre staff gave the patient constant reassurance and asked them to report any pain or discomfort. Staff treated the patient as part of the operating team, gaining permission and providing explanations throughout surgery.
- Staff provided physical support and help during change of positions and the surgeon constantly reassured and updated the patient to the stages of the operation.
- The provider told us patients had access to a feedback box where they could post comments. In addition, the service also directly approached patients asking for written feedback.
- All negative feedback was logged as complaints and discussed at the team meetings. We saw the feedback

box prominently displayed at the reception desk with cards and a pen. However, we noted there were no completed cards in the box. The provider agreed uptake was always low. We also saw the log of complaints and negative feedback.
- The service did not conduct patient experience surveys of surgery and the clinic had no inpatient services to survey.

Understanding and involvement of patients and those close to them

See information under this sub-heading in the Outpatients section

Emotional support

See information under this sub-heading in the Outpatients section

Are surgery services responsive?

We regulate cosmetic surgery services but we do not currently have a legal duty to **rate** them when they are provided as a single specialty service

Service planning and delivery to meet the needs of local people

- The service did not treat NHS patients and therefore had no contracts with local clinical commissioning groups (CCGs).
- Minor surgical procedures such as a one stitch face lift were carried out at the clinic.
- Patients were offered a range of flexible options for consultation and surgery follow up clinics.

Access and flow

- The manager told us they aimed to offer consultation appointments within two weeks of the patient's first contact with the service. There was no evidence to show that waiting times, delays and cancellations were minimal and managed appropriately. There was no formal arrangement for managing patient flow. The provider assured us 'these issues are practically irrelevant in private aesthetic practices'**.**
- They told us that because they were a small service they could 'tell by eye' if the flow rate for first consultation, treatment and follow up appointments was on track for a patient.
- We reviewed a patient file for surgical procedures and noted they moved from first contact with the service through to procedure in a timely way and at a pace they told us that suited them.
- The service did not offer unplanned surgery. If a patient required this they would be directed to the local NHS acute service. The provider told us' unplanned/ emergency surgery simply doesn't occur within the range of treatment we provide'.
- The consultant surgeon wrote very detailed letters to other practitioners involved with the patient's care where there were any complexities in their health condition.
- The provider did not formally audit cancellations. They said it provided no useful purpose for them.

Meeting people's individual needs

- The manager told us the clinic did not provide a service for patients with complex needs or vulnerabilities. They did decline to carry out procedures where the cost to the patient would exceed the likely benefit or fail to meet their expectations. We saw an example of this from a prospective patient's record.

Learning from complaints and concerns

- A notice encouraging patient feedback, with cards and a box were prominently sited at the main reception desk.
- The provider had a procedure in place for responding to complaints including target response times to different stages.
- However, we noted the complaint procedure was out of date (dated in 2008), referred to a previous regulatory body and there was no review or update since that time. It did not, for example, refer to the Duty of Candour requirement and therefore there was no prompt or trigger point for activating this duty.
- From April 2016 to July 2017 the service received two complaints. One was the outcome of a mini facelift and the second was about non-refund of fees when the patient cancelled a surgical procedure. The CQC did not receive any complaints in this period for treatment carried out at this registered location.
- We followed the course of two complaints through the records. We saw from records the provider responded in a timely way and in detail to each complainant and

included copies of consent forms and the clinician's consultation notes. However, without an independent review stage, complainants were 'cut off' if they remained unsatisfied with the provider's response.
- No complaints were referred to or ISCAS (Independent Healthcare Sector Complaints Adjudication Service) and the service did not subscribe to ISCAS or other independent adjudication services. This meant there was no stage three independent reviews in the provider's complaint process and this reduced the opportunities for the service to learn from feedback.
- We saw the log of complaints and negative feedback. All negative feedback was logged as a complaint and records showed these were also discussed at the team meetings for learning and improvement.

Are surgery services well-led?

We regulate cosmetic surgery services but we do not currently have a legal duty to **rate** them when they are provided as a single specialty service

Leadership / culture of service related to this core service

- The service was led by the registered manager, a registered medical practitioner who was also the provider and an owner of the service. They were in day-to-day operational control of the service and worked as a clinician within the service. They were supported on a day-by-day basis by a specialist nurse practitioner.
- Staff spoke highly of the support they received from the manager, specialist nurse and the consultant surgeon. Many staff had worked at the clinic for some years. They said they felt 'part of the business'.
- However, the manager told us they were not very good at the management side of running the service. They undertook to look into employing a staff member that would be experienced in keeping systems records required by regulatory bodies up to date.
- Staff confirmed weekly meetings took place but there was no record of these except some references to follow up action in email to staff.

Vision and strategy for this core service

- The provider told us, "The practice is doctor led to ensure it operates the business along a medical model and that our clients are our patients to whom we owe a medical duty of care. Our aim is to operate a service that is patient centred rather than sales centred."
- The service did not provide preventative invasive interventions. We saw examples from patient files of patients being declined procedures because their outcome expectations were unrealistic. The registered manager told us they tried to refer some patients to therapy providers.
- The provider did not engage with credit transactions to pay for treatment for both ethical and practical reasons.

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

- Effective governance systems were not in place. We were not assured that there was sufficient recognition, assessment, and mitigation of risks to patient safety. For example, many records required by regulatory bodies such as for the COSSH had not been updated since 2006.
- Most policy and procedures on file were 'off the peg' and dated 2010 when the provider registered with the CQC. Very little updating had been done to take account of progressing practice or changing legislation. For example, the fire safety risk assessment was generic, there was no Duty of Candour process in place and the fit and proper person's requirement had not been addressed.
- In many respects, the provider could not assure us of its grasp on governance, and its regulatory responsibilities and was not able to demonstrate effective governance and quality of care monitoring systems were in place.
- For example, the adverse events and near misses policy dated 2008 (with no review or update since), did not make reference of the requirement for the provider to notify the CQC about particular adverse events. The disciplinary procedure and workers concerns procedures did not refer to whistle blowing or to Duty of Candour. The consent policy in place set out as supporting legislation the Incapacity (Scotland) Act 2000 and not the English Mental Capacity Act 2005 with its relevant code of practice.
- The provider did not keep a risk register for the service. This meant managers were not systematically sighted on monitoring identified risks such as, staff crossing the

road between the two units throughout the day and the decontamination of surgical instruments workaround put in place. It also meant there was no robust process for staff to report emerging risks.
- We asked the provider to tell us what measures it had put in place to mitigate the risks we pointed out during our inspection visit but it did not respond within the timeframe we set out.
- The provider told us complaints and complications were recurrent agenda items at team and business meetings. We found there were no other formal governance arrangements within the service.
- No proper arrangements were in place to support the use of laser equipment as required by the Control of Artificial Optical Radiation at Work Regulations 2010 and the registered manager told us they had not realised for example, that annual service contract was necessary.
- Equipment maintenance and servicing systems were not robust with much of the available documentation out of date. The manager could give us no assurance about where the day-to-day responsibility for making these arrangements and keeping records up to date lay.
- The consultant surgeon was a member of BAAPS and registered on the Royal College of Surgeons specialisms register. We noted they submitted performance data annually to its national audit.
- The provider kept up to date appropriate information on the fitness of all staff to be employed at the clinic including enhanced DBS certificates, identification and references and evidence of qualifications.
- However, there were no arrangements in place to formally address the Fit and Proper Persons requirement for persons 'directing' the service. This meant some documents and information for 'directors' were not available such as evidence of qualifications.
- The provider confirmed it had insurance cover for all procedures and treatments it offered. The consultant surgeon was covered under the PLASTICIS Scheme, which is endorsed by BAAPS. The rest of the staff were covered by separate clinic insurance.

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

- There was a system in place to gather patients' feedback and comments. This was a feedback box at reception and by directly approaching patients asking for written feedback. The provider agreed uptake was always low.
- Patient feedback forms were a standing agenda item at clinic team meetings. We noted however, for the sample we looked at February, May and June 2017 the meetings recorded.
- Patients could also provide feedback using the provider's website.
- Feedback was that some patients found the positioning photography booth behind the reception counter was not private. This resulted in the booths position being altered slightly so patients being photographed did not directly face the waiting room area.

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

- At the time of our inspection, the manager reported the service intended to recruit an additional surgeon in time.

Outpatients and diagnostic imaging

Safe	
Effective	
Caring	
Responsive	
Well-led	

Are outpatients and diagnostic imaging services safe?

Safe means the services protect you from abuse and avoidable harm.

We regulate cosmetic surgery services but we do not currently have a legal duty to **rate** them when they are provided as a single specialty service

Incidents

See information under this sub-heading in the Surgery section.

Cleanliness, infection control and hygiene

- Treatment rooms were clean and clutter free to enable effective cleaning. The laser treatment room was used only once each week and cleaned immediately before use. There was signage on the door indicating no entry without wearing shoe covers.

Environment and equipment

See information under this sub-heading in the Surgery section.

- There were two surgical lasers on site (Soprano XL Blue and DEK CO2 laser). The manager told us they operated these for outpatient treatments.
- However, there was no register with the laser. Staff confirmed that they did not keep a theatre log for laser surgery.
- The manager was not able to provide up to date information in respect of the requirements to have a Laser Protection Advisor retained for help and support during the use of laser by medical professionals, as it should for medical lasers in line with the 2014 Laser Radiation Guidance. The manager confirmed the service did not retain a laser protection advisor.
- The last laser protection advisory report available was dated 2010 and the last service level agreement for the lasers was dated 2014. Since our inspection visit the manager has made contact with a laser protection advisor to commission their service.

Medicines

See information under this sub-heading in the Surgery section.

- We noted the emergency epi-pen pre-loaded syringe that was stored in a fridge had expired in April 2016. Other medications, mainly topical treatments, were stored in a large lockable cupboard in the nurse's room. Two of these topical medicines had also passed their efficacy date (Fuciden in 2016 and Terracotrill in December 2016).
- A clinical nurse specialist agreed they were out of date but could offer no explanation nor was able to describe the system in place for auditing medications. They undertook to remove them immediately.

Records

See information under this sub-heading in the Surgery section.

Safeguarding

See information under this sub-heading in the Surgery section.

Mandatory training

See information under this sub-heading in the Surgery section.

Nursing staffing

- Outpatients services were supported by a clinical nurse specialist.

Medical staffing

Outpatients and diagnostic imaging

- Outpatient services were supported by cosmetic surgery consultant, a registered medical practitioner and hair transplant surgeon and dermatologist.

Emergency awareness and training

See information under this sub-heading in the Surgery section

- The registered manager, who was always on site when the clinic was open, was a registered medical practitioner and could respond to medical emergencies. The patient would be stabilised if necessary until the emergency services arrived.

Are outpatients and diagnostic imaging services effective?

Effective means that your care, treatment and support achieves good outcomes, helps you to maintain quality of life and is based on the best available evidence.

We regulate cosmetic surgery services but we do not currently have a legal duty to **rate** them when they are provided as a single specialty service

Evidence-based care and treatment

See information under this sub-heading in the Surgery section

Patient outcomes

See information under this sub-heading in the Surgery section

Competent staff

See information under this sub-heading in the Surgery section

- We were told staff received appropriate training before delivering new treatments and had regular updates, such as an in house Diode laser non-invasive lipolysis by a clinical trainer in May 2017.

Multidisciplinary working

See information under this sub-heading in the Surgery section

Access to information

See information under this sub-heading in the Surgery section

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

See information under this sub-heading in the Surgery section

Are outpatients and diagnostic imaging services caring?

Caring means that staff involve and treat you with compassion, kindness, dignity and respect.

We regulate cosmetic surgery services but we do not currently have a legal duty to **rate** them when they are provided as a single specialty service

Compassionate care

- We spoke with four patients who visited the clinic as outpatients. Patients told us that they were treated with dignity and respect. We observed this in all interactions between staff and patients.
- Staff were kind and caring in their approach. All patients told us that staff were caring.
- The waiting area at the clinic was not confidential. The reception area was exposed to the general waiting area, reception staff and the administration area. We asked patients if they were concerned about confidentiality and privacy in the waiting area. None of the patients saw this as an issue of concern.
- Patients were involved in making decisions about their care and treatment. They were given detailed information the care and treatment they were exploring. They were given the opportunity to discuss expectations and limitations.
- Patients were given the option to take time to think about treatments or to make a decision based on factual information and their own experiences.
- All patients we spoke with were very positive regarding the standard of care they received.
- Information for patients about the service was easy to understand and accessible.
- All patients told us that the staff were friendly and approachable and promoted a relaxed atmosphere.
- One to one consultations and treatments took place in rooms were doors were closed. Each room offered a private space where conversations could not be overheard.

Outpatients and diagnostic imaging

- Curtains were provided in consulting rooms to maintain a patient's privacy and dignity during examinations, investigations and treatments.
- There were sensitive discussions around costs and the range of options that were offered. The clinic did not offer any lending options. This meant that only patients who had access to self-funding were offered treatment.

Understanding and involvement of patients and those close to them

- All patient notes had entries that clearly highlighted patient understanding and, where appropriate, involvement of those close to them.
- There were at least three occasions where patients involved those close to them in their consultations. For example, we observed one young patient was escorted by their parent who provided them with support while discussing treatment at a follow up appointment. The nurse involved everyone in the discussions.
- Only one of the patients we spoke with told us it was their first time using the service. All of the other patients had used the clinic in the past. Some had been using the service for around ten years.

Emotional support

- The clinic encouraged patients to seek counselling for emotional support when it declined to offer the treatment a patient requested for medical or ethical reasons.

Are outpatients and diagnostic imaging services responsive?

Responsive services are organised so that they meet your needs.

We regulate cosmetic surgery services but we do not currently have a legal duty to **rate** them when they are provided as a single specialty service

Service planning and delivery to meet the needs of local people

See information under this sub-heading in the Surgery section

- Patients who required complex cosmetic surgery that was performed by other providers had their initial assessment and follow up appointments at the clinic with the consultant surgeon.

Access and flow

- Patients were offered a range of flexible options for consultation and follow up clinics. One patient told us that they had explored various providers before deciding on CC Kat for their treatment. They based their decision on the expertise, knowledge and flexible options offered.
- Patients were given options to access care and treatment at a time to suit them when possible. The service also offered weekend and early evening appointments.
- One patient told us they were frustrated that there had been a mix up with their appointment time and that they had to wait. Despite this, they were happy with their experience of the service and did not want to complain.

Meeting people's individual needs

- One patient was concerned about their pre-procedure photographs being sent through the post. The receptionist provided alternative options for delivery. For example, the patient had the option to receive their photographs via email or recorded delivery. The patient opted for recorded delivery to avoid the potential for them being lost.
- One patient requested an online consultation to avoid unnecessary travel time and costs. This was agreed based on the nature of the procedure. This was clearly documented in the patient's notes. The patient was very pleased with this flexible option.
- Leaflets were on display about each treatment offered by the service in the reception area.

Learning from complaints and concerns

See information under this sub-heading in the Surgery section

- Patients were given the option to make comments using comment cards and a patient feedback box was in the waiting area. All patients we spoke with told us they did not use the comment cards. One patient told us that

they did not notice there was an option to provide feedback using the comment cards in the waiting room. They would use it now that they realised it was an option

- There were patient testimonials online providing compliments to the clinic and the staff who worked there.
- One patient told us they were aware of the clinic's social media page. They told us they would be concerned about leaving feedback on the social media page, as they would not want people to know that they had surgery and treatments.
- One patient complained about the outcome of their surgery. The consultant dealt with the complaint, clearly outlining the expectations that were discussed in advance of the treatment and the possible outcome. The consultant then went on to offer alternative options to help resolve the concerns about the outcome.

Are outpatients and diagnostic imaging services well-led?

Well-led means that the leadership, management and governance of the organisation make sure it provides high-quality care based on your individual needs, that it encourages learning and innovation, and that it promotes an open and fair culture.

We regulate cosmetic surgery services but we do not currently have a legal duty to **rate** them when they are provided as a single specialty service

Leadership and culture of service

See information under this sub-heading in the Surgery section

Vision and strategy for this core service

See information under this sub-heading in the Surgery section

Governance, risk management and quality measurement

See information under this sub-heading in the Surgery section

Public and staff engagement

See information under this sub-heading in the Surgery section

- The provider told us it encouraged staff to upgrade their skills and to take on greater responsibilities (and rewards). Within the small team, it had managed to develop a culture of pride and ownership in the company. In turn, future roles were being identified as the business evolved. Staff we spoke with confirmed they were offered rewards and felt engaged with the service.

Innovation, improvement and sustainability

- The manager told us the service intended to have a Consultant Dermatologist in regular attendance at the clinic in the near future along with expansion of the non-medical staff group in time.

Outstanding practice and areas for improvement

Areas for improvement

Action the provider MUST take to improve

- The provider must put in place an effective system for ongoing identification mitigation and monitoring of all risks within the service.
- The provider must ensure fire risk assessments are in place for each location, appropriate emergency procedures are in place for each location and ensure staff have received training in these.
- The provider must ensure a system fit for purpose is implemented to promote patient safety during surgical procedures. For example, ensuring instrument counts are undertaken and patient identification is undertaken appropriately.
- The provider must ensure all staff have received the required level of mandatory training and contemporaneous records of these are kept.
- The provider must ensure a full assessment of the dirty utility arrangement in place is undertaken by an IPC expert.
- The provider must ensure access to a laser protection advisor is in place at all times.
- The provider must review the arrangements for accessing the defibrillator in an emergency, taking into account staff have to cross a road if it was required in one of the buildings.
- The provider must ensure an appropriate mental capacity policy and procedure that addresses the Mental Capacity Act 2005 and Code of Practice are in place and staff are aware of it.
- The provider must put in place a system to ensure consultants offering services have practising privilege's to protect uses of the service.
- The provider must ensure processes are in place to formally address the Fit and Proper Persons requirement for persons 'directing' the service including all of the documents and information about 'directors' of the service required by Regulation 5 of the HSCA 2008 (Regulated Activities) Regulations 2014.
- The provider must ensure an effective procedure is in place for making appropriate notifications to the CQC.
- The provider must ensure they have suitable processes in place to comply with the requirements of the Duty of Candour Regulation.

Action the provider SHOULD take to improve

- The provider should ensure a system is in place to demonstrate the defibrillator kit is regularly checked and review the risk assessment for its effective accessibility to services in the adjacent building to which it is kept.
- The provider should ensure that equipment maintenance and servicing systems are more robust and update the available documentation.
- The provider should ensure that major incident plan or procedures are put in in place for loss of power or utility.
- The provider should ensure a suitable process is in place for managing medication fridge temperature checks.
- The provider should ensure all health and safety records are up to date.

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 5 HSCA (RA) Regulations 2014 Fit and proper persons: directors **Regulation 5 Fit and Proper Persons** 1. This regulation applies where a service provider is a body other than a partnership. 2. Unless the individual satisfies all the requirements set out in paragraph (3), a service provider must not appoint or have in place an individual— A. as a director of the service provider, or B. performing the functions of, or functions equivalent or similar to the functions of a director. **The requirements referred to in** 1. paragraph (2) are that— A. the individual is of good character, B. the individual has the qualifications, competence, skills and experience which are necessary for the relevant office or position or the work for which they are employed, C. the individual is able by reason of their health, after reasonable adjustments are made, of properly performing tasks which are intrinsic to the office or position for which they are appointed or to the work for which they are employed, 1. A. the individual has not been responsible for, been privy to, contributed to or facilitated any serious misconduct or mismanagement (whether unlawful or not) in the course of carrying on a regulated activity or providing a service elsewhere which, if provided in England, would be a regulated activity, and B. none of the grounds of unfitness specified in Part 1 of Schedule 4 apply to the individual.

This section is primarily information for the provider

Requirement notices

2. In assessing an individual's character for the purposes of paragraph (3)(a), the matters considered must include those listed in Part 2 of Schedule 4.
3. The following information must be available to be supplied to the Commission in relation to each individual who holds an office or position referred to in paragraph (2)(a) or —
   A. the information specified in Schedule 3, and
   B. such other information as is required to be kept by the service provider under any enactment which is relevant to that individual.
4. Where an individual who holds an office or position referred to in paragraph (2)(a) or (b) no longer meets the requirements in paragraph (3), the service provider must—
   A. take such action as is necessary and proportionate to ensure that the office or position in question is held by an individual who meets such requirements, and
   B. if the individual is a health care professional, social worker or other professional registered with a health care or social care regulator, inform the regulator in question.

How the Regulation was not met

There were no processes in place to formally address the Fit and Proper Persons requirement for persons 'directing' the service.

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** 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

This section is primarily information for the provider

Requirement notices

(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;

How the regulation was not met

There was no access to a laser protection advisor.

A full assessment of the dirty utility arrangement in place had not been undertaken by an IPC expert.

The arrangements in place for the defibrillator were not robust.

No appropriate mental capacity policy and procedure that addresses the MCA 2005 and code of practice were in place.

There was no system in place to ensure consultants offering services had practising privilege's to protect uses of the service.

Regulation 12 (1)(2)(a)(b)(c)(e)(h)(i)

Regulated activity	Regulation
Surgical procedures Treatment of disease, disorder or injury	Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment

Regulation 13: Safeguarding service users from abuse and improper treatment

13.—(1) Service users must be protected from abuse and improper treatment in accordance with this regulation.

(2) Systems and processes must be established and operated effectively to prevent abuse of service users.

How the regulation was not met

Not all staff had received training to ensure the safety of both adults and children, who visited the premises.

Staff need to have the ability to recognise abuse and understand what safeguards they need to undertake.

This section is primarily information for the provider

Requirement notices

Regulated activity	Regulation
Surgical procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance Regulation 17: Good governance 17.—(1) Systems or processes must be established and operated effectively to ensure compliance with the requirements in this Part. (a) assess, monitor and improve the quality and safety of the services provided in the carrying on of the regulated activity (including the quality of the experience of service users in receiving those services); (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; **How the regulation was not being met** No notifications have been sent to the care quality commission in line with regulatory requirements and there was no system in place to do so. The procedures for identifying and managing risk was not sufficiently robust to support the service There was a lack of governance systems and processes, such as policies and procedures and audit of existing systems to support the service.

Regulated activity	Regulation
	Regulation 20 HSCA (RA) Regulations 2014 Duty of candour Regulation 20: Duty of candour 20.— (1) Registered persons must act in an open and transparent way with relevant persons in relation to care and treatment provided to service users in carrying on a regulated activity.

This section is primarily information for the provider

Requirement notices

(2) As soon as reasonably practicable after becoming aware that a notifiable safety incident has occurred a registered person must—

(a) notify the relevant person that the incident has occurred in accordance with paragraph (3), and

(b) provide reasonable support to the relevant person in relation to the incident, including when giving such notification.

(3) The notification to be given under paragraph (2)(a) must—

(a) be given in person by one or more representatives of the registered person,

(b) provide an account, which to the best of the registered person's knowledge is true, of all the facts the registered person knows about the incident as at the date of the notification,

(c) advise the relevant person what further enquiries into the incident the registered person believes are appropriate,

(d) include an apology, and

(e) be recorded in a written record which is kept securely by the registered person.

(4) The notification given under paragraph (2)(a) must be followed by a written notification given or sent to the relevant person containing—

(a) the information provided under paragraph (3)(b),

(b) details of any enquiries to be undertaken in accordance with paragraph (3)(c),

(c) the results of any further enquiries into the incident, and

(d) an apology.

(5) But if the relevant person cannot be contacted in person or declines to speak to the representative of the registered person —

(a) paragraphs (2) to (4) are not to apply, and

(b) a written record is to be kept of attempts to contact or to speak to the relevant person.

This section is primarily information for the provider

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(6) The registered provider must keep a copy of all correspondence with the relevant person under paragraph (4).

(7) In this regulation—

"apology" means an expression of sorrow or regret in respect of a notifiable safety incident;

"moderate harm" means—

(a) harm that requires a moderate increase in treatment, and

(b) significant, but not permanent, harm;

"moderate increase in treatment" means an unplanned return to surgery, an unplanned re-admission, a prolonged episode of care, extra time in hospital or as an outpatient, cancelling of treatment, or transfer to another treatment area (such as intensive care);

"notifiable safety incident" has the meaning given in paragraphs (8) and (9);

"prolonged pain" means pain which a service user has experienced, or is likely to experience, for a continuous period of at least 28 days;

"prolonged psychological harm" means psychological harm which a service user has experienced, or is likely to experience, for a continuous period of at least 28 days;

"relevant person" means the service user or, in the following circumstances, a person lawfully acting on their behalf—

(a) on the death of the service user,

(b) where the service user is under 16 and not competent to make a decision in relation to their care or treatment, or

(c) where the service user is 16 or over and lacks capacity in relation to the matter;

"severe harm" means a permanent lessening of bodily, sensory, motor, physiologic or intellectual functions, including removal of the wrong limb or organ or brain damage, that is related directly to the incident and not related to the natural course of the service user's illness or underlying condition.

This section is primarily information for the provider

Requirement notices

(9) In relation to any other registered person, "notifiable safety incident" means any unintended or unexpected incident that occurred in respect of a service user during the provision of a regulated activity that, in the reasonable opinion of a health care professional—

(a) appears to have resulted in—

(i.) the death of the service user, where the death relates directly to the incident rather than to the natural course of the service user's illness or underlying condition,

(ii.) an impairment of the sensory, motor or intellectual functions of the service user which has lasted, or is likely to last, for a continuous period of at least 28 days,

(iii.) changes to the structure of the service user's body,

(iv.) the service user experiencing prolonged pain or prolonged psychological harm, or

(v.) the shortening of the life expectancy of the service user; or

(b) requires treatment by a health care professional in order to prevent—

(i.) the death of the service user, or

(ii.) any injury to the service user which, if left untreated, would lead to one or more of the outcomes mentioned in sub-paragraph (a).

How the provider was not meeting this regulation

There were no Duty of Candour policy or process in place.