

CC Kat Aesthetics Limited

CC Kat Aesthetics

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

Requires Improvement



Are services safe?

Requires Improvement



Are services well-led?

Requires Improvement



Summary of findings

Overall summary

We inspected the cosmetic surgery service provided by C C Kat Aesthetics Limited because we received information giving us concerns about the safety and quality of the services.

We reviewed the service against the key questions of safe and well led. We did not inspect the service against the key questions of effective, caring or responsive during this inspection as our concerns did not relate to these key questions.

Our rating of C C Kat Aesthetics stayed the same. We rated it as requires improvement because:

- The service did not always ensure medicines were safely stored and in date. Staff did not always use equipment and control measures to protect patients, themselves and others from infection. Staff did not always manage clinical waste well. The service did not always sufficiently monitor patient outcomes to ensure they could identify and mitigate concerns in a timely way.
- The governance arrangements for the service were not always robust. The service had not addressed all concerns we had raised at our last inspection. The service's risk register did not include all the main risks to the service.

However:

- The service had enough staff to care for patients and keep them safe. Staff had training in key skills, understood how to protect patients from abuse, and managed safety well. Staff assessed risks to patients, acted on them and kept good care records. The service learned lessons from incidents. Staff collected safety information and used it to improve the service.
- Leaders supported staff to develop their skills. The service had reliable information systems. Staff understood the service's vision and values, and how to apply them in their work. Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. Staff were clear about their roles and accountabilities. The service engaged well with patients to plan and manage services and all staff were committed to improving services continually.

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Surgery	Requires Improvement 	

Summary of findings

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Summary of this inspection

Background to CC Kat Aesthetics

C C Kat Aesthetics is operated by C C Kat Aesthetics Limited. This location opened in February 2019 and had previously operated from another location in Birmingham since 2008. It is in Birmingham, West Midlands and mainly serves the Birmingham and West Midlands area. It also accepts patient referrals from outside this area.

The service provides day case cosmetic surgery to self-funding patients aged 18 years and over.

The location has had a registered manager in post since 2010. The clinic manager was currently in the process of submitting their application to the Care Quality Commission to become the registered manager for the service.

The service is a small service mainly specialising in cosmetic surgery. The service has a small team of staff that work across both surgery and outpatient services. C C Kat Aesthetics offers on-site services ranging from skincare consultation, skin treatments, injectable aesthetic treatments, laser treatments to a full range of cosmetic surgery procedures. The service also has surgeons who have practising privileges to conduct orthopaedic and obstetric and gynaecology procedures.

We did not inspect cosmetic procedures such as injectable aesthetic treatments and laser hair removal as these services are not regulated by the Care Quality Commission.

The service has a dedicated surgical suite with admission room, operating theatre and recovery room. The service has no overnight beds. The service has two floors and has a small car park at the back of the premises.

We reviewed the service against the key questions of safe and well led. We did not inspect the key questions of effective, caring or responsive during this inspection as our safety and quality concerns about the service did not relate to these key questions.

We spoke with eight members of staff at all levels.

During the inspection, we reviewed 10 sets of patient records. We also reviewed information about the service including performance data, meeting minutes and policies.

Activity:

The service was shut from 23 March 2020 to 1 June 2020 due to COVID-19.

From September 2019 to October 2020, the service had conducted a total of 291 surgical procedures. Of these, 136 procedures had been conducted using conscious sedation since this service started in February 2020. The remaining 155 procedures were performed under local anaesthesia.

Breast enlargement was the most regularly performed surgery under conscious sedation. There had been 53 of these procedures performed from March 2020 to September 2020.

Track record on safety for the last 12 months:

Summary of this inspection

- Zero never events
- 10 clinical incidents
- Three complaints

No services were accredited by a national body.

Services provided at the clinic under service level agreement:

- Clinical and non-clinical waste removal
- Maintenance of medical equipment
- Air conditioning and theatre ventilation
- Decontamination of equipment
- Fire-related equipment

How we carried out this inspection

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>.

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:

We told the service that it must take action to bring services into line with regulation 12 legal requirements.

- The service must ensure all staff comply with having their arms bare below their elbows. (Regulation 12).
- The service must ensure the dressing room has a dedicated handwashing sink. (Regulation 12).
- The service must ensure waste management is handled appropriately in accordance with best practice guidance. (Regulation 12).

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

- The service should ensure staff complete sepsis training every year. (Regulation 12)
- The service should ensure the mandatory training matrix is fully and accurately completed. (Regulation 12).
- The service should ensure medicines are stored safely. (Regulation 12).

Summary of this inspection

The regulatory action section at the end of this report details the legal requirements the service did not meet.

Our findings

Overview of ratings

Our ratings for this location are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Surgery	Requires Improvement	Not inspected	Not inspected	Not inspected	Requires Improvement	Requires Improvement
Overall	Requires Improvement	Not inspected	Not inspected	Not inspected	Requires Improvement	Requires Improvement

Surgery

Safe

Requires Improvement 

Well-led

Requires Improvement 

Are Surgery safe?

Requires Improvement 

Our rating of safe stayed the same. We rated it as requires improvement because:

- The service provided mandatory training in key skills to all staff and made sure everyone completed it. However, the mandatory training matrix used to monitor when staff training was due was not sufficiently robust.

At our last inspection we raised concerns that staff were not up-to-date with their mandatory training. At this inspection, this had significantly improved as staff were as up-to-date as possible with all mandatory training. As at November 2020, the overall mandatory training compliance rate was 88%. Advanced Life Support training for staff had been delayed due to COVID-19 which meant the overall mandatory training compliance rate was below the service target of 100%.

The mandatory training available to staff included key areas such as health and safety, infection prevention and control, safeguarding adults and children, PREVENT and consent. PREVENT training aims to stop vulnerable people from being exploited and being drawn into terrorism. The mandatory training met the needs of patients and staff.

Several staff also worked for NHS trusts, other independent healthcare providers or locum agencies. They either completed their mandatory training with their substantive employer, at C C Kat or training was arranged with an external training company. They understood the process to update the clinic manager when they had completed their training. Training file documentation showed staff provided evidence to the service leaders and the medical advisory committee (MAC) each year that they were up-to-date with their mandatory training. This was in line with the service's practising privileges policy.

However:

Staff completed sepsis training every three years. This meant staff may not have an up-to-date knowledge about sepsis management and the use of sepsis screening tools. The clinic manager planned to provide staff with annual sepsis training from the start of the mandatory training year.

Service leaders did not always ensure mandatory training completion dates were accurately recorded on their mandatory training matrix. For example, the recovery nurse's safeguarding children level 2 certificate stated they completed this training on 24 February 2020. However, the training matrix inaccurately stated they completed this on 24 March 2020. We saw supporting documentation showing third-party staff had completed their mandatory training. However, the service's training matrix did not record all mandatory training completion dates for staff. We were not assured the service used the training matrix as a robust monitoring tool to ensure all staff remained up-to-date with their mandatory training.

- Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it.

Surgery

The service had clear systems and processes to safeguard adults, children and young people from avoidable harm, abuse and neglect in line with legislation and local safeguarding arrangements.

All new staff completed safeguarding adults and children levels 1 and 2 during the first month of their probation period. Staff training files we reviewed showed this training was prioritised.

At our last inspection, not all staff had completed their safeguarding and PREVENT training. This was in accordance with the safeguarding children and young people: roles and competencies for health care staff, intercollegiate guidance document (March 2014). Staff training rates had now improved for safeguarding adults and children levels 1 and 2 training as at October 2020, the staff compliance rate was 100%.

There had been no patient safeguarding referrals within the last 12 months. Staff understood what action to take if they had safeguarding concerns.

Staff could obtain safeguarding support and advice from the safeguarding lead who had completed adults and children safeguarding level 3.

- The service mostly controlled infection risk well. The service used systems to identify and prevent surgical site infections. They kept equipment and the premises visibly clean. Staff did not always use equipment and control measures to protect patients, themselves and others from infection.

At our last inspection, the service was not regularly conducting infection prevention and control audits. This had now improved as the service had a monthly programme of infection prevention and control (IPC) audits to monitor staff compliance with effective IPC measures. In June 2020, the service increased the IPC audit frequency from monthly to weekly due to the risk of COVID-19. The IPC audit results from October 2019 to October 2020 were above the service's target rate of 90% at 100%. Where staff non-compliance with effective IPC measures was identified, we saw evidence service leaders addressed this with the staff involved to help prevent recurrence.

The service had a contract with an external cleaning agency who cleaned the premises each day. This included cleaning the theatre daily and conducting deep cleans of the theatre every month.

All staff wore appropriate personal protective equipment in line with national guidance to prevent the transmission of COVID-19.

Sterilisation of equipment was now in line with government legislation. The service used single use surgical instruments or reusable instruments which were sterilised by an external medical sterilisation company.

Staff used measures to prevent patient surgical site infections. Service leaders monitored the number of patient surgical site infections. There were no patient surgical site infections from October 2019 to October 2020.

During our inspection, we raised concerns with the service about the theatre airflow and pressures from the main corridor into theatre. This is the patient's entrance and exit into theatre which is adjacent to the main entrance into the clinic. The provider had evidence that the air changes in the theatre were compliant with current guidance: Heating and ventilation systems, Health Technical Memorandum (HTM), 03-01: Specialised ventilation for healthcare premises HTM 03-01. However, the service could not provide evidence that the theatre airflow between the doors was compliant.

Surgery

The provider sent evidence that a full review of the airflow and pressure is planned for early December 2020. As part of this review, the service obtained expert advice from an external ventilation engineer who confirmed the theatre ventilation system was compliant.

However:

Not all staff had their arms bare below the elbows to enable effective handwashing to reduce the risk of spreading infections. A theatre staff member was wearing a watch and additionally a necklace and was at risk of transmitting infections.

Disposable curtains in two consultation rooms were visibly clean however, staff had not recorded the date of when they were last changed. This was not in line with best practice guidance. Staff may be unaware of when the curtains needed to be changed. Following our inspection, senior leaders had addressed this with the external cleaning agency to help prevent recurrence. The clinic manager discussed learning from this concern in a morning huddle after our inspection.

- The design, use of facilities, premises and equipment mostly kept people safe. The maintenance of the environment and equipment followed national guidelines. Staff did not always manage clinical waste well.

The dressing room did not have a dedicated handwashing sink for staff. The nearest sink was in the general toilet used by staff and patients. This meant staff could not easily access handwashing facilities and were unable to clean their hands at the point of care.

The theatre temperature was increased for a patient undergoing surgery as their body temperature had decreased. Whilst the theatre temperature was still within the recommended temperature range, best practice guidance states methods should be used to warm the patient rather than increasing the overall theatre temperature. This is because the risk of bacterial contamination increases with an increase in the theatre temperature. Staff did not record the theatre temperature on the theatre white board in line with good practice guidance.

The resuscitation trolley, defibrillator and emergency medicines were easily accessible to staff if a patient deteriorated on the ground floor as they were stored in the theatre on the ground floor. However, staff may not be able to quickly access emergency treatment if a patient's condition deteriorated in the outpatient area on the first floor.

Following the inspection, the service notified us that they had purchased first aid equipment which was now easily accessible to staff on the first floor.

Staff did not always handle waste appropriately. Some clinical waste bins had yellow clinical waste bin bags inside black non-clinical waste bin bags. Out of four sharps bins we checked, two were not labelled for traceability purposes. We found one sharps bin was stored on the floor which put it at risk of being easily accessed or knocked over. This was not in line with national guidance (Health and Safety Executive Health and Safety (Sharp Instruments in Healthcare) Regulations 2013: Guidance for employers and employees (March 2013). Following our inspection, we reviewed meeting records which showed senior leaders had addressed this with the external cleaning agency to prevent recurrence.

However:

All equipment we checked was up-to-date with their safety checks. This was an improvement from our last inspection where we had found some equipment was out-of-date by several years. The service now held a log of when equipment was due to be serviced or had been serviced.

Surgery

The service had back up provision so equipment in theatre could still be used during an electrical failure. Equipment such as the patient monitors, infusion pumps and operating table had battery backup. The theatre had battery-powered head lights to replace operating theatre lights. Staff could use heating blankets to keep patients warm as they do not need an external power source.

- Staff completed and updated risk assessments for each patient and removed or minimised risks. Staff identified and quickly acted upon patients at risk of deterioration.

At our last inspection, staff lacked an understanding about specific risks to patients. Staff did not conduct venous thromboembolism assessments to assess patients' risk of suffering from deep vein blood clots. This had improved as staff now conducted venous thromboembolism (VTE) assessments at patients' pre-assessment appointments. Staff had accurately recorded these assessments in all 10 patient records we checked.

The service had a clear patient admission criterion for patients to be considered suitable to have their cosmetic procedures at this service. Surgeons would only operate on low-risk patients at this site. Patients at a higher risk of complications after their surgery, with co-morbidities and/or a body mass index (BMI) above 30 would have their procedures at one of two local private hospitals. As at November 2020, this service had two full operating days at one of these hospitals per month.

Once the patient had met the discharge criteria, they were able to leave the service. The anaesthetist and surgeon stayed on site until the last patient was fit for discharge. The service had a clear process if a patient's discharge was delayed following surgery and if a patient needed to be readmitted after discharge. Staff informed us of how this process had successfully worked in practice when a patient needed to reattend surgery after they had been discharged.

Staff would call 999 to request the patient to be transferred to a local acute NHS hospital by ambulance during a patient emergency. The anaesthetist would accompany the patient and hand over care of the patient on arrival. There had been no patients requiring transfer from this service to the local acute NHS hospital in the 12 months before our inspection.

Theatre staff recorded swab counts on a whiteboard in theatre. This meant all staff were aware of the number of swabs used. The service used a surgical safety checklist in theatre based on the World Health Organisation (WHO) recommendations. The WHO surgical safety checklist is a tool used to improve the safety of surgical procedures by ensuring all the theatre operating team conduct the necessary safety checks during the patient's surgical procedure. The WHO checklist had been fully completed in all 10 patient records we reviewed. The lead nurse conducted monthly audits of staff compliance fully completing the WHO surgical safety checklist. From March 2020 to October 2020, the overall compliance rate was 95%. Where the audit found staff had not fully completed this checklist, learning from these cases were discussed at team meetings to help prevent recurrence.

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

At our last inspection, the service did not have enough staff to monitor patients following their surgery. During this inspection, staffing levels of recovery staff had improved as the service now had a dedicated recovery nurse. The 10 patient records we reviewed showed full patient observations were recorded during a patient's recovery after their surgery.

Surgery

Actual nursing and medical staffing levels met planned staffing levels on the day of our inspection. As all surgery at the service was planned, the surgeon was available when needed. All procedures carried out under conscious sedation were staffed by the surgeon and anaesthetist, a scrub nurse assisted by one runner, one recovery nurse and one Operating Department Practitioner (ODP). Conscious sedation is a combination of medicines to help patients relax (a sedative) and to block pain (an anaesthetic) during a medical procedure.

Patient care was consultant-led. Three consultants held substantive posts at the service. A further seven consultants worked at the service under practising privileges. Practising privileges is used by independent healthcare providers to give medical staff formal permission to work in their organisations.

The service had low sickness and staff turnover rates. From October 2019 to October 2020 there had been 10 staff sickness days in total. The service had low turnover rates. There had been one clinical and one non-clinical staff member leave the service in the 12 months before our inspection. As at November 2020, the service did not have any staff vacancies.

- Staff kept detailed records of patients' care and treatment. Records were clear, up-to-date, stored securely and easily available to all staff providing care.

We reviewed 10 sets of patient records. They were all comprehensively completed. They included specific consent forms for each cosmetic procedure type. The records clearly stated the possible risks, complications and side effects of the specific procedures.

The service used paper records for all patients having treatment. Once patients had undergone surgery, staff scanned their paper patient records onto the service's computer system. Staff then securely destroyed the records.

Staff gave patients information packs following their procedure. These included details of who to contact in an emergency after they had been discharged after their procedure.

The service recorded details of cosmetic implants on the Breast and Cosmetic Implant Register (BCIR). All providers of breast implant surgery need to send breast implant details to the register. The registry records the details of any patients who have had breast implant surgery. This means patients can be traced if a product is recalled or there are other safety concerns relating to a specific implant type. It also allows the identification of possible trends and complications relating to specific implants.

- The service used systems and processes to safely prescribe, administer and record medicines. The service did not always ensure medicines were safely stored and in date.

Controlled drugs were securely stored in locked cupboards. The nurse in charge and clinic manager held the medicine cupboard keys so medicines were only accessible to authorised staff. This was an improvement from the last inspection where we found the recovery room medication cupboard was unlocked and risked being accessed by unauthorised people.

The drugs used to provide conscious sedation were short acting and the anaesthetists were experienced at using this method. The anaesthetists use a standardised drug protocol and drugs were administered into the patient's vein using infusion pumps. All anaesthetists were supervised by the anaesthetic lead who checked anaesthetists delivered conscious sedation in an effective and safe way.

All patients were sent a prescription two weeks before their surgery. This included pain relief medication and antibiotics where necessary. Patients were asked to bring their medications on the day of surgery. At our last inspection, the service

Surgery

did not have a policy of when to prescribe antibiotics. This had improved as the service now had an up-to-date policy on antibiotic prophylaxis (treatment given to prevent disease) to ensure staff prescribed them safely. This guidance was in line with the National Institute for Health and Care Excellence (NICE) guidance (NICE, Surgical site infections: prevention and treatment (NG125) (April 2019).

Staff conducted medicines management audits each month. The compliance rates for July, September and October 2020 were 100% and 92% for June and August 2020. Service leaders took actions in response to non-compliance to ensure all staff followed the medicines management policy.

However:

Non-controlled supplies used in non – regulated activities were not always securely stored. We found the non-controlled drugs cupboard in a clinical room did not have a lock which meant it was at risk of being accessed by unauthorised staff. During the inspection, staff informed us they had a suitable lock to secure this cupboard.

Not all non-controlled medication was in date. We found two topical creams stored on the dressing trolley which were four years out-of-date. Staff disposed of these immediately once we notified them. Following our inspection, we reviewed minutes of staff meetings which showed service leaders had raised this concern with staff to ensure out-of-date supplies were disposed of.

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

From October 2019 to October 2020, the service had no never events and 10 incidents. Never Events are serious, largely preventable patient safety incidents that should not occur if healthcare providers have implemented existing national guidance or safety recommendations. All 10 clinical incidents were reported in line with the service's significant event reporting policy.

We reviewed the service's incident investigation report for the recent incident graded medium severity where a patient had to return to surgery due to post-surgical complications. Senior staff completed the incident report on the day of the incident. The report clearly recorded the incident details. Senior staff held a meeting the day after the incident to discuss learning from this incident.

However, the date of the incident was incorrectly recorded at the top of the incident form and there was no unique reference number for the incident report for audit purposes. Lessons learned from this incident were recorded on the incident form. However, the incident form did not have an associated action plan with details of how service leaders intended to share this learning and to monitor that staff learning had taken place.

Staff discussed learning from incidents at their team meetings and at the quarterly clinical governance meetings. During the inspection, staff were aware of this post-surgical incident and the actions taken in response.

Staff understood their responsibilities to meet the duty of candour legal requirements. The duty of candour is a regulatory duty that relates to openness and transparency. The duty requires providers of health and social care services to inform patients (or other relevant persons) of certain notifiable safety incidents and provide reasonable support to that person, under Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Staff gave examples of

Surgery

apologising to patients when there were any concerns about any part of their care and treatment. The service demonstrated they had complied with the duty of candour for the recent medium graded incident. Service leaders had held several meetings with the patient and those close to them to offer their apologies and to openly explain what had happened. Staff had recorded the details of all meetings in the patient's records.

However, the incident form for the recent medium rated incident did not include whether staff had complied with the duty of candour. The incident form did not include a duty of candour section to prompt staff to ensure this was completed with the patient and their family in a timely way.

- The service used monitoring results well to improve safety. Staff collected safety information and shared it with staff, patients and visitors.

As the service was an independent healthcare provider, it was not required to use the NHS Safety Thermometer. The safety thermometer is a measurement tool used to drive improvement in health care. Service leaders monitored safety information for the service.

Patients had day case surgery which meant there was a low risk of suffering from a venous thromboembolism (VTE) as a result of their treatment. The service monitored the incidence of patient VTEs. From October 2019 to October 2020, the service reported no patient VTE incidents. However, the service currently conducted this audit once a year which meant service leaders may then not be able to address any potential VTE incident themes or concerns in a timely way.

The service had strong links with other cosmetic surgery providers in the local region. They benchmarked their safety performance with these providers and shared good practice. The service shared their learning from beginning to conduct some surgical procedures under conscious sedation.

Are Surgery well-led?

Requires Improvement 

Our rating of well-led stayed the same. We rated it as requires improvement because:

- Leaders had the skills and relevant experience to run the service. The clinic manager was new in post and understood and managed the priorities and issues the service had faced since their appointment. They were visible and approachable in the service for patients and staff. They supported staff to develop their skills and take on more senior roles.

The service had a clear management structure for each area of the service with service leads for each cosmetic surgery speciality.

At our last inspection, leaders lacked some skills and abilities to safely run the service. At this inspection, we found this had improved as an experienced clinic manager had recently been appointed. They were in the process of applying to CQC to become the registered manager for the service.

The clinic manager had a clear understanding of governance processes gained from over eight years' experience as a registered manager at other cosmetic surgery providers. However, as they were new in post, we could not fully assess their understanding of all the main challenges and risks to the service.

Surgery

At our last inspection, service leaders lacked knowledge of safety and assurance systems needed to run a safe and effective service. At this inspection, we found improvements had been made as staff used safety measures to monitor the safety of cosmetic surgical procedures for patients. However, further improvements were needed as safety performance measures were not always regularly reviewed. For example, some audits to monitor patient complications after surgery were conducted once a year or every six months. This meant service leaders may not be able to identify incident themes in a timely way.

- The service had a vision for what it wanted to achieve and a strategy to turn it into action, developed with all relevant stakeholders. The vision and strategy were focused on sustainability of services and aligned to local plans within the wider health economy. Leaders and staff understood and knew how to apply them and monitor progress.

At our last inspection, the service's vision and values were not well established. At this inspection, we found this had improved as the service now had a clear vision and values for the service.

Staff and patients had been involved with the development of the values for the service. Staff knew the service values were: 'professional, ethical, integrity, caring and ambitious'. They understood how they were aligned to maintaining patient safety and ensuring patients had the best possible outcome.

The mission for the service was to be 'the most trusted to deliver an exceptional aesthetic result and an experience to each and every person'. Staff were confident the high standards of care they delivered to each patient was in line with this mission.

- Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. The service promoted equality and diversity in daily work and provided opportunities for career development. The service had an open culture where patients, their families and staff could raise concerns without fear.

Staff at all levels were positive and proud to work for the service. They enjoyed supporting patients through their whole patient journey. Staff had supportive working relationships with colleagues. They worked together as a team to achieve the best possible outcome for patients.

The service had the safety and well-being of staff as a priority. For example, when a staff member wanted to take some leave, service leaders took immediate action by changing their shifts to meet their requirements.

Leaders of the service promoted an open culture and encouraged staff to discuss any concerns with their line manager or service leaders. Staff at all levels felt able to challenge each other. During the inspection, staff did not raise any concerns about bullying or challenging behaviours from colleagues.

Staff were confident they could raise concerns safely and without fear of punishment. The service had an up-to-date whistleblowing policy which included clear guidance about how staff would be supported by service leaders to raise concerns.

Service leaders gave examples of where they had addressed concerns with staff performance when it fell below the service's standards.

Staff at all levels had development opportunities and high-level appraisals.

Surgery

- Leaders mostly operated effective governance processes, throughout the service and with partner organisations. Staff at all levels were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service.

At our last inspection, service leaders did not operate effective governance processes. At this inspection, we found leaders had made some improvements to the service's governance arrangements. We saw evidence that all levels of governance and management interacted with each other appropriately.

At our previous inspection, the service did not hold clinical governance meetings. The service now held quarterly clinical governance meetings. Clinical and non-clinical staff attended these meetings. However, the January 2020 meeting did not have a clear agenda and recorded action plans. This was noted as an improvement action in the meeting notes. We reviewed the clinical governance meeting minutes from April, June and October 2020. These minutes showed improvements had now been made as they included discussions regarding actions brought forward from previous meetings and attendees monitored any improvements needed.

The service had effective governance systems regarding ensuring third party staff had appropriate recruitment checks in order to grant staff practising privileges. The medical director had responsibility for reviewing staff practising privileges. The Medical Advisory Committee reviewed the competencies of third-party staff to ensure they have the relevant skills and experience for their intended role before they began to work at the service.

Senior staff used a practicing privileges checklist to record that all necessary documentation such as two professional referees, current Disclosure and Barring Service (DBS) enhanced disclosure and their most recent appraisal or revalidation had been received. The service had an up-to-date practicing privileges policy which included guidance for staff to ensure they complied with the requirements of the practicing privileges held with the service. The medical director reviewed consultants practising privileges every year.

Staff working under practising privileges had an appropriate level of indemnity insurance in accordance with The Health Care and Associated Professions (Indemnity Arrangements) Order 2014 and their professional body. The consultant personnel records we reviewed confirmed this.

However:

Some basic governance processes at the service still required improvement. For example, the governance around ensuring waste and sharps were managed safely needed to be strengthened. Medication management was still not sufficiently robust despite this being raised as a concern at our last inspection.

Leaders and teams did not always use systems to manage performance effectively. They identified and escalated relevant risks and issues and identified actions to reduce their impact. They had plans to cope with unexpected events. Staff contributed to decision-making to help avoid financial pressures compromising the quality of care.

At our last inspection of the service, we found leaders were not focussed on the main risks of the service or how these risks could be mitigated. At this inspection, we found some improvements had been made.

The service now had a risk register to monitor the progress of actions taken to mitigate identified risks to the service. The clinic manager updated the risk register each month. They discussed identified risks with staff during the daily morning huddle, at the clinical governance meetings and during the quarterly medical advisory committee (MAC) meetings. The progress of any action plans were updated daily at the huddle and were only removed from the agenda once the risk had been mitigated.

Surgery

The service had up-to-date policies to support the service's risk monitoring. For example, the service had a risk management policy, significant events policy, clinical governance policy and a complaints policy.

The service prioritised patient care over financial pressures. Staff told us they received financial support to improve the safety of equipment by ensuring all necessary equipment was calibrated.

However:

The risk register dated November 2020 was not representative of all the main risks to the service. For example, on-going concerns we had raised during our June and July 2019 inspection and new concerns raised in this inspection were not recorded on the risk register. The register did not record when the risk was added to the risk register, when the risk was due for review and they were not allocated to a risk owner. This meant it was unclear how long a risk had been on the risk register or who was responsible for reviewing and mitigating the risk.

- The service collected reliable data and analysed it. Staff could find the data they needed, in easily accessible formats, to understand performance, make decisions and improvements.

Staff could easily access patient records to ensure they had access to all information needed to provide safe patient care. Paper patient records were used on the day the patients were having surgery. Following surgery, they were scanned onto the service's electronic record system and were accessible to staff electronically.

The service now collected data to monitor the effectiveness of the service. This was an improvement since our July 2019 inspection where we found the service was not conducting audits or monitoring patient outcomes.

The service reviewed complaints for the service and used feedback to make improvements to the service. The clinic manager shared this feedback with staff during daily huddles. From October 2019 to October 2020, the service had three complaints which service leaders reviewed in detail. The service collated positive feedback mainly received from patients on social media.

- The information systems were integrated and secure. Data or notifications were consistently submitted to external organisations as required.

The service submitted data to external bodies such as the Private Healthcare Information Network (PHIN) so they could benchmark their performance against similar cosmetic surgery providers.

The service submitted data to the British Association of Aesthetic Plastic Surgeons (BAAPS) annual audit of surgical site infections for cosmetic surgery complications.

In the year before our inspection, the service had not had any notifiable incidents which needed to be reported to external organisations. The clinic manager understood their responsibilities for submitting statutory notifications to the Care Quality Commission (CQC) as required.

- Leaders and staff actively and openly engaged with patients, staff, equality groups, the public and local organisations to plan and manage services. They collaborated with other similar providers to help improve services for patients.

Staff were involved in discussions about planned developments for the service which were regularly discussed at team meetings. The service had a social media group for staff to share information and to ensure all staff were up-to-date.

Surgery

The service produced monthly newsletters for the public. These included information about new procedures to improve patient outcomes and experience. For example, the March/April 2020 newsletter provided information about the benefits of using conscious sedation. The newsletter stated that this method improves patient outcomes as there were fewer side effects and a quicker recovery time than from having a general anaesthetic.

The service had improved their social media platforms to engage with the public and to promote their cosmetic procedures. Since the service had improved their social media platforms, the amount of patient feedback received have tripled. The service had numerous ways to collate patient feedback with social media being the main method used.

The service also used an external organisation, to collect patient feedback. The patient feedback cycle completed during September 2019 achieved a patient satisfaction score of 92%. The service made changes in response to this feedback. For example, the service had upgraded their phone system to include call options. This had allowed patient's phone calls to be directed quicker and to the right team member. The last patient feedback review of 60 patient responses was conducted in September 2020. This data was currently being analysed by the external organisation.

The service ensured they provided people considering cosmetic surgery with up-to-date information to help them choose a suitable procedure type. The service displayed their current CQC ratings at the service and on their website. However, they are not displayed in a prominent place for the public to easily see.

However:

At our last inspection, we found the service did not have a staff survey so staff could raise concerns anonymously. The service had made some improvements by introducing a staff feedback form. However, we were not assured that staff could raise concerns anonymously using this method. The clinic manager was in the process of arranging for an anonymous staff survey to be set up by an external company. Service leaders planned to send this to staff every six months so they were aware of any staff concern themes and could act in a timely way to address them.

- All staff were committed to continually learning and improving services. They had an understanding of quality improvement methods and the skills to use them. Leaders encouraged innovation and participation in research.

The service had addressed some of the concerns we reported at the June and July 2019 inspection. The improvements the service had made included:

- The service had a mandatory training matrix to monitor staff training compliance.
- Sterilisation of equipment was in line with government legislation.
- Staff were up-to-date with children's safeguarding level 2 in line with the safeguarding children and young people: roles and competencies for health care staff, intercollegiate guidance document. (March 2014).
- Staff had an improved understanding about monitoring specific risks to patients.
- Staff conducted VTE and sepsis assessments for patients.
- Staff ensured patients were closely monitored for signs of deterioration before, during and following surgery.
- The service had a policy for the safe prescribing and use of antibiotics.
- Services leaders had relevant experience and skills to run the service.
- Service leaders had a risk register to record and monitor the main risks to the service.
- The service collected and reviewed performance data and used it to improve the service.
- The service had improved ways patients could provide feedback and used it to improve the service.
- The vision and values for the service were better established.

Surgery

Staff were aware of the concerns we identified at our last inspection and changes the service had made in response. Service leaders had already begun to address some of the concerns we raised at our inspection in November 2020.

However, some improvements had not been made despite this being raised at our previous inspection:

- Staff did not ensure all medication was securely stored.
- The service did not have a formal staff survey.

We saw evidence of innovative practice to improve the outcomes for patients with the introduction of conscious sedation for some cosmetic procedures. Conscious sedation had various benefits for patients including less post-surgical side effects and a quicker discharge process.

Service leaders had considered potential risks when planning new procedure types for the service. The service begun to conduct small numbers of procedures using conscious sedation in February 2020 to ensure this practice was conducted safely before they increased the number of procedures conducted. The lead anaesthetist for the service planned the introduction of conscious sedation over a nine-month period in 2019 before it was fully introduced. The anaesthetist leading the development of this technique had previously used this sedation method at larger independent hospitals where they were also employed. They undertook a risk assessment of staffing levels, equipment and drug availability for this technique. This identified several areas which required enhancement and investment to ensure safe delivery of the conscious sedation technique. For example, the service has an Operating Department Practitioner (ODP) who is qualified to assist the anaesthetist and to support the recovery of the patient.

Staff had development opportunities to increase their knowledge of cosmetic surgery specialisms.