The Plastic Surgery Group

Quality Report

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

Ratings

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

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

Letter from the Chief Inspector of Hospitals

The Plastic Surgery Group is operated by The Plastic Surgery Group Limited. The location inspected at 100 Harley Street is used to see patients in an outpatient setting, for surgical pre-assessment and minor procedures and non-surgical aesthetic treatments. All major surgical procedures (such as breast enhancement, liposuction, facelift) are carried out under practising privileges at other separately registered facilities. Post-surgical appointments such as reviews and wound care also take place at 100 Harley Street. Facilities include a consultation room and clinic room.

The service provides cosmetic surgery. The only procedures we regulate taking place on site are labiaplasty and ear fold operations, performed under local anaesthesia (without use of sedation).

We inspected this service using our comprehensive inspection methodology. We gave 48 working hours' notice of the inspection because evidence gathering in an unannounced inspection would be impacted by the fact that the service undertakes procedures at variable times. We carried out the inspection on 6 August 2019.

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.

Services we rate

The is the first time we rated this service. We rated it as **Good** overall because:

- The design, maintenance and use of facilities, premises and equipment kept people safe. Staff were trained to use them. Staff managed clinical waste well.
- Staff completed risk assessments for each patient and removed or minimised risks. Staff identified and quickly acted upon patients at risk of deterioration.
- The service had enough staff to care for patients and keep them safe. They managed medicines well.
- Staff gave patients enough to drink. Staff followed national guidelines to make sure patients fasted before surgery.
- Staff assessed and monitored patients regularly to see if they were in pain, and gave pain relief in a timely way.
- Staff monitored some of the effectiveness of care and treatment. There was limited evidence that managers used information from the audits to make improvements and achieve good outcomes for patients.
- Healthcare professionals worked together as a team to benefit patients. They supported each other to provide good care.
- Managers made sure staff were competent. Staff worked well together for the benefit of patients, supported them to make decisions about their care, and had access to information. Key services were available five days a week.
- Staff treated patients with compassion and kindness, respected their privacy and dignity, took account of their individual needs, and helped them understand their conditions. They provided emotional support to patients.
- The service planned care to meet the needs of their patient population, took account of most patients' individual needs, and made it easy for people to give feedback. People could access the service when they needed it and did not have to wait too long for treatment.
- Leaders supported staff to develop their skills. Staff felt respected, supported and valued. They were focused on the needs of patients receiving care.

However:

- Not all medical staff had completed all mandatory training modules.

Summary of findings

- The safeguarding policy did not reference female genital mutilation (FGM). Following our inspection, we were provided with evidence that this policy was updated, and senior staff told us training had been given in this area.
- We were not assured that the clinic was using a safer surgical checklist based on the World Health Organisation (WHO) guidance for minor operations performed at this location. There were no WHO checklists in any of the operative notes viewed on the day of inspection. Completion was not audited. Following inspection, the service produced new checklist documentation they told us they would use for any minor procedures at the registered location.
- There were no environmental or hand hygiene audits taking place, as per local policy. There were also no formal infection prevention control meetings, and this was not a standing agenda item at the monthly staff meetings.
- The service had not managed patient safety incidents well historically. We were not assured that staff always recognised and reported incidents and near misses. Managers usually investigated incidents, but staff were not aware of a formal system in place to investigate serious incidents.
- The service could not evidence it provided all care and treatment based on national guidance and evidence-based practice.
- There was no formal access to translation or interpretation services for patients whose first language was not English. The service did not have information leaflets available in other languages or formats on the day of inspection.
- There was no information displayed in the clinic about how to raise a complaint.
- The service had a vision for what it wanted to achieve, but this was not clear. There was no clear strategy to turn the vision into action. Leaders and staff did not understand them and did not know how to apply them and monitor progress.
- Leaders did not operate effective governance processes throughout the service. Staff at all levels were not always clear about their roles and accountabilities. They had regular opportunities to meet, but did not always discuss and learn from the performance of the service.
- The registered nurse at the service had been enrolled on a nurse prescriber course to aid with her professional development but there were not governance structures that would support this at the time of inspection.
- The service collected some data but not all staff could find the data they needed, in easily accessible formats, to understand performance, make decisions and improvements. The information systems were not historically integrated.
- There was limited evidence of patient or staff engagement to plan and manage services.

Following this inspection, we told the provider that it should make improvements, even though a regulation had not been breached, to help the service improve. Details are at the end of the report.

Nigel Acheson
Deputy Chief Inspector of Hospitals (London and South)

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Surgery	Good 	Surgery was the main activity of the service. We rated this service as good because it was safe, effective, caring and responsive, although it requires improvement for being well-led.

Summary of findings

Contents

Good

The Plastic Surgery Group

Services we looked at
Surgery

Summary of this inspection

Background to The Plastic Surgery Group

The Plastic Surgery Group is operated by The Plastic Surgery Group Limited. The service opened at this registered location in October 2018. It is a private cosmetic surgery clinic in London. The clinic accepts self-referrals from patients living in London and internationally. The service does not provide services to NHS-funded patients or patients under the age of 18.

At the time of inspection, the service was in the process of applying for the lead consultant to be the registered manager, after the previous manager had left their post in June 2019. Their application for registered manager with CQC had been submitted and was being processed.

Our inspection team

The team that inspected the service comprised a CQC lead inspector, a CQC assistant inspector, and a specialist advisor with expertise in surgery. The inspection team was overseen by Nicola Wise, Head of Hospital Inspection.

Why we carried out this inspection

The service has no overnight beds. It is registered to provide the following regulated activities:

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

During the inspection, we visited the whole clinic, including the reception, waiting area, consultation room, clinic room and storage areas. We spoke with four staff including the operations manager, the registered nurse, the clinic administrator and the lead consultant. There were no patients attending the clinic on the day of inspection, so we were unable to speak to any directly. We reviewed 11 sets of patient records.

There were no special reviews or investigations of the hospital ongoing by the CQC at any time during the 12 months before this inspection. This was the service's first inspection since registration with CQC on 15 October 2018.

Activity (October 2018 to March 2019)

- In the reporting period, the service had 1,142 outpatient attendances. All of these were privately funded. Of these, five were minor procedures falling under our scope of regulation performed at the clinic.
- The service employed two surgeons, one registered nurse, one operations manager and one clinic administrator.

Track record on safety (October 2018 to August 2019)

- No never events
- Eight clinical incidents, all resulting in 'no' or 'low' harm
- No serious injuries
- No incidences of hospital acquired Meticillin-resistant Staphylococcus aureus (MRSA)
- No incidences of hospital acquired Meticillin-sensitive staphylococcus aureus (MSSA)
- No incidences of hospital acquired Clostridium difficile (c.diff)
- No incidences of hospital acquired E-Coli
- Three complaints

Services provided at the hospital under service level agreement:

- Clinical and general waste collection

Summary of this inspection

- Cleaning service
- Fire alarm & lighting servicing
- Fire extinguisher checks
- Portable appliance testing
- Legionella risk assessment
- Fixed electrical testing
- Laboratory testing
- Equipment servicing
- Blood specimen testing
- Cleaning of laundry

Summary of this inspection

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?

Good

This is the first time we rated safe for this service. We rated it as **Good** because:

- 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.
- The design, maintenance and use of facilities, premises and equipment kept people safe. Staff were trained to use them. Staff managed clinical waste well.
- Staff completed risk assessments for each patient and removed or minimised risks. Staff identified and quickly acted upon patients at risk of deterioration.
- 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.
- Staff kept detailed records of most patients' care and treatment. Most records were clear, up to date, stored securely and easily available to all staff providing care.
- The service used systems and processes to safely prescribe, administer, record and store medicines.
- Shared learning from reported incidents took place with staff. Managers ensured that actions from patient safety alerts were implemented and monitored.

However:

- Not all medical staff had completed all mandatory training modules.
- The safeguarding policy did not reference female genital mutilation (FGM). Following our inspection, we were provided with evidence that this policy was updated, and senior staff told us training had been given in this area.
- We were not assured that the clinic was using a safer surgical checklist based on the World Health Organisation (WHO) guidance for minor operations performed at this location. There were no WHO checklists in any of the operative notes viewed on the day of inspection. Completion was not audited. Following inspection, the service produced new checklist documentation they told us they would use for any minor procedures at the registered location.

Summary of this inspection

- There were no environmental or hand hygiene audits taking place, as per local policy. There were also no formal infection prevention control meetings, and this was not a standing agenda item at the monthly staff meetings.
- There was no formal written policy relating to the use of antibiotics or antibiotic stewardship.
- The service had not managed patient safety incidents well historically. We were not assured that staff always recognised and reported incidents and near misses. Managers usually investigated incidents, but staff were not aware of a formal system in place to investigate serious incidents.

Are services effective?

Good

This is the first time we rated effective for this service. We rated it as **Good** because:

- Staff gave patients enough to drink. Staff followed national guidelines to make sure patients fasted before surgery.
- Staff assessed and monitored patients regularly to see if they were in pain, and gave pain relief in a timely way.
- Staff monitored some of the effectiveness of care and treatment. There was limited evidence that managers used information from the audits to make improvements and achieve good outcomes for patients.
- The service made sure staff were competent for their roles. Managers appraised staff's work performance.
- Healthcare professionals worked together as a team to benefit patients. They supported each other to provide good care.
- Key services were available five days a week to support timely patient care.
- Staff gave patients advice regarding their procedure.
- Staff supported patients to make informed decisions about their care and treatment. They followed national guidance to gain patients' consent.

However:

- The service could not evidence it provided all care and treatment based on national guidance and evidence-based practice.

Are services caring?

Good

This is the first time we rated caring for this service. We rated it as **Good** because:

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

Summary of this inspection

- Staff provided emotional support to patients to minimise their distress. They understood patients' personal, cultural and religious needs.
- Staff supported and involved patients to understand their condition and make decisions about their care and treatment.

Are services responsive?

Good

This is the first time we rated responsive for this service. We rated it as **Good** because:

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

However:

- There was no formal access to translation or interpretation services for patients whose first language was not English. The service did not have information leaflets available in other languages or formats on the day of inspection.
- There was no information displayed in the clinic about how to raise a complaint.

Are services well-led?

Requires improvement

This is the first time we rated well-led for this service. We rated it as **Requires improvement** because:

- The service had a vision for what it wanted to achieve, but this was not clear. There was no clear strategy to turn the vision into action. Leaders and staff did not understand them and did not know how to apply them and monitor progress.
- Leaders did not operate effective governance processes throughout the service. Staff at all levels were not always clear about their roles and accountabilities. They had regular opportunities to meet, but did not always discuss and learn from the performance of the service.
- The registered nurse at the service had been enrolled on a nurse prescriber course to aid with her professional development but there were not governance structures that would support this at the time of inspection.

Summary of this inspection

- The service collected some data but not all staff could find the data they needed, in easily accessible formats, to understand performance, make decisions and improvements. The information systems were not historically integrated.
- There was limited evidence of patient or staff engagement to plan and manage services.
- The clinic lacked a robust approach to quality improvement.

However:

- Leaders had the integrity, skills and abilities to run the service. 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.
- Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. The service provided opportunities for career development. The service had an open culture where patients, their families and staff could raise concerns without fear.
- Leaders identified and escalated relevant risks and issues and identified actions to reduce their impact. They had plans to cope with unexpected events.

Detailed findings from this inspection

Mental Health Act responsibilities

Start here...

Mental Capacity Act and Deprivation of Liberty Safeguards

Start here...

Overview of ratings

Our ratings for this location are:

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

Notes

Good

Surgery

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

Are surgery services safe?

Good

This is the first time we rated safe for this service. We rated it as **good.**

Mandatory training

The service provided mandatory training in key skills to all staff and made sure most staff completed it. However, not all medical staff had completed all training modules.

- The mandatory training was comprehensive and met the needs of patients and staff. Training was provided to staff in the following subjects: conflict resolution, data security awareness, equality and diversity, fire safety, health, safety and welfare infection prevention control (IPC) level one and level two, moving and handling level one and level two, resuscitation, safeguarding adults level two, safeguarding children level two. Managers monitored mandatory training and alerted staff when they needed to update their training.
- Most staff received and kept up to date with their mandatory training. The operations manager, clinic administrator and registered nurse had completed all mandatory training at the time of inspection. The two lead consultants had 82% compliance at the time of inspection, with neither compliant with IPC level two. One consultant had not completed conflict resolution training, and the other had not completed fire safety training.
- Following inspection, we were provided with a policy of the management of sepsis, which had been drafted in August 2019. We were also provided with a training certificate for the registered nurse, which indicated training in sepsis management was completed on the day of inspection. Staff we spoke to on the day of inspection were able to tell us about the signs of sepsis.

Safeguarding

Staff understood how to protect patients from abuse. Most staff had training on how to recognise and report abuse and they knew how to apply it. However, the safeguarding policy did not reference female genital mutilation (FGM). Following our inspection, we were provided with evidence that this policy was updated, and senior staff told us training had been given in this area.

- The clinic did not treat anyone under the age of 18. Staff had access to an up-to-date safeguarding policy, but this did not reference female genital mutilation (FGM). Following our inspection, we were provided with evidence that this policy was updated, and senior staff told us training had been given in this area.
- Staff received training specific for their role on how to recognise and report abuse of different kinds. At the time of inspection, all staff had completed safeguarding vulnerable adults' level two training and safeguarding children level two training. The registered nurse had also completed safeguarding children level three training. Neither surgeon had completed level three training for children or adults at the time of inspection. Following the inspection, we were informed that both surgeons had been booked to attend this training.
- Staff knew how to identify adults and children at risk of, or suffering, significant harm. Staff knew how to make a safeguarding referral and who to inform if they had concerns. The lead consultant had been identified as the safeguarding lead.

- Staff told us they had never had to raise a safeguarding concern that required escalation but were aware of how they would do so. We observed appropriate safeguarding referral contact details displayed in the clinic. In the 12 months prior to inspection, the clinic did not report any safeguarding concerns to the local authority and no safeguarding notifications were recorded by the CQC.
- Senior staff told us that they ensured professional registration, fitness to practice, and validation of qualification checks were undertaken for all staff. All staff files we reviewed had relevant Disclosure and Barring Service (DBS) checks in place.

Cleanliness, infection control and hygiene

The service controlled infection risk well. The service used systems to identify and prevent surgical site infections. Staff used equipment and some control measures to protect patients, themselves and others from infection, but there was no formal governance structure in place surrounding this. They kept equipment and the premises visibly clean.

- Clinic areas were visibly clean and had suitable furnishings which were clean and well-maintained. All rooms were cleaned between patients. Staff cleaned equipment after patient contact but did not label equipment to show when it was last cleaned. The equipment we looked at was clean.
- We viewed the cleaning schedule which the external cleaners used. The external cleaning company cleaned the entire clinic twice per week, and after each minor operation such as labiaplasty or ear fold which took place at the clinic. Senior staff informed us that the external cleaning company had recently been changed as there had been concerns with the previous contractor. This had been added to the risk register and the new cleaner was being monitored. Staff told us they were happy with the standards of cleaning so far, but there was no formal audit of this, or historic cleaning records that we could view on the day of inspection.
- The infection control link nurse was the registered nurse. The link nurse's role is to increase awareness of infection control issues and motivate staff to improve practice. However, the link nurse was unclear regarding her role and did not conduct any environmental or hand hygiene audits, as per local policy. There were also no formal infection prevention control meetings, and this was not a standing agenda item at the monthly staff meetings. Following inspection, we were informed that hand hygiene audits had been added to the monthly audit schedule.
- We saw there was access in all areas to hand washing facilities, hand sanitiser and supplies of personal protective equipment (PPE). There were no patients in the clinic on the day of inspection, so we were unable to observe hand hygiene practice. There were no posters up to remind staff of when to wash their hands, only on the method of doing so. Following inspection, we were informed that such posters had been added to the clinic.
- Surgical site infection (SSI) information was collected. Information provided indicated there had been no SSIs since the service opened.
- The clinic screened all elective surgical patients for MRSA prior to admission to other centres, in line with Department of Health guidelines. MRSA is a bacterium that can be present on the skin and can cause serious infection.

Environment and equipment

The design, maintenance and use of facilities, premises and equipment kept people safe. Staff were trained to use them. Staff managed clinical waste well.

- The design of the environment followed national guidance. The clinic was clean and clutter-free, and rooms were kept clean and tidy.
- Staff carried out daily safety checks of specialist equipment. All equipment we checked had been recently serviced and labelled to indicate the next review date. All equipment was serviced annually by an external company.
- There was a blood glucose monitoring device available. However, when this was checked the testing strips had expired in November 2018. It was clear that daily testing of the machine was not carried out. The registered nurse acted immediately to replace the test strips.
- The service had enough suitable equipment to help them to safely care for patients. The clinic had the relevant emergency equipment available in a grab bag, which was checked weekly by staff. A defibrillator was available and we saw that defibrillator was checked regularly.

- All sterile items utilised in the clinic were single use. Disposable equipment was easily available, in date and appropriately stored.
- Staff disposed of clinical waste safely. We observed safe systems for managing and storing waste and clinical specimens. Staff used sharps appropriately; the containers were dated and signed when full to ensure timely disposal, not overfilled and temporarily closed when not in use.
- A legionella risk assessment had been carried out (legionella is a term for a particular bacterium which can contaminate water systems in buildings) and there were no actions to follow up from this.
- The provider informed us that relevant control of substances hazardous to health (COSHH) risk assessment had been carried out. This ensured that flammable substances within the clinic were stored safely. The cupboard was not locked but the risk assessment had ascertained this was not necessary, due to the nature of the substances stored in the cupboard and the fact that unsupervised patients did not enter this room.

Assessing and responding to patient risk

Staff completed risk assessments for each patient and removed or minimised risks. Staff identified and quickly acted upon patients at risk of deterioration. However, we were not assured that the clinic was using a safer surgical checklist based on the World Health Organisation (WHO) guidance for minor operations performed at this location.

- There was an admission policy in place, with appropriate exclusion criteria. Some patients were excluded from treatment, whilst others required further investigation, a medical support letter from a GP and approval by the lead consultant. Patients with a body mass index (BMI) of 30 or over were not considered for surgical procedures.
- The admission policy also stated that the psychological vulnerability of each patient needed to be considered, to determine whether the mental health condition was well controlled and if the assessment process needed to be slowed down to protect the patient. Further clarification would be sought from the patient's GP if necessary, with more than one consultation taking place where required. Those who had experience major psychiatric disturbance in the six months prior to proposed treatment would not be accepted.
- Consultations for procedures were completed face to face, with the lead clinician assessing and examining the patient and explaining their treatment options, the risks and the expected outcome of treatment. All patients were asked to complete a medical history and health questionnaire before consultations or procedures.
- On the day of inspection, we did not see any evidence that staff used a safer surgical checklist based on the World Health Organisation (WHO) guidance. The surgical safety checklist for patients is intended for use throughout the perioperative journey, to prevent or avoid serious patient harm. By following the checklist, health care professionals can minimize the most common and avoidable risks endangering the lives and well-being of surgical patients. The registered nurse was not aware of the WHO checklist or what this entailed. In the eleven patient records we looked at, we could not see any documentation or mention of the WHO checklist for minor procedures (such as labiaplasty or ear fold) that took place at the clinic, or for major procedures performed at other centres under practising privileges.
- We were later provided with some completed WHO checklists for major procedures that took place at other centres, but no evidence was provided to indicate this took place for minor procedures at this registered location. As a result, a safer surgery policy was drafted in August 2019 which indicated this would take place in future. New checklist documentation was produced for any minor procedures taking place at the registered location. There was no audit of WHO checklist completion taking place at the time of inspection, but this had been added to a revised audit plan submitted following inspection.
- Patients were able to contact staff at the clinic for support at any time. They were given a telephone number to call following their procedure, which went through to a member of clinic staff 24 hours a day, seven days a week. Those who had undergone major surgery at other centres also had contact details for those centres. Patients were called the day after a procedure by a member of clinic staff to check on their wellbeing and recovery.

- The provider told us that staff were monitored for symptoms of sepsis as part of the wound care process post-surgery. Staff we spoke to were able to tell us about the signs of sepsis. There were posters in the clinic detailing these as a reminder.
- In an emergency situation, the standard 999 system was used to transfer the patient to an NHS hospital. All staff had received life support training appropriate to their role. In July 2019, we saw evidence that staff had taken part in an emergency training scenario, and this was planned to take place on a monthly basis. Since opening, there had been no unplanned transfers to other hospitals. If a patient needed to return to theatre, the surgeon who had performed the operation remained on-call. Surgeons and Anaesthetists were required to remain within one hour of the hospital where a procedure had taken place (under practising privileges) whilst the patient remained an inpatient.
- It is a requirement of the Royal College of Surgeons that the consultation identifies any patients who are psychologically vulnerable and they are appropriately referred for assessment. The provider informed us that all patients were screened pre-operatively and those with any existing mental health concerns were referred back to their GP for more information and support before any procedure was considered. We were provided with evidence of this happening in practice, and the patient was given a full refund.

Nursing and support staffing

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.

- The service employed one full-time registered nurse for the purposes of non-surgical interventions and post-operative wound care. There were no vacancies or turnover since the service became operational. All appointments at the location were planned in advance to ensure that the registered nurse was on duty and available.
- There was one operations manager (who performed some non-surgical procedures) and one clinic administrator employed by the service at the time of inspection, who managed non-clinical duties, such as appointment booking and theatre scheduling.
- During consultation and follow up clinics, three members of staff were always present to ensure there were enough staff available to assist both the consultant and patient where required. During surgical procedures, the nurse was present alongside a surgeon.
- In the case of staff sickness, we were told that post-operative wound care appointments could be redirected to the resident medical officer (RMO) at a hospital with which the provider held practising privileges with. All non-urgent appointments would be cancelled and rearranged. This had not occurred since the clinic opened.

Medical staffing

The service had enough medical staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment.

- The service had enough medical staff to keep patients safe. Two surgeons on the specialist register for plastic surgery worked at the service. They both held substantive posts in the NHS. They performed minor procedures at the clinic and major cosmetic procedures under practising privileges at other separately registered centres. The granting of practising privileges is an established process whereby a medical practitioner is granted permission to work within an independent hospital. Medical staff had their appraisals and revalidation undertaken by their respective NHS trusts. We received confirmation that their NHS appraisals covered the whole scope of each surgeon's practice, including work undertaken both inside and outside of the NHS.
- There were no vacancies or plans to take on other consultants at the time of inspection. One surgeon, also employed by the clinic, had left since the clinic opened, due to conflicting commitments. This left two surgeons employed at the time of inspection.

Records

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

- Information governance training was part of the annual mandatory training requirement for all staff working at the clinic. All staff had completed this.

- At the time of inspection, all staff could access patient notes easily. The service used an electronic system to store medical records and observations. Prior to June 2019, patient's operative notes had been stored on remote servers accessed from the internet. We found that these historic files were not easily accessible for all staff.
- The service had commissioned a bespoke patient record system that was being codesigned by staff. This was planned to go live later in the year. Clinic staff would use this communicate with each other and could set tasks to be signed off as part of the patient journey.
- Formal consent was sought in regard to photographic images, with these stored electronically. Some records were kept on paper, for example consent forms. These paper records were all scanned onto the electronic system, with the paper copies being disposed of securely.
- We reviewed eleven sets of medical notes and found that these complied with General Medical Council (GMC) standards for documentation in most cases. However, there was no record of WHO checklists present in the operative notes on the day of inspection. The service did not undertake documentation audits at the time of inspection, as per their local policy.
- Information was shared with GPs if patients gave their consent. Patients received a discharge letter after any surgery that they could share with their GP.

Medicines

The service used systems and processes to safely prescribe, administer, record and store medicines. However, there was no formal written policy relating to the use of antibiotics or antibiotic stewardship.

- Staff stored and managed medicines and prescribing documents in line with the provider's policy. There was a 'medicine management policy', updated in July 2019, which referred to national guidance. Staff kept a small range of medicines in a locked cupboard with restricted access to ensure security. All medicines that we checked were within date. Medication fridge temperatures were monitored daily. There were no controlled drugs kept at the clinic.
- There was a service level agreement (SLA) in place with a local pharmacy for the supply of medicines. Staff told us that they liaised with the pharmacist and conducted weekly audits of any medicines in stock to ensure any unused items were returned and stock levels did not become too high. We saw evidence of this on the day of inspection. Staff were able to contact the pharmacist to order stock when needed, and return any unwanted or expired medicine.
- No sedation was administered on the premises for any procedure. The surgeon used a combination of lidocaine ointment and ice to numb the area before local anaesthesia was administered.
- Staff followed current national practice to check patients had the correct medicines. Allergies were clearly recorded in patient records.
- The clinic used a letter head rather than private prescription pad for take home medications. This could only be dispensed at the local pharmacy which supplied the medication to the clinic.
- The clinic did not use prophylactic antibiotics. Patients received intravenous antibiotics at the time of surgery at the hospital where major operations took place under practising privileges. However, there was no policy relating to the use of antibiotics or antibiotic stewardship.

Incidents

The service had not managed patient safety incidents well historically. We were not assured that staff always recognised and reported incidents and near misses. Managers usually investigated incidents but staff were not aware of a formal system in place to investigate serious incidents. Shared learning from incidents took place with staff. Managers ensured that actions from patient safety alerts were implemented and monitored.

- The clinic had a policy in place to guide staff on how to report any incidents. Staff we spoke with were aware of how they would report incidents, but we were not assured that staff knew what incidents to report. Most logged incidents were dated after April 2019, with only one being reported before this Staff did not seem sure of what constituted a reportable incident or near miss.
- The service reported no never events between April 2018 and May 2019. Never events are serious incidents that are entirely preventable as guidance or safety recommendations providing strong systemic protective barriers are available at a national level and should have been implemented by all healthcare providers. Staff did not seem to know what a never event was when asked.

- No serious incidents (SIs) were reported between April 2018 and March 2019. Staff were not able to describe the formal process in place for investigating serious incidents should they occur.
- Between October 2018 and the date of inspection, there were eight incidents reported on the electronic system. These related to returns to theatre (six), wound complications (one) and a negative pressure dressing incident (one). All of these resulted in 'low' or 'no' harm.
- Staff told us that when they reported an incident, they received feedback and told us that learning was shared across the service. We saw minutes of meetings where incidents and relevant learning points were discussed. There was evidence that changes had been made as a result of incidents, such as the purchasing of a vacuum pump for post-operative wound care.
- Staff understood the duty of candour. They were open and transparent, and told us they would give patients and families a full explanation if things went wrong. They told us that no incidents had reached the threshold for duty of candour so far.
- The clinic had systems in place for receiving, disseminating and acting on patient safety alerts from the Medicines and Healthcare Regulatory Agency (MHRA).

Safety Thermometer (or equivalent)

The service did not use monitoring results well to improve safety.

- The clinic, unlike NHS trusts, was not required to use the national safety thermometer to monitor areas such as venous thromboembolism (VTE). However, services are required to have equivalent systems in place. The clinic reported no incidences of VTE or pressure ulcers in the reporting period, as patients did not stay overnight. We did not see evidence of a system where this information could be collated.

Are surgery services effective?

Good

This is the first time we rated effective for this service. We rated it as **good.**

Evidence-based care and treatment

The service could not evidence it provided all care and treatment based on national guidance and evidence-based practice.

- Staff did not always follow up-to-date policies to plan and deliver high quality care according to best practice and national guidance. We saw minutes from recent team meetings which referenced review of policies, but these were only from the two months prior to inspection. Some policies referenced appropriate National Institute for Health and Care Excellence (NICE) and Royal College guidelines, but not all policies reviewed referenced current best practice guidance or were tailored to the clinic. Senior staff told us that they planned to continue to review policies in meetings going forward to better adapt them to the needs of the clinic. Staff would then be sent a small quiz to check their knowledge on the policy content. Following inspection, senior staff indicated that this was a priority and all policies would undergo review by September 2019.
- The clinic had recently started to conduct some basic local audits relating to medicines and fridge temperatures. At the time of inspection, no audits took place in relation to infection prevention control, hand hygiene, pain relief, fasting or documentation, amongst other topics. Evidence of actions taken as a result of audit findings was therefore limited. The provider submitted data to the Private Healthcare Information Network (PHIN).

Nutrition and hydration

Staff gave patients enough to drink. Staff followed national guidelines to make sure patients fasted before surgery.

- Staff made sure patients had enough to drink. The clinic provided water, tea and coffee to all patients.
- Patients were sent information on surgery prior to any procedure, which included information on fasting times. Records indicated that checks were made to ensure patients had adhered to fasting times before surgery at other centres went ahead. However, the service did not conduct a fasting audit to ensure that all patients followed the Association of Anaesthetists of Great Britain and Ireland (AAGBI) best practice guidance on fasting prior to surgery. There was no evidence to show that patients fasting before surgery were not without food for long periods.

- Nausea and vomiting were managed effectively. We saw patients were prescribed anti-sickness medication if required.

Pain relief

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

- Records indicated that staff prescribed, administered and recorded pain relief accurately. The registered nurse told us they routinely asked patients about pain. The notes we reviewed showed that patients had been given regular pain relief after their operations at other centres, as required. The service did not audit pain management.

Patient outcomes

Staff monitored some of the effectiveness of care and treatment. There was limited evidence that managers used information from the audits to make improvements and achieve good outcomes for patients.

- The service did not participate in national clinical audits. At the time of inspection, there was not a comprehensive local audit programme in place. There was therefore limited evidence at the time of inspection that managers used information from the audits to improve care and treatment. Following inspection, we were provided with a revised local audit schedule.
- Between October 2018 and the date of inspection, there were six returns to theatre. These were due to issues such as post-operative haematomas, investigation of infection and suturing. The service discussed these incidents at multidisciplinary team meetings and made changes to practice as a result. These included changes to allow negative pressure wound therapy at the location, and purchasing a testing machine to ensure only non-smoking patients were accepted for surgery.
- The clinic was supplying national data to the Private Healthcare Information Network (PHIN).
- There had been no instances of sepsis in the 12 months prior to inspection. The provider did not conduct an audit specifically on sepsis management. Staff were encouraged to monitor signs of infection and sepsis as part of the wound care process post-surgery.

Competent staff

The service made sure staff were competent for their roles. Managers appraised staff's work performance.

- Staff were experienced, qualified and had the right skills and knowledge to meet the needs of patients.
- Managers gave all new staff a full induction tailored to their role before they started work. These included topics such as: first aid, fire safety, local health and safety, policies, customer service, company expectations and role specific duties.
- Managers supported staff to develop through yearly, constructive appraisals of their work. We saw evidence that all staff had received an appraisal this year. Managers identified any training needs their staff had and gave them the time and opportunity to develop their skills and knowledge. All staff were encouraged to attend training sessions to update themselves with refresher training on non-surgical treatments. We saw that the clinic administrator was also booked to receive training from the surgeons on surgical treatments offered to improve her knowledge base. The registered nurse at the service had been enrolled on a nurse prescriber course to aid with her professional development and enable her to prescribe non-surgical injectables independently.
- Managers made sure staff attended team meetings or had access to full notes when they could not attend.
- The provider informed us that surgeons only worked within their scope of practice and operated completely within their area of known practice and ability. Both of the surgeons employed by the clinic were on the specialist register for plastic surgery and held substantive posts in the NHS. We received confirmation that their NHS appraisals covered the whole scope of each surgeon's practice, including work undertaken both inside and outside of the NHS. Consultants were appraised through their NHS Trust. They attended conferences and further training appropriate to their role. All surgeons had current medical indemnity cover.

Multidisciplinary working

Healthcare professionals worked together as a team to benefit patients. They supported each other to provide good care.

- Staff held regular multidisciplinary meetings to discuss patients and improvements to their care where there had been complications. We saw minutes from these meetings.

- Staff told us that they enjoyed working with their colleagues and were complimentary about the support they received from one another. We observed good working relationships between all staff.
- Staff told us that there were no issues working with external providers, such as the hospitals at which the surgeons performed major operations under practising privileges.

Seven-day services

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

- The clinic was usually open five days a week for consultations and post-operative wound care appointments. There were usually one to two operative lists running per week for major operations performed under practising privileges at separately registered locations.
- Patients were able to contact staff at the clinic for support at any time. They were given a telephone number to call following their procedure, which was manned by a member of clinic staff 24 hours a day, seven days a week. Those who had undergone major surgery at other centres also had contact details for those centres. If a patient needed to return to theatre, the surgeon who had performed the operation remained on-call. Surgeons and Anaesthetists were required to remain within one hour of the hospital where a procedure had taken place (under practising privileges) whilst the patient remained an inpatient.

Health promotion

Staff gave patients advice regarding their procedure.

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

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

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

- Staff made sure patients consented to treatment based on all the information available. Staff clearly recorded consent in the patients' records. We saw evidence that patients came in for an initial consultation appointment, where they met with the surgeon who would perform their procedure. At this appointment, all the risks and benefits of the procedure were discussed, as well as all relevant patient history. The Royal College of Surgeons' professional standards for cosmetic surgery states that consent must be obtained in a two-stage process, with a cooling-off period of at least two weeks between the stages to allow the patient to reflect on their decision. All eleven records that we reviewed had a clear gap of at least two weeks from consultation to the surgery procedure. The patient reconfirmed their intention to go ahead with a procedure by completing the consent form on the electronic system on the day of the procedure.
- There was a procedure in place for consent in relation to use of images for promotion, education or publication.
- There was clear guidance relating to capacity in the clinic's policy, where it stated that any doubts regarding a client's capacity would be referred to the lead consultant, who would liaise with the patient's GP.

Are surgery services caring?

Good

This is the first time we rated caring for this service. We rated it as **good.**

Compassionate care

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

- On the day of our inspection, there were no patient consultations or wound care appointments booked in at the clinic, so we were unable to observe interactions with patients or seek their feedback directly.
- We saw a large amount of 'thank you' cards from patients with positive comments about their treatment. We saw multiple examples of feedback praising the kind, considerate and respectful attitudes of various members of staff.
- Senior staff told us that feedback was often posted online, on two independent review websites, which

provided patients with the opportunity to provide feedback on the individual surgeon and the clinic. There were a large number of positive reviews on these websites.

- Patients were also encouraged to give feedback via a real time rating system on a handheld tablet immediately after their procedure, but we were told the old registered manager had not given the clinic the login details for this system when he left. They were therefore unable to access historic results, but planned to start this again.
- Patient feedback, including compliments, was collected and shared with all staff during team meetings.
- Staff followed policy to keep patient care and treatment confidential, and were able to describe how they would hold sensitive conversations with patients. Staff made sure that people's privacy and dignity needs were understood and respected, including during physical or intimate care and examinations. There was a chaperone policy in place, and the registered nurse and operations manager had undertaken formal training in how to act as a chaperone.

Emotional support

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

- Staff gave patients and those close to them help, emotional support and advice when they needed it. Staff told us they recognised that many patients were anxious about having surgery and they made sure patients always had enough time to ask questions during their consultations and before minor procedures.
- Staff understood the emotional and social impact that a person's care, treatment or condition had on their wellbeing and on those close to them. At the initial consultation, patients were asked about their medical history, social circumstances and mental health status. If the patient was prescribed any mental health medications or was undergoing psychological therapy, they would be asked to produce a medical support letter from their GP, psychiatrist, therapist or counsellor. The provider informed us that if further information was required at this stage, they would liaise with the appropriate health professional further. Any concerns indicating vulnerability would mean the patient' procedure would be placed on hold while the service liaised with the patient, their relatives and other health practitioners where appropriate. The service had an informal arrangement with a psychiatrist located near the clinic who the consultants could discuss any concerns with, and signpost patients to if necessary.

Understanding and involvement of patients and those close to them

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

- Staff made sure patients and those close to them understood their care and treatment. The clinic told us they could offer patients as many consultations as necessary to ensure patients were happy with the procedure. Any additional consultations were offered free of charge. Patient records showed discussion of potential risks and complications of surgery, as well as the benefits and alternatives available.
- Patient information was available explaining what to expect on the day of the procedure, and then upon discharge, and who patients could contact if they had any concerns about their recovery. This information was tailored according to the type of procedure being undertaken. Staff called patients the day before any procedure to ensure they were aware of what to do on the day.
- Patients were offered the opportunity to have a friend or relative present during consultations, unless safeguarding concerns were raised in relation to this. Patients were required to have a friend or family member to act as a chaperone to help the patient home after discharge from major procedures.
- All patients were private and self-funding. All pricing for procedures was readily available on the provider's website, and this was confirmed at the initial consultation stage.

Are surgery services responsive?

Good

This is the first time we rated responsive for this service. We rated it as **good.**

Service delivery to meet the needs of the patient population

Good

Surgery

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

- Managers planned and organised services so they met the needs of the patient population. As the clinic provided private elective cosmetic surgery, appointments were planned in advance at times to suit the patients. The clinic was open five days a week for consultations and post-operative wound care appointments. Theatre lists were planned at least two weeks in advance. There were usually one to two operative lists running per week for major operations performed under practising privileges at separately registered locations.
- The hospital was in central London, with good public transportation links, making it accessible to patients from a wide geographical area.
- Facilities and premises were appropriate for the services being delivered. There was a small waiting area, where hot and cold drinks were available for patients. There was a device that allowed patients to select music if they wished to have something playing during the procedure.

Meeting people's individual needs

The service took account of most patients' individual needs and preferences. Staff made some reasonable adjustments to help most patients access services.

- The clinic was accessible by a lift, but the single toilet for patient use was located down one flight of stairs on a landing. This did not enable disabled access.
- The service did not offer interpretation services for patients where English was not their first language. When a patient booked in for a consultation, these patients would be asked to bring their own interpreter. The operations manager was clear that they would expect any interpreter to be a professional, and not a family member or friend of the patient.
- The service did not have information leaflets available in other languages or formats on the day of inspection. The operations manager informed us that they could provide patient information in any format, such as another language, if given adequate time to do so. They indicated they would find a company specialising in translating medical information to help with this. Information was also available on the company website.
- Following surgery, patients were provided with a contact telephone number for the service. If patients had any concerns following discharge from the hospital, they were encouraged to phone for advice and support.
- Any female patient who required a chaperone to be present could be provided with one. Details of the chaperone would be recorded in the patient's notes. The registered nurse and operations manager had undertaken training in how to act as a chaperone.
- The service did not routinely treat patients with complex needs, as it did not accept patients for admission that were deemed to lack capacity regarding treatment decisions, as it provided elective cosmetic surgery.

Access and flow

People could access the service when they needed it and received the right care promptly. However, the clinic did not audit waiting times for consultation or surgery.

- Patients could contact the clinic via email or telephone. The clinic administrator or the operations manager responded to any initial patient enquiries. Patients considering surgical procedures would have a face-to-face consultation with the relevant surgeon. Following this appointment, subsequent consultations could be offered or the surgery could be booked.
- The service did not audit patient waiting times for surgery or consultations. This was because all procedures were elective and performed by only two surgeons. Patients were able to choose their preferred dates. Senior staff told us that any appointments required at short notice could be accommodated during an evening or weekend outside of normal working hours, if necessary.
- Theatre lists for procedures undertaken at other centres under practising privileges were finalised at least two weeks in advance. Each list could not exceed ten hours, with no single operation planned to take more than four hours.
- The clinic did not monitor average waiting times for appointments, so it was not clear if patients would normally have to wait for longer periods in the waiting area.
- Between opening in October 2018 and March 2019, the service had 1,137 attendances for consultations or

post-operative wound care. In addition, four labiaplasty operations and one ear fold procedure took place at this location. No procedures or appointments had been cancelled for a non-clinical reason in this time.

- If patients had an issue following surgery, they were provided with a phone number to contact a clinician to discuss this. In an emergency, the patient was directed to an acute hospital accident and emergency department. For non-emergency issues, the patient would be reviewed by their surgeon. Any revisions to their surgical outcomes could be arranged as a planned episode of surgery.
- Patients were provided with post-operative care instructions, and pre-booked appointments were made for follow-up care either at this clinic location, where required. Staff at the clinic called the patient 24 hours after the procedure to check in with them and confirm the follow-up appointment dates. These usually occurred at seven days following an operation (with the registered nurse), and at six weeks and six months with the surgeon.

Learning from complaints and concerns

It was easy for people to give feedback and raise concerns about care received, although there was no information displayed in the clinic about how to raise a complaint. The service treated concerns and complaints seriously, investigated them and shared lessons learned with all staff.

- The service did not clearly display information about how to raise a concern in patient areas. There were no leaflets or posters available for patients on how to do this. Guidance on making a complaint was included with the post-operative information sent to patients. There was also a link on the provider's website that allowed patients to view the company complaints policy and email the operations manager directly.
- Staff knew how to acknowledge complaints and patients received feedback from managers after the investigation into their complaint. The service aimed to acknowledge all complaints within two working days and provide a full response within 20 working days, which they achieved. Where this timeframe was not possible, a letter would be sent to the complainant to inform them of the revised schedule. Patients could contact the Independent Sector Complaints Adjudication Service (ISCAS) if they were unhappy about the outcome of their complaint. No complaints had yet been referred to ISCAS. Following the inspection, when asked, the service were initially unable to produce evidence of a subscription to ISCAS. However, they later provided evidence that they had subscribed to ISCAS from September 2019. Staff were booked to receive training on this.
- Between May 2018 and April 2019, there had been three formal complaints made to the service. On the day of inspection, only one of these was present on the complaints tracker, which related to post-operative care. Enhanced follow up was provided to this patient. Following inspection, the details of the other two complaints were provided, which related to cancellation of a procedure and a patient being late for an appointment. Patients were always encouraged to meet with their surgeon to resolve any issues.
- Managers shared feedback from complaints with staff. Complaints were discussed at the bi-monthly multidisciplinary team (MDT) meetings. The complaints tracker was available for all staff to view so they had visibility of both active and completed complaints.

Are surgery services well-led?

Requires improvement

This is the first time we rated well-led for this service. We rated it as **requires improvement.**

Leadership

Leaders had the integrity, skills and abilities to run the service. They understood and managed the priorities and issues the service faced. 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 clinic was managed by a lead consultant, with support on the day-to-day running of the service by the operations manager. There were three other members of staff, including another consultant, a registered nurse and a clinic administrator. The managing director of the company had resigned in June 2019 as he did not have the time to run the company. Senior staff told us that no formal handover of many aspects of the business had taken place, leaving many uncompleted tasks. The

managing director had also been the registered manager of the service. The lead consultant was in the process of submitting their application to become the registered manager for this location.

- All staff informed us they found the lead consultant and operations manager to be approachable and supportive. As a small team, all staff worked together regularly and were able to seek advice and speak freely with one another. We saw evidence of formal staff meetings where staff could raise any issues, which had been documented for the last two months. Appraisals encouraged staff to develop and take on new responsibilities appropriate to their roles, such as the operations manager leading on the development of the bespoke patient record system.

Vision and strategy

The service had a vision for what it wanted to achieve, but this was not clear. There was no clear strategy to turn the vision into action. Leaders and staff did not understand them and did not know how to apply them and monitor progress.

- The service's vision was to provide the highest level of patient focussed care for their patients. They aimed to do this by providing the latest evidence-based treatments and ensuring patients received as much information as possible to support their decision making. The mission statement was to become the leading provider of plastic and cosmetic surgery in England, through maintaining quality and safety standards. In another document, the practice ethos was articulated, based on the principles of mutual respect, holistic care, continuity of care and continued learning.
- The strategy of the service was not clear. A strategy document was provided, but this was from April 2017, before the business had been registered at the current location. Information provided prior to inspection articulated the strategy as growing the business 'in line with core values of decency, honesty and the highest surgical standards.'
- Although the team of staff was small, there was no knowledge of the vision of the company, and no consensus regarding the strategy. Senior staff told us that the clinic previously planned to employ additional surgeons, but now they wished to focus on building the business around the two existing consultants. They would free up more time to operate privately and eventually leave their substantive NHS posts. However, we did not see this documented anywhere, or any plans on how this would be managed in terms of governance. There was currently no structure in place to ensure that appraisals were completed or scope of practice was reviewed outside of the NHS.

Culture

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

- We observed good team working amongst staff on the day of inspection. Staff we spoke with told us they felt supported, respected and valued within the team. Staff told us they were happy working at the clinic and felt they contributed to creating a positive work environment. They described working at the clinic as being like part of a family. Staff were provided with the opportunities to develop within their role.
- Staff told us that they felt confident to raise any concerns. There was an up-to-date policy on raising concerns, which outlined how to escalate any issues. Senior staff told us that any errors were discussed openly and managed in a fair way, with an emphasis on learning, in order to better design systems that promoted safe behaviours. However, we were not assured that staff always reported errors appropriately to enable this to happen.
- Throughout our inspection, we saw evidence of responsible marketing that complied with the guidance contained within the Committee on Advertising Practice's (CAP). We did not see any evidence of irresponsible incentives or 'hard sell' tactics.

Governance

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

- At the time of inspection, we were not assured that there were effective structures, processes and systems

of accountability to support the delivery of good quality, sustainable services. The recent departure of the managing director had left the service with many uncompleted tasks and a lack of cohesive governance structures in place. A gap analysis by an external company had been commissioned, which recommended external assistance with governance, management systems and reporting. As a result, departmental meetings had started to be documented and some audits of medicines and environment had taken place.

- There was no effective system to review and update policies that were not fit for purpose. Not all policies reviewed referenced current best practice guidance or were tailored to the clinic. Following inspection, senior staff indicated that this was a priority and all policies would undergo review by September 2019. Some policies, such as the sepsis management policy, had only been drafted in August 2019.
- We were not assured of the governance procedures for managing and monitoring service level agreements with third parties, as the provider was not able to produce a list of external contractors they worked with when asked.
- The registered nurse at the service had been enrolled on a nurse prescriber course to aid with her professional development and enable her to prescribe non-surgical injectables independently. The service had identified a mentor for her, but there did not seem to be clear expectations or guidelines to support her development. Following inspection, we were provided with a policy document drafted in August 2019, but this did not go into detail regarding what medicines she would be expected to prescribe, or the governance structures that would support this.
- There was no medical advisory committee (MAC) at the time of inspection, as there were only two surgeons operating at the service. This was a concern if the service planned to grow by focusing on growing the private work of the consultants, as there were no governance arrangements in place for appraisal or review should they leave their NHS posts.
- The clinic held a monthly operational meeting to review incidents, as well as a multidisciplinary team meeting every two months. There was some evidence that incidents and complex cases were discussed, but we were not assured that all incidents were being reported to ensure learning took place. There was no standing agenda item for infection control, complaints or incident review. In the information provided prior to inspection, the service indicated that it also held bi-annual medical advisory committees, clinical governance meetings, infection control committees, health and safety committee meetings, but there was no evidence that these took place or were booked in.
- Following inspection, the provider compiled an action plan which included seeking specialist advice on governance and compliance with CQC regulations, and governance framework refresher trainer for all staff. Senior staff planned to compile a clinical governance review for the previous 12 months and then update this monthly, beginning in September 2019.

Managing risks, issues and performance

Leaders identified and escalated relevant risks and issues and identified actions to reduce their impact. They had plans to cope with unexpected events.

- We saw the clinic's risk register, which had recently been drafted following the gap analysis that had been commissioned. It was up to date and referenced ongoing risks. These were graded with level of risk and reviewed regularly, with appropriate actions taken to mitigate against them. Staff were able to tell us about current risks on the register, such as the increase in returns to theatre and the lack of a formal process for capturing user feedback.
- There was no meaningful audit programme taking place. At the time of inspection, no audits took place in relation to infection prevention control, hand hygiene, pain relief, fasting or documentation, amongst other topics. The service was not collecting any data in relation to Quality Patient Reported Outcome Measures (Q-PROMS). Following inspection, the service submitted a revised audit plan which included WHO checklist completion, records and infection prevention control.
- There was no back-up generator on the premises. Following inspection, we were provided with evidence that this was being considered in the updated business continuity plan.
- All surgeons performing cosmetic surgery had professional indemnity insurance in place. We saw evidence of this in staff records.

Managing information

Good

Surgery

The service collected some data but not all staff could find the data they needed, in easily accessible formats, to understand performance, make decisions and improvements. The information systems were not historically integrated.

- The lead surgeon, applying to be the new registered manager, was registered with the Information Commission, as required under the Data Protection Act 1998.
- The service used an electronic system to store medical records and observations. Prior to June 2019, patient's operative notes had been stored on remote servers accessed from the internet. We found that these historic files were not easily accessible, although they were encrypted, and all laptops had two factor authentication.
- The service had commissioned a bespoke patient record system that was being codesigned by staff. This was planned to go live later in the year. Clinic staff would use this communicate with each other and could set tasks to be signed off as part of the patient journey.
- There was a shared drive available to staff, which contained links to current guidelines, policies and procedures. On the day of inspection, not all staff were able to access information we requested and it unclear whether all appropriate information was stored here.
- All staff had access to their work email, where they received organisational information on a regular basis, including operational changes.
- Patients received a discharge letter with clinical information after surgery. The letter could be shared with the GP if the patient wished to do this.

Engagement

There was limited evidence of patient or staff engagement to plan and manage services.

- Patients were also encouraged to give feedback via a real time rating system on a handheld tablet immediately after their procedure, but we were told the old registered manager had not given the clinic the login details for this system when he left. They were therefore unable to access historic results, but had started this again recently. Patient feedback was currently only available on two online review sites.
- There was no formal mechanism for staff feedback other than team meetings, and there was no staff survey due to the small size of the service. Staff told us that they would be comfortable suggesting improvements to the service, and had been involved in compiling the risk register and various policy changes. The operations manager was codesigning the new patient records system.

Learning, continuous improvement and innovation

The clinic lacked a robust approach to quality improvement.

- We found the centre lacked reasonable challenge from internal or external sources regarding quality improvement, governance, safety and effectiveness. The service had recently commissioned a gap analysis of the clinic, but only some of these actions had been implemented at the time of inspection. There was no focus on quality improvement or innovation. There was no formal access to quality improvement methodology, or training for staff to encourage innovative practice.

Outstanding practice and areas for improvement

Areas for improvement

Action the provider SHOULD take to improve

- The provider should ensure that all medical staff have completed their mandatory training.
- There provider should ensure that there is formal governance in place relating to infection prevention control, including audit and discussion.
- The provider should begin to implement the new safer surgery policy and undertake a safer surgical checklist based on the World Health Organisation (WHO) guidance for minor operations performed at this location.
- The provider should ensure safer surgical checklists based on WHO guidance are present in all patient records and audit their completion.
- The provider should ensure there is a formal written policy relating to the use of antibiotics or antibiotic stewardship.
- The provider should provide further training to all staff on what constitutes an incident or near miss and support them to report these, with appropriate investigation and learning taking place.
- The provider should review all policies and guidelines to ensure they are fit for purpose and reference national guidance, as per their stated plan.
- The provider should consider providing formal access to translation or interpretation services for patients whose first language is not English, and information in other accessible formats.
- The provider should display clear information in the clinic about how to raise a complaint.
- The provider should revise their vision and strategy to ensure it is clear and actionable. This should be communicated to all staff so that progress can be measured.
- The provider should introduce governance processes and an audit schedule that allows benchmarking of the service insofar as possible.
- The provider should provide adequate guidance and governance to support the nurse prescribing course.
- The provider should ensure that all patient information is integrated.
- The provider should consider how to formally collect patient and staff feedback.