Lase Cosmetic Limited

Lase Cosmetic

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	Good
Are services safe?	Good
Are services effective?	Good
Are services caring?	Outstanding
Are services responsive to people's needs?	Good
Are services well-led?	Good

Summary of findings

Overall summary

This service has not previously been inspected. We rated it as good.

- 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. The service controlled infection risk well. Staff assessed risks to patients, acted on them and kept good care records. They managed medicines well. The service managed minor safety incidents well and learned lessons from them. Staff collected safety information and used it to improve the service.
- Staff provided a high standard of care and treatment and gave patients pain relief when they needed it. Managers monitored the effectiveness of the service and 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 comprehensive information. They followed the two-stage consent process.
- 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 and their families.
- The service planned care to meet patients' individual needs and made it easy for people to give feedback.
- Leaders ran services well using reliable information systems and supported staff to develop their skills. 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.

However:

- The clinic used two systems for storage of staff files. Although all documentation was present, these required better organisation because documents were not always easy to find, and compliance checks could not always be carried out quickly and efficiently.
- The service did not have a specific Fit and Proper Person policy, and although the service did not use the Regulation's Schedule 3 checklist, their own compliance checks showed all necessary documents were collected.
- There was no formal risk register, but risks were managed well by the small clinic team. However, this might not continue to be a manageable process should the business expand.

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Surgery	Good	

Summary of findings

Contents

Summary of this inspection

Background to Lase Cosmetic

Lase Cosmetic clinic is operated by Lase Cosmetic Limited. The service registered with CQC in 2019.

The clinic is located in Newcastle upon Tyne and provides independent cosmetic surgery and aesthetic treatments to members of the public on a self-referral basis. A specialist skin lesion service is also offered. The clinic did not treat children under the age of 18 years old. The non-surgical treatments do not fall within the CQC scope of registration and will not be reported on.

The clinic has a spacious reception area, an office, meeting room, consultation and treatment rooms, and an operating theatre, all set out over an entire floor of a modern building.

The service is registered to provide the following regulated activities:

• Surgical procedures

• Treatment of disease, disorder and injury

Surgery is carried out on a day case only basis. Consultations are carried out for any surgical treatment and cases requiring general anaesthetic or additional services are referred to local private hospitals. There are thorough pre- and post-operative care pathways in place and care is tailored to each individual patient. The clinic does not treat children under the age of 18 years old.

There has been a registered manager in post since 2019. The service has not been previously inspected or rated.

How we carried out this inspection

The team inspecting the service comprised a CQC lead inspector and two specialist advisors with expertise in surgery. The inspection was overseen by Sarah Dronsfield, Head of Hospital Inspection.

During the inspection, we visited all areas of the clinic, including consultation and treatment rooms and the operating theatre. We spoke with seven staff members including surgical staff, theatre staff, the registered manager, and the service director. We spoke with two patients and reviewed four sets of patients' records. We also reviewed information relating to service activities, provider policies, performance and patient feedback.

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.

Outstanding practice

We found the following outstanding practice:

- The clinic had a focus on delivering safe care above all other priorities. All, policies and processes were established with patient safety paramount in all situations.

Summary of this inspection

- The wide-ranging use of technology facilitated efficient service delivery, streamlined information sharing for patients and staff, and ensured a high standard of communication.
- Staff used a minimally invasive approach in all cases, utilising a mix of technology, equipment, and aesthetic procedures to reduce the need for more invasive, surgical procedures and reduce recovery times.
- Patient feedback was continually and overwhelmingly positive; patients felt truly valued and included, and said staff went the extra mile to provide a consistently high standard of care, from initial assessment to post-operative review, and further advice and care following procedures.

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 SHOULD take to improve:

- The service should ensure storage of staff files is organised to enable staff to find documents easily and compliance checks are carried out quickly and efficiently.
- The service should ensure a specific Fit and Proper Person policy is implemented prior to further staff recruitment.
- The service should ensure formal risk register is implemented to record and effectively manage risks to the service.

Our findings

Overview of ratings

Our ratings for this location are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Surgery	Good	Good	☆ Outstanding	Good	Good	Good
Overall	Good	Good	☆ Outstanding	Good	Good	Good

Good

Surgery

Safe	Good
Effective	Good
Caring	Outstanding
Responsive	Good
Well-led	Good

Are Surgery safe?

Good

Mandatory training

The service provided mandatory training in key skills to all staff and made sure everyone completed it.

Staff received and kept up to date with mandatory training; this was delivered 'in-house' and by external providers through the clinic's regional and national network links, both face to face and through eLearning. The mandatory training was comprehensive and met the needs of patients and staff. All staff we spoke with understood their responsibility to complete mandatory training and felt they received all training necessary to enable them to work effectively.

The clinic manager monitored training for all clinical and administrative staff using a training matrix and alerted staff when they needed to complete updates.

We reviewed staff records and saw information regarding mandatory training compliance was recorded, along with evidence of course completion such as certificates. Training was comprehensive and included: basic life support, infection prevention and control (IPC); fire safety and emergency evacuation; equality and diversity; medicines management; complaints; conflict resolution; data protection and information governance; mental health and mental capacity; and manual handling. Further role specific training was also completed and recorded.

Safeguarding

Staff understood how to protect patients from abuse Staff had training on how to recognise and report abuse and they knew how to apply it.

All staff received training appropriate to their role, which reflected national guidance and included how to recognise and report abuse. Training included safeguarding vulnerable adults and children, preventing radicalisation and female genital mutilation (FGM). Staff knew how to make a safeguarding referral and who to inform if they had concerns.

Safeguarding policies and procedures were easily accessible in both electronic and paper formats, and staff knew where to find them; we saw safeguarding guidelines and contact information displayed in staff areas. The service's safeguarding policy contained details of the local authority safeguarding team, appropriate definitions, information regarding FGM, processes to follow, and where additional information could be found.

Good

Surgery

The lead clinician and other medical staff working at the clinic had completed Safeguarding children level three training. All other clinic staff, including bank staff, had received level two training, with refresher training delivered as appropriate. At the time of our inspection all staff were compliant with safeguarding training requirements. Staff gave examples of how to protect patients from harassment and discrimination, including those with protected characteristics under the Equality Act described safeguarding concerns they had managed as a team.

The service promoted safety in recruitment procedures and ongoing employment checks. We reviewed a range of electronic and paper staff records and although these were not all the same, the registered manager provided evidence that appropriate DBS checks had been carried out.

The clinic did not treat children under the age of 18 years old. If there was any concern about a patient's age, photographic identification would be requested and reviewed; this would then be scanned and uploaded to the patient's digital record. The clinic also followed a process to carry out pre-operative checks with patient's GPs, and if a patient was found to be under 18 staff would not provide treatment.

There had been no safeguarding concerns reported to CQC from March 2021 to February 2022.

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 control measures to protect patients, themselves and others from infection. They kept equipment and the premises visibly clean.

All areas of the clinic, including the reception area, offices, storage rooms and patient treatment areas, were clean, tidy and free from clutter. All areas had suitable furnishings which were clean and well-maintained. The service employed a cleaner and we saw evidence of completed cleaning records. Flooring throughout the clinic was well-maintained and visibly clean. Maintaining cleanliness and hygiene was the responsibility of all staff and we saw cleaning was carried out at the time of our inspection by different staff members. Ventilation systems were in use in the reception area and in operating theatre. Test and service reports of the theatre ventilation system showed this complied with national guidance (HTM03/01).

Staff used records to identify how well the service prevented infections. Infection prevention and control (IPC) audits were scheduled every six months, and we saw cleaning was carried out and recorded daily, and legionella temperature safety checks were carried out every six months. Staff ran taps daily to reduce the incidence of legionella and annual water safety management was overseen by an external contractor. IPC training was mandatory for all staff.

Staff followed infection control principles including the use of personal protective equipment (PPE) and aseptic techniques when required; we saw PPE was readily available and used effectively in different areas of the clinic. Staff wore appropriate theatre attire and were bare below the elbows. The service had an identified IPC lead, who was the theatre manager. Hand washing facilities and hand sanitising gel dispensers were available in all clinic areas for staff, patients and visitors to use.

Staff worked effectively to prevent, identify and treat surgical site infections. All surgical patients were required to shower using soap prior to admission, and all were monitored for signs of infection during surgery and recovery. At the time of discharge, patients were given advice leaflets with information about how to prevent infection occurring as well as signs

and symptoms to be aware of, and this was also discussed during follow up calls and appointments with the clinic. Any surgical site infection identified would be discussed at the clinic's quarterly clinical governance meetings. We saw meeting minutes showing a discussion took place regarding oozing from a wound and how this was managed. Surgical infection audits were scheduled every three months and no surgical site infections had been identified or reported.

All surgical instruments used at the clinic were single patient use only and were disposed after use; this eliminated the risk of cross contamination.

Patients were not routinely screened for methicillin-resistant staphylococcus aureus (MRSA), which is a bacterium resistant to certain antibiotics, unless they were deemed to be at risk during the surgical pre-assessment process. Patients were required to provide a negative COVID-19 lateral flow test in the day of planned surgery. This pre-operative screening was in line with national guidance. Staff followed a Sepsis Recognition policy that included up to date National Institute of Clinical Excellence (NICE) guidance. The Infection Prevention and control policy included guidance regarding decontamination, legionella control, personal hygiene, PPE, and waste disposal. It also directed staff to further information and advice.

Staff cleaned equipment after every patient contact, and we saw equipment was labelled to show when it was last cleaned.

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 clinic environment, including treatment rooms, operating theatre and the recovery room, followed national guidance and all areas were well maintained. All the clinic rooms and theatre were arranged over one floor with a wide staircase and a lift. There was also a service staircase at the back of the building. In the event of a patient requiring emergency evacuation from theatre and the lift was unavailable, staff were trained to use a carry chair down the stairs, but this had not been necessary at the time of our inspection.

Staff carried out daily and weekly safety checks of specialist equipment and we saw records of the checks had been completed. All refrigerator temperatures had been regularly checked and recorded by staff. Portable appliance testing (PAT) had been carried out on relevant equipment and all tests were in date. The service kept an equipment log with details of servicing and expiry dates. However, most items were relatively new and had not required servicing at the time of the inspection. The provider was in the process of arranging contracts to come into place later in the year as service and maintenance cycles were due to begin. We saw email communications with contractors to establish these.

The service employed an external contractor to carry out air quality testing, electrical systems maintenance, fire safety assessments, water checks and portable appliance testing. Daily checks were carried out by staff, and weekly fire alarm tests took place.

The service had enough suitable equipment to help them to safely care for patients. We checked a selection of consumable equipment in different areas of the clinic and all items checked were within their expiry date. The service carried out minor procedures only which did not include surgical implants.

Good

Surgery

We discussed the processes in place when the service had recently experienced an external power failure. Staff told us theatre equipment and patient monitoring machines had their own back-up electrical supply. There had been no patients in the clinic when the power had failed. The Emergency Evacuation of Patients policy gave simple instructions to staff for making patients safe prior to evacuation and there was appropriate emergency equipment available so any procedures in progress could be managed safely.

Staff disposed of waste, including clinical waste and sharps, safely, and we saw containers for sharps' disposal were in date, had been signed appropriately and were not overfilled, which was in line with national guidance. Waste disposal practices and principles were outlined in the service's Disposal of Clinical and Non-clinical Hazardous Waste Policy, which included information such as identification and management of IPC issues, sharps' related injuries, contact with bodily fluids, waste disposal, and issues relating to staff welfare. There was a service level agreement (SLA) in place with an external company for the disposal of clinical waste. Clinical waste was transferred securely, using the back stairs and at times when patients were not present for example, on early mornings before clinics began.

Patients were accompanied throughout their journey within the clinic and were never left alone in treatment rooms or recovery, but the clinic layout allowed staff quick access to patients should they need help.

Assessing and responding to patient risk

Staff completed and updated risk assessments for each patient and removed or minimised risks. Staff identified and quickly acted upon patients at risk of deterioration. The service made sure patients knew who to contact to discuss complications or concerns.

Staff completed risk assessments for each patient on assessment, during admission and prior to discharge. Comprehensive pre-operative consultations and assessments for all patients were carried out in line with national guidance and included a risk assessment of the patient's suitability for the procedure. Any risks identified, including concerns regarding a patient's psychological wellbeing, were escalated and the service could refer patients for psychological testing if clinicians felt this was necessary. Patients were provided with a range of information and advice at their initial consultation relating to their specific procedure; this was generated automatically as part of the electronic patient record.

We saw the protocol for the acutely unwell patient displayed in recovery. All clinical staff had an awareness of sepsis risks and reception staff had access to an information folder at the front desk to help triage telephone calls from concerned patients. Reception staff said clinicians were all available should a patient report feeling unwell.

Medical staff described a surgical consultation and records showed procedures were discussed in detail along with associated risks. Patients were required to complete an extensive medical history questionnaire which was discussed and documented. Pre-operative assessments were completed by the lead nurse and the clinic manager corresponded with other healthcare providers if further information was required. There was an SLA in place with a clinical laboratory service for the provision of laboratory pathology services. Other services such as blood testing were carried out at a local private hospital prior to accepting the patient for surgery. Any blood test or pathology results were reviewed and acted on by the surgeon.

Staff knew about and dealt with any specific risk issues. Managers told us patients who attended the clinic were generally low risk, and they were careful about their selection of patients for surgical procedures; the American Society of Anaesthesiologists' (ASA) classification of physical health was used to assess patient risk, and only those classified ASA one (completely healthy) or ASA two (with a history of mild disease) were accepted.

Good

Surgery

All patients attending theatre were assessed for venous thromboembolism (VTE) as part of their initial medical questionnaire and prior to surgery as part of the World Health Organisation (WHO) surgical safety checklist. All patients undergoing surgery were asked to wear compression stockings to minimise this risk; a pneumatic compression device was also used during surgical procedures and in the recovery room. The clinic had reported no patients with VTE.

Theatre staff showed us completed WHO safety checklists for all procedures carried out these were completed thoroughly. Patient records contained checklists and VTE assessments and all documentation was completed appropriately.

Staff huddles were held prior to each clinic and theatre list and safety briefs and debriefs were held before and after each surgical procedure. Staff also met weekly to discuss procedures and developments. Clinical meetings were held with each surgeon to discuss upcoming and previous surgeries, processes and improvements.

Staff used the national early warning score (NEWS2) tool to promptly identify deterioration in a patient's condition; this involved monitoring of clinical observations including heart rate, respiratory rate, blood pressure, oxygen saturations and temperature. Theatre staff said any concerns identified were immediately escalated to the surgeon for review. Records showed staff completed clinical observations on patients during and following surgery; the follow-up observations were completed at 15-minute intervals for two hours, then every 30 minutes until patients met the discharge criteria.

The Sepsis recognition policy gave information about when and how external referrals would be made, including in the event of an emergency such as trauma or sepsis. Should either of these events occur and the patient required emergency treatment, they would be transferred to the local NHS hospital by calling 999 for an ambulance.

Staff received training on transferring patients safely; at the time of our inspection there had been no emergency transfers from the clinic. All patients had consultant-led care and a consultant surgeon was present in the clinic at all times until the last surgical patient had been discharged.

Local anaesthetic only was used in theatre with a small dose of a drug to reduce anxiety if a patient required it. There was no sedation or general anaesthesia offered at the time of the inspection.

The recovery room was equipped with standard equipment including a resuscitation trolley, oxygen, suction and emergency drugs. We saw evidence of daily checks being completed. Staff told us a theatre case would not be started if there was still a patient in recovery.

We discussed potential risks following surgery including haematoma and bleeding; staff and managers told us there were standard operating procedures in place and there was a manager on call at all times, should a patient need urgent support following discharge. There had been one instance of a patient experiencing some minor oozing from a wound, but this had resolved quickly. There had been no requirement for a patient to return to theatre for intervention.

There were no facilities for patients to stay overnight following surgery. All cases were considered on an individual basis and if a surgeon assessed the patient would require a longer stay, they would refer them for surgery at the local private hospital. Following surgery, all patients, were cared for in the recovery room by a nurse and the surgeon stayed on site until all patients on their list were fully recovered. Patient records showed surgical reviews took place after one week and after six weeks.

Patients were discharged once they had recovered fully from their procedure. staff ensured their clinical observations were within normal parameters and there were no adverse symptoms and discharge checklists had been completed. Comprehensive post-operative advice was given, along with any necessary medicines or equipment and a follow-up appointment.

The clinic provided full discharge information to patients' GPs.

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. Managers reviewed staffing levels and skill mix and gave bank staff a full induction.

The service had enough medical, nursing and support staff to keep patients safe. Staffing levels could be adjusted according to the needs of patients and planned surgical or clinic lists. Managers ensured the correct numbers and grades of staff were present in line with national guidance and clinic policy and told us the operating theatre and recovery were staffed according to need.

Five consultant surgeons were contracted with practising privileges and all had substantive or honorary local NHS Trust positions. There was a standard operating procedure in place for safe theatre staffing; we reviewed this and saw it was comprehensive and set out guidance for minimum safe numbers of staff required for different procedures, along with risk assessments, escalation processes and incident reporting information.

There was always a registered nurse assigned to the recovery room for surgical cases. Managers told us no surgical lists would be planned unless the agreed minimum number and skill mix of staff were present. There had been no cancelled procedures due to lack of staff.

All patients seen at the clinic had consultant-led care and a consultant surgeon was present in the clinic at all times during a surgical patient's admission.

The service had no staff vacancies at the time of our inspection and there was a low staff turnover rate. However, two staff had recently left to progress their careers. There had been four instances of short-term staff sickness in the last 12 months.

The service utilised one or two regular bank staff for each surgical list. Bank staff were familiar with the clinic's policies and procedures; no agency or locum staff were employed at the time of our inspection.

Records

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

Patients' notes were stored electronically and were comprehensive. All staff had access to the information needed to deliver safe care and treatment as they all had the ability to log into the records on site or remotely. Managers told us access to records was tailored to each staff member so they could only view information relevant to their role, and access to the electronic system was protected with individual log-in details, passwords, and a firewall.

Patients told us they could view their own records on a large screen in the consulting room as the consultant was typing them, and consultants explained the procedure they would undertake using diagrams drawn using the electronic system.

Good

Surgery

We reviewed four sets of patient documentation and saw all patients had a comprehensive electronic record which contained individual patient details, appointments, consultation notes, pre-assessment and admission documentation, medical records, photographs and all communication, consent, surgical documentation, and checklists including completed NEWS charts. Perioperative and post-operative care was recorded with follow-up treatment, discharge checklists approved by the surgeon, and a record of the discharge treatment and advice given. There was evidence a follow up call was arranged and review appointments were made. Written notes from theatre were scanned and added following the patient discharge and paper originals were destroyed to ensure duplicate records were not created. Account information was held in the same system.

Records were stored securely; the majority of patient and clinic records were electronic, staff explained they were stored in line with relevant guidance prior to being destroyed.

We reviewed the service's consent policy, theatre documentation policy, and document control policy. All gave details of relevant definitions, guidelines and responsibilities.

The last two medical records audits showed all records were fully completed and met all the service standards. Each audit checked ten records for patients of at least three surgeons and all had met the required criteria.

Medicines

The service used systems and processes to safely prescribe, administer, record and store medicines.

Staff followed systems and processes to prescribe and administer medicines safely. The service managed safe prescription and administration of medicines. Staff followed the provider's medicines management policy which included, safe storage, stock rotation, prescribing guidelines, logs and records for administration of medicines. There was also a detailed policy for controlled drugs. There were no controlled drugs held or administered at the time of the inspection, but the service planned to offer general anaesthetic and had applied for and were awarded the Home Office Controlled Drugs licence to prepare for this.

Staff reviewed each patient's medicines prior to surgery as part of the safety brief and explained to patients what they would be given and any potential side effects. Patients were given antibiotics and pain relief to take home with them, if appropriate for each individual and depending on the procedure carried out and in line with the clinic's antimicrobial stewardship and medicines policies. We saw staff provided detailed advice about medicines before discharge. Staff checked patients understood what their medicines were for, how they should take them, and how to contact the clinic if they had any concerns. The service ordered medicines from a pharmacy provider as and when required.

We reviewed patients' records and clinic documentation and saw staff completed medicines records accurately and kept them up to date.

Managers told us the service was very conscious of not over-prescribing, particularly in relation to antibiotics. Surgeons prescribed antibiotics depending in individual patient requirements surgery, with a course following discharge depending on the procedure. Managers told us they ensured effective compliance with the service's antimicrobial management policy and through discussions with surgeons and at clinical governance meetings. Managers reminded surgeons, when they provided the prescription for patients on discharge to consider whether antibiotics were required or not. All were considered on case by case basis and since opening the clinic in 2019, two post-operative minor infections had been effectively treated with antibiotics.

Good

Surgery

Staff stored and managed all medicines safely and securely in locked cupboards in treatment rooms, storerooms and the operating theatres, in line with national guidance. Refrigerators and freezers were also secure. Only the necessary clinical staff had access to medicines and electronic prescribing documents, and this was strictly controlled. We checked a range of medicines and all were in-date.

The service had installed an appropriate controlled drugs (CDs) cabinet in line with national legislation and in preparation for offering general anaesthetic in future. There was an appointed controlled drugs accountable officer (CDAO) responsible for the management of CDs but no CDs were stored at the time of the inspection.

The service received medicine safety alerts, and these were shared with all clinicians by email and in staff meeting minutes.

Incidents

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. If things went wrong, staff had appropriate processes to apologise and give patients honest information and suitable support. Managers ensured that actions from patient safety alerts were implemented and monitored.

Staff knew what incidents to report and how to report them. They raised concerns and reported incidents and near misses clearly, in line with the service's policy.

The provider had a clear incident reporting policy containing definitions of incidents, reporting procedures, actions to be taken, recording of information and how incidents were shared for learning purposes.

We discussed examples of incidents with managers and observed they had recognised some very minor incidents that had been investigated appropriately, with involvement of patients when necessary. Feedback from incidents was shared with staff to facilitate improvement and learning.

Any issues identified in the service were discussed as a team and regular safety huddles and staff meetings took place where information was shared. Staff were not aware of any recent near misses or incidents but told us they would feel comfortable and confident to report them and knew they would be investigated and discussed appropriately. The service used an electronic incident reporting system and an external representative had provided training and refresher updates.

Incidents and concerns were also discussed and shared with staff within the network at clinical governance meetings and actioned appropriately. We discussed an example with managers of a minor complication a surgeon had experienced with a patient following surgery, and saw that it was escalated, managed and shared. Staff received feedback from investigation of incidents, both internal and external to the service, and discussed this to determine how it could drive improvements in patient care. Managers told us they would debrief and support staff after any serious incident.

Staff learned from safety alerts and incidents to improve practice and received relevant medical device and medicine safety alerts through the central alerting system (CAS); managers told us these were shared with all clinicians by email and during staff meetings and safety huddles.

The Duty of Candour requires healthcare providers to be open and transparent, and to notify patients (or other relevant persons) of certain ‘notifiable safety incidents’ and provide reasonable support to that person, under Regulation 20 of the

Good

Surgery

Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Although there had been no incidents meeting the threshold for the Duty of Candour to be carried out, staff understood the regulation and knew their responsibilities in relation to it. They told us they would be honest, apologise, and give patients a full and timely explanation if things went wrong. They would keep patients informed of any actions taken.

The provider's Duty of Candour policy gave appropriate definitions and responsibilities, details of notifiable and significant incidents, how to notify, and references for further information.

Are Surgery effective?

Good

Evidence-based care and treatment

The service provided care and treatment based on national guidance and evidence-based practice. Managers checked to make sure staff followed guidance. The service met cosmetic surgery standards published by the Royal College of Surgeons.

The clinic held regular clinical discussions and governance meetings with other similar services and healthcare professionals. Managers told us this encouraged the sharing of good practice, along with updates in relation to national guidance. The clinic ensured all policies, procedures and pathways were regularly updated.

Staff followed up-to-date policies to plan and deliver high quality care according to best practice and national guidance. This included holistic assessment of people's suitability for proposed treatments. During consultations, surgeons reviewed and assessed each patient's medical history, general health, mental health, and any previous cosmetic surgery. Expected outcomes and potential risks were discussed openly and honestly, in line with national guidance and professional standards from the Royal College of Surgeons, the Association of Anaesthetists of Great Britain and Ireland (AAGBI), and the National Institute for Health and Care Excellence (NICE). All documents were available electronically, updated regularly, and disseminated appropriately.

Staff used a range of technology and equipment to enhance the delivery of effective care and treatment. For example, the service offered aesthetic treatments such as non-surgical skin tightening instead of, or in conjunction with, surgical interventions to reduce the amount of surgery and recovery time required. Surgeons encouraged, and used, the least invasive methods available to ensure the patient's required result. If any staff member felt patients' expectations were unreasonable or caused the surgeons any concern, they would offer a psychological review, refer the patient elsewhere, or explain why they would not carry out a procedure. Managers told us approximately 30 patients had not been deemed appropriate for surgery since the clinic had opened in 2019. In these cases, some patients were offered aesthetic non-surgical treatments or surgeons explained why surgery would be unnecessary or inappropriate. Two surgeons told us of cases where they had refused patients' requests in the month before our inspection. They told us they never felt pressured to perform unnecessary procedures and used their professional integrity, experience, and the support of other surgeons to make the best decisions for patients.

We saw the clinic had up to date guidance for staff relating to the management of medical emergencies, including resuscitation guidelines and management of anaphylaxis. These were in line with national clinical guidance.

Nutrition and hydration

Patients were not required to fast before procedures and were offered drinks and snacks after any treatment.

Good

Surgery

Pain relief

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

Staff prescribed, administered and recorded pain relief accurately. In the patients' records we reviewed all documentation relating to the prescription and administration of pain relief was completed and signed appropriately.

Staff assessed patients' pain using a recognised tool and gave pain relief in a timely manner, in line with individual needs and best practice. The patients we spoke with told us their pain had been managed very well during and after the procedure, and they had been provided with appropriate pain relief on discharge. They were also asked during follow up calls and appointments if their pain continued to be well managed, and all patients knew how to contact the clinic following discharge if they experienced pain which they were unable to control.

Staff told us they asked patients if they experienced pain during a procedure and told them to say so immediately. This had occurred on two occasions and the surgeon had paused the procedure, administered additional local anaesthetic, and asked the patient if their pain had been eradicated before recommencing. We saw patient feedback that confirmed this, and the patients had been very happy with the way their pain was managed. Pain audits carried out every three months showed all patients asked had experienced less pain during and after their procedure than they had expected.

Patient outcomes

Staff monitored the effectiveness of care and treatment. They used the findings to make improvements and achieved good outcomes for patients.

The service carried out a range of regular clinical and non-clinical audits including pain audits. However, they were not required to participate in national clinical audits due to limited procedures offered. The service did not submit data to the Private Healthcare Information Network (PHIN).

Questionnaires were sent to patients following consultation and procedures. Patients told us, and records showed, outcomes for patients were positive, consistent and met expectations. The service reviewed the results of patients' surgery at different stages of the healing process.

Managers and staff carried out a comprehensive programme of repeated audits to check improvement over time and results were used to improve patient outcomes. All audits were overseen by staff with audit experience with a clear audit policy and process including action plans and measures taken when improvement was required. Staff discussed audit planning, audit goals and objectives, and outcomes at weekly staff meetings. The clinic also used information such as patient feedback, and benchmarked their results against national published guidance, for example NICE guidelines, and from governing bodies. Managers used information from the audits to plan the implementation of changes to improve care and treatment, record audit outcomes and results including the changes made. Staff shared relevant information within the clinic and with staff and surgeons within regional and national networks. The most recent clinical governance meeting minutes showed the results of a blepharoplasty (eyelid surgery) audit were discussed with staff within the network.

Managers told us, following research undertaken relating to patient recovery within their substantive NHS roles and independent health networks, that discharging patients home as soon as safe to do so was the best way to aid recovery from surgery; good pain control, aftercare and follow-up were ensured for all patients.

Good

Surgery

Since opening the clinic in 2019, there had been no unplanned readmissions and no unplanned returns to theatre. Patients signed an agreement prior to surgery which contained details of the surgical revision policy; managers told us thorough preparation, consultation and sharing of detailed information were essential to manage patients' expectations and likely outcomes. If revision surgery was necessary, it would be performed without cost if the surgical team felt it would improve the outcome. Two scar revisions had been carried out since the clinic opened in 2019.

Competent staff

The service made sure staff were competent for their roles. Managers appraised staff's work performance and held supervision meetings with them to provide support and development.

Managers made sure staff attended team meetings or had access to full notes when they could not attend. All staff were required to attend safety briefs and staff huddles prior to clinics and procedure lists. Meeting minutes documented staff attendance and apologies were noted for those unable to attend.

Staff were experienced, qualified and had the right skills and knowledge to meet the needs of patients. There were five consultants working at the clinic (three of whom were on the specialist register as plastic surgeons and two were cancer specialists). All recovery staff were registered nurses with appropriate training and experience.

Consultants were trained in resuscitation and immediate life support (ILS) and all other staff in basic life support (BLS). resuscitation training was checked by the registered manager at the time of application and during revalidation; we saw documented evidence of this in the staff records we reviewed.

Managers gave all new staff a full induction tailored to their role before they started work. A local induction was completed for bank staff However, we were told all were regular staff who were familiar with the clinic's processes and procedures. All new staff completed a shadowing exercise before being considered for their first full shift.

The surgeons had the skills, competence and experience to perform the treatments and procedures they provided. They were all registered with the General Medical Council (GMC) on the specialist surgical register and each performed specialist surgical procedures at independent or NHS hospitals in addition to their work at the clinic, and most participated in teaching and training.

We asked managers about practicing privileges and fit and proper person checks; they discussed the list of requirements they had during recruitment and all items were present in the staff records we checked. We reviewed each of the surgeons' staff records and saw they had current medical indemnity insurance in line with General Medical Council (GMC) guidance. This was necessary in order to protect patients, should they suffer harm as a result of negligence.

Managers supported staff to develop through an annual appraisal programme. All appraisals were carried out by the clinic manager other than the surgeons' appraisals, which were done externally. We saw documented evidence of this in the files we checked. Managers supported the learning and development needs of staff and made sure they received any specialist training for their role. Any training needs were identified, and we saw all staff were supported and funded to develop their skills and knowledge, and to contribute to the development of the service. Two support staff had recently left the service following encouragement and support to undertake further training to develop professionally.

There was a clear human resources management process with a staff handbook, together with lone worker, stress, and whistleblowing policies. All were clear and supportive of employees. The recruitment and selection process was comprehensive and included job descriptions, staff induction, interview templates, and details of employment checks. There was a checklist showing all required documents for staff files and although these were split across electronic and

paper formats, all staff files we reviewed had recruitment information and employment checks included, in line with the policy. There was a checklist specific to bank staff that included additional contact information. The company directors had completed fit and proper person checks prior to CQC registration and no other directors had been employed. All files for both employees and consultants working under practising privileges contained detailed the checks to be competed at the recruitment stage, with details of induction. In the staff files we reviewed, and information provided following the inspection, including that of the clinical director, we saw all checklists were present and completed appropriately.

Managers told us they had processes in place to identify and manage poor staff performance promptly and to help staff improve, including consultants and directors. However, it had not been necessary for them to implement these processes since opening the clinic.

Multidisciplinary working

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

Staff held regular and effective multidisciplinary meetings to discuss patients and improve their care. We saw the team worked very well together and delivered care and treatment in a co-ordinated way. There were positive working relationships between all staff, and they told us they were all focused on providing the best care possible to patients. Managers told us they were careful to select the right staff, who would work well with the rest of the team and believed in the clinic ethos.

Treatment provided was consultant-led. All team members knew who had overall responsibility for each patient's care. Staff worked across health care disciplines and with other agencies when required to care for patients.

We saw there was excellent multidisciplinary communication at all times. Theatre safety briefings and debriefs took place before and after surgical procedures, attended by all staff, and we saw there was inclusive and supportive discussion. Theatre staff took control of the theatre environment and safety checks and the whole team valued the support staff's contribution to patient care. Briefings included an overview of the planned procedure, equipment and medicines likely to be needed, potential risks and plans for recovery and discharge.

When consultants considered a patient could be treated more effectively than at the clinic, they had a network of independent health specialists they called upon for advice or referral to another provider's care. There were good links with independent hospitals and NHS services that they referred to for specialist care. Consultants gave very clear examples of patient referrals to another provider where the clinic could not offer the most appropriate care or treatment.

Staff referred patients for psychological assessments when they were concerned about the patient's perception of their body image or for those with unreasonable expectations.

The clinical director was a member of British Association of Aesthetic Plastic Surgeons (BAAPS) and attended their annual meetings, providing feedback to the other surgeons on updates and new techniques to promote best practice in the field, encourage collaborative working and provide a supportive network to discuss and help others with more challenging cases.

Seven-day services

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

Good

Surgery

The clinic was open from 10am to 9pm three days a week with plans to open for more days as the business expanded. Surgical lists were planned in advance, with consultations and procedures requiring local anaesthetic taking place on set days. Managers told us they would accommodate patients' needs as much as possible and would do their best to accommodate patients for consultations or reviews at any time by appointment. for example, early mornings if required.

The service provided all patients with a 24-hour telephone number to call if they if they had any problems or concerns. This was covered mostly by the company director and lead nurse, with support from other clinicians when needed. Any concerns requiring escalation could be discussed with a surgeon. Patients told us the follow up care and support they received from the clinic had been excellent and very responsive.

Health promotion

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

Staff assessed each patient's health during consultations and provided support for any individual needs to live a healthier lifestyle for example, one patient told us they had been given advice on protecting their skin following surgery for removal of skin lesions.

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 and ensured that patients gave consent in a two-stage process with a cooling off period of at least 14 days between stages. They understood how to support patients.

Staff understood how and when to assess whether a patient had the capacity to make decisions about their care. They gained consent from patients for their care and treatment in line with legislation and guidance and made sure patients consented to treatment based on all the information available. Staff clearly recorded consent in the patients' records. Managers and surgeons told us it was very unlikely a patient lacking capacity would seek treatment at the clinic, and there had been none to date. However, if there were any concerns about capacity, they would refer the patient to their GP for referral elsewhere.

All staff received and kept up to date with training on the Mental Capacity Act, Mental Health Act and Deprivation of Liberty Safeguards, and they understood the relevant consent and decision-making requirements from legislation and guidance. Staff could tell us how they would access relevant policies, and who they would contact for further advice or support.

Managers told us the patient pathway had been designed to ensure compliance with national guidance on consent. The electronic patient record contained automated processes which ensured necessary documentation was completed and checked. All patients were provided with information sheets at the time of their initial enquiry and there were processes in place to ensure a second consultation, two-stage consent process and 14-day cooling off period.

We followed the consultation process from a recent consultation and saw how detailed pre-operative information was documented and shared with patients. Patients told us their expectations were realistically, and sensitively, managed, and potential risks and outcomes were explained, and the pre-operative information and support they received had been excellent and very thorough.

Psychological assessments were completed, and staff told us further psychological support would be sought if necessary.

Good

Surgery

The service had a clear consent policy that gave details of the regulatory guidelines and the importance of ensuring consent was gained properly, with patients given information and support to make an informed decision about care. The policy files also included information regarding mental capacity and advised staff where they could find further information. Staff received training in consent relevant to their role, in line with the policy.

All patient records we reviewed contained documented consent in line with national guidance. The results of two completed consent audits of patients' records corroborated this.

Staff understood the relevant consent and decision-making requirements of legislation and guidance, including the Mental Health Act, Mental Capacity Act and they knew who to contact for advice. Staff had a good working knowledge of the relevant principles and processes to be followed, staff training and how further information and guidance could be accessed.

Are Surgery caring?

Outstanding ☆

Compassionate care

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

There was a strong, visible person centred culture and all staff were highly motivated and inspired

to offer care that was kind and promoted people's dignity. Relationships between people who used

the service, those close to them, and staff were strong, caring, respectful and supportive. These

relationships were highly valued by staff and promoted by leaders. Staff recognised and respected

the totality of people's needs and found innovative ways to meet them.

All staff we spoke with, including managers, had a clear focus on patient care and aimed to provide the highest standard of care possible to all patients at the clinic. This was reflected in the comments we received and feedback we reviewed from patients. Staff were discreet and responsive when caring for patients; privacy and dignity was promoted at all times, and we saw procedures and personal information were not discussed in public areas. The clinic appeared welcoming and calm, and all staff we observed were kind and considerate when speaking with patients.

Feedback from people who used the service was continually positive about the way staff treated them; they thought staff went the extra mile and their care and support exceeded expectations. We spoke with two patients, and both were overwhelmingly positive about the care they received and their experience as a whole; they told us staff were 'so kind', 'nothing was too much trouble' and the care was 'amazing'. The service subscribed to an independent feedback service and we reviewed comments posted on its website. These included: 'a fantastic team' 'you're made to feel welcome from the very start', 'the whole experience was fantastic from beginning to end'. 'All of the staff were incredibly welcoming and friendly and put me at ease throughout. The care and attention to detail from everyone on the team is first class. I could not recommend them more highly'.

Good

Surgery

Patients told us they were given plenty of time to ask questions and discuss any issues; information and answers were provided clearly and sensitively, and the surgeon took time to ensure that all the patient's needs and expectations had been addressed. Prior to surgery, patients were seen several times both virtually and face-to-face. This meant they had time to discuss and evaluate options, and the decision-making process took place in stages rather than in one consultation. At post-operative reviews, patients were again given the time they needed.

Staff told us, and patients confirmed, they worked hard to ensure the patient's experience was comfortable and positive. Staff provided reassurance, information and support throughout their episode of care; they actively encouraged patients to ask questions throughout their procedure. Patients told us they had been comforted and put at ease if they felt anxious and felt safe at all times. We observed the service provided patients with a chaperone when required.

Staff followed policy to keep patient care and treatment confidential. Paper and electronic records and documentation were stored securely, and patients received assurance that any information or photographs they shared for the purposes of assessment would be secure or encrypted. Surgical notes were taken to an office near the theatre immediately after the operation was completed. These were scanned straight away, and the paper copies were destroyed. The service was working towards fully electronic records, but staff thought this may take some time.

Staff understood and respected the individual needs of each patient and showed understanding and a non-judgmental attitude; emotional and social needs were as important as physical needs. Patient feedback confirmed they felt their initial assessments had been planned sensitively and they were not rushed or pressurised into choosing particular treatments or procedures; doctors took time to explore the most appropriate individual options, offer alternatives, and were honest about expectations and outcomes.

Emotional support

Staff provided emotional support to patients, their families and those accompanying to minimise their distress. They took time to understand patients' individual needs.

People who used the service and those close to them were active partners in their care and were

empowered to make decisions based on the best possible information. Staff were fully committed

to working in partnership with people and making this a reality for everyone; patients and those

close to them were offered help, advice and emotional support when they needed it.

Patients told us: They have 'always been there to answer any questions I've had throughout my recovery' the doctor makes 'patients feel like they're cared for and in the best capable hands', 'they went out of their way to make me feel safe throughout my treatment and reviews', Staff told us they did everything they could to make patients comfortable and worked hard to make everyone's experience at the clinic positive. We saw comprehensive advice was given at all stages of the patient journey.

Staff demonstrated empathy when having difficult conversations. We discussed examples of surgeons speaking openly with patients about procedures they felt weren't right for them, and they told us they took pride in the fact they were clear and honest with patients when they felt treatment was not necessary or appropriate. Patients' comments included they felt they weren't pressured or encouraged to undergo a certain procedure, their expectations and perceived outcome were managed sensitively and openly, and they didn't feel clinic staff were trying to sell them something they didn't want or need.

Good

Surgery

We saw 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 and they took time to empathise and reassure when needed. Patients' relatives and those accompanying them were supported and involved in the process should the patient wish them to be. One patient's relative commented '(the doctor) reassuringly dealt with the skin lesion, taking time, care and kindness to explain the treatment and after care. I knew (my relative) was in safe hands and what might have been cause for anxiety transformed into a pleasant day out with lunch in a nearby street cafe thrown in. Thank you Lase for you care and professionalism; you made an enormous difference'.

We saw patients were supported at all times from the very first stage of consultation, and the support given to each patient was timely and tailored to their individual needs. The support continued after discharge as all patients were given a 24 hour telephone number they could contact if they had any queries or concerns and the company director took personal responsibility for answering these calls whenever possible, and also for carrying out regular follow-ups and welfare checks. Staff said patients regularly used this service for questions and reassurance.

Theatre staff told us how they ensured patient privacy and dignity at all times, in particular during intimate procedures.

Surgeons were experienced in reconstructive surgery and removal of cancerous lesions and patients told us how they felt prepared for results of tests, how bad news was discussed sensitively and empathetically and how plans were made for timely reviews.

Understanding and involvement of patients and those close to them

Staff supported patients, families and carers 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 and supported patients to make informed decisions about their care. Patients told us they had been provided with as much information as they needed prior to, during, and after their procedure and all those we spoke with said communication and documentation from the clinic had been excellent.

We reviewed patient documentation and saw that all patients had a comprehensive electronic record which contained their individual profile, appointments, account information, medical records, photographs and all communication; any written notes were scanned and added. Patients told us they had been fully involved and informed at all times and staff took time to ensure they and those close to them understood all aspects of care and treatment.

Although some pre-operative appointments were held virtually, all patients were required to attend a face-to-face appointment prior to the procedure for examination and to discuss planning. Patients were given as much time as they needed post-operatively and had time to rest. When patients were assessed as ready and safe for discharge, staff ensured they understood all aftercare and medicine regimes, and had all the necessary follow-up information.

Staff talked with patients, families and carers in a way they could understand, using communication aids including large tv screens. Procedures were clearly explained to patients and those accompanying them, with diagrams used where appropriate. During the surgical consultation, all notes were made electronically and projected onto a screen behind the surgeon, so the patient was able to view them.

Prior to surgery, patients were seen several times both virtually and face-to-face. This meant they had time to discuss and evaluate the options available to them, and the decision-making process took place in stages rather than in one consultation.

Good

Surgery

Patients and their families could give feedback on the service and their treatment and staff supported them to do this. Staff gave questionnaires to patients following treatment which contained free-text boxes, enabling patients to provide comments if they wished. The clinic subscribed to an independent feedback service which we saw was well utilised by patients who had attended, and managers responded to all comments received. Information on how to make a complaint was displayed. Staff and managers told us responding to and resolving a concern or complaint would always be prioritised.

Patients gave overwhelmingly positive feedback about the service. Those we spoke with said their whole experience at the clinic had been excellent and staff were friendly, caring and approachable. A selection of positive feedback we reviewed stated: 'All the procedures were carefully explained along with expected outcomes and I felt relaxed and at ease'. 'There was never any pressure to make decisions, just good ethical advice based on my needs and honesty as to what I definitely did not need, (the surgeon) was fantastic, he talked through all my options and spent time explaining everything in detail, there was absolutely no 'hard sell' at all, he suggested talking to (the nurse about a non-surgical procedure) as he thought I'd be a great candidate for it' instead of surgery. 'The whole team at Lase are absolutely amazing from reception through to the amazing nurses and surgeons'. Patients also commented on the very high standard of communication, professionalism, openness and honesty, support and aftercare they received. We viewed independent feedback for the service online and saw, out of 70 comments, 100% of patients said the service was 'excellent'.

It was clear from our observations, interviews and review of patient feedback all clinic staff went above and beyond expectations to ensure patients and those close to them were fully involved, informed and had realistic expectations of the procedure at all stages of their journey; there was a common goal to make each patient experience the best it could be. There were appropriate and sensitive discussions about the cost of treatment and surgeons were honest when advising patients about procedures; advice was clearly driven by what was in the best interests of the patient rather than cost.

Are Surgery responsive?

Good

Meeting people's individual needs

The clinic was inclusive, and services were tailored to meet patients' individual needs and preferences. They were delivered in a way to ensure flexibility, choice and continuity of care. Staff made reasonable adjustments to help patients access services and there was a system for referring patients for psychological assessment before starting treatment, if necessary.

The service had very clear equality, dignity and human rights policies and processes in place and all staff told us they worked hard to create a supportive, caring and inclusive environment for patients and colleagues. It was clear the diversity and dignity of patients and staff were respected and valued by all and the patient feedback we reviewed supported this.

The services were flexible, provided informed choice and ensured continuity of care. Managers and staff planned and delivered care in a way that reflected people's needs, and patients told us they had been given choices of appointment times and consultation methods to suit them. Patients were provided with detailed information specific to their procedure.

Good

Surgery

Facilities and premises were innovative and met the needs of a range of people who used the service. Staff had access to communication aids and services to help patients become partners in their care and treatment. There was support made available for patients who were blind, deaf, and hard of hearing. We saw procedures were clearly explained to patients, with diagrams used where appropriate. During consultations, all notes were made electronically and projected on a screen behind the surgeon, so the patient was able to view them. The patients we spoke with said this had been very helpful. Staff accessed interpreters or signers when needed and the clinic had access to an online translation service.

Patients who attended the clinic with psychological and emotional needs were assessed and referred to other services when required. Surgery would not be undertaken if there was any doubt about the procedure being appropriate.

Patients were offered a choice of food and drink post-operatively which met their cultural and religious preferences. Staff had provided a meal for a patient and their relative at a nearby cafe. Patients and those accompanying them could also access a drinks machine in the clinic reception area.

The clinic was easily accessible by public transport, with ample parking available. The building was newly built with three floors and the clinic was housed on the second floor. There was a large lift available for people who were unable to use the stairs. Managers had purchased a folding evacuation chair and staff had recently undertaken an evacuation exercise, but this had not yet been required.

Patients told us they felt all their needs had been met and staff went above and beyond their expectations to ensure high standards. One patient told us they had been given all the information they might need at the initial consultation and it was much more detailed than they had expected. Patient feedback questionnaires and in an online service told us they felt staff cared about them, they were not rushed or pressured into making decisions, having any procedure. They were given plenty of time to rest and recover before they felt ready for discharge. All patients said the follow up care and support had been excellent.

Access and flow

People could access services and appointments in a way and at a time that suited them and received care appropriate to their needs. Technology was used innovatively to ensure people had timely access to treatment, support and care.

Managers monitored waiting times and made sure patients could access services when needed and receive treatment within agreed timeframes. Telephone calls were answered immediately, and patients told us they had no problems with waiting for calls to be answered and if any member of the team was not available the clinic organised for staff to call the patient at an agreed time.

When one surgeon's waiting list began to exceed the clinic's and patients' expectations, which was outside of the surgeon's control, staff alerted managers who discussed the problem with the surgeon. The surgeon, once made aware of the problem, immediately scheduled some sessions to address the waiting time and patients were contact and offered early appointments. This had not happened since. There were no current delays in appointments and the clinic set aside sufficient time for consultations so there were no waits in reception or missed appointment times, although staff said patients would be promptly informed of any delays. Reception staff told us they considered customer service to be the most important part of their role and their aim was to ensure patients felt safe and valued from the moment they entered the clinic. There was no negative patient feedback about accessing advice, care or treatment.

Patients were able to make appointments by telephone or through the service's website. The clinic was flexible in providing appointment times suitable to individual patients and could arrange consultations out of hours if requested.

Good

Surgery

Managers told us they would only cancel or rearrange appointments if absolutely necessary, and with a full explanation to the patient. There had not been any cancellations since the service had returned to normal service following the COVID-19 pandemic. There were planned theatre and consulting sessions each week and these ran on time. Staff aimed to organise sessions so that each patient could feel they were the only priority throughout their visit. Patient feedback confirmed this, and one patient commented 'I felt like I had been to a spa for the day'.

The patients we spoke with, and the feedback we reviewed, demonstrated patients were happy with the flexibility of the service and the timely access to consultation and treatment they had received. The service effectively used a range of technology to support this, determined by patient preference, and offered initial virtual consultations to patients who found it difficult to attend the clinic or had a long distance to travel.

The clinic offered skin cancer treatment and assessment of benign and malignant skin lesions; two of the surgeons employed by the clinic were skin cancer and reconstructive surgery specialists and one surgeon worked in this specialism at an NHS teaching hospital trust. All lesions were assessed in line with national guidance and information was stored securely in the patient's electronic record. Surgeons discussed any cases of concern at formal MDT meetings. The clinic had a service level agreement with a laboratory service for histopathology services and samples were sent on the day of surgery and tracked by staff. All suspected cancer patients would be offered timely treatment at the clinic or urgent referral to their local NHS hospital. Patient feedback confirmed they had received advice, assessment, results and reviews in a timely way. The clinic had direct access to all relevant multi-disciplinary services and pathways within the NHS.

Managers and staff worked to make sure patients did not stay longer than they needed to, but patients were given the time they needed to rest and recover following surgery. Managers told us research outcomes relating to patient recovery and discharging patients home as soon as it was safe to do so was the best way to aid recovery from surgery. Good pain control, effective aftercare and review appointments were ensured for all patients. Staff planned patients' discharge carefully, and specific criteria were required to be met before patients left the clinic. Review appointments were made prior to the procedure being carried out to ensure patients had appointment times and staff contact details before leaving the clinic.

Learning from complaints and concerns

It was easy for people to give feedback and raise concerns about care received. The service treated concerns and complaints seriously, investigated them and shared lessons learned with all staff. The service included patients in the investigation of their complaint. The service had a system for referring unresolved complaints for independent review.

Patients, relatives and carers knew how to complain or raise concerns and those we spoke with told us, if they had experienced any problems, they would have been happy to raise them with the service. Information about how to complain was displayed in patient areas and on its website. Managers told us the complaints' policy and related information was shared with all patients in their initial correspondence with the clinic. Staff told us ensuring a positive patient experience was at the heart of what they did, and they took complaints and concerns very seriously. They knew where to find the policy and how to handle complaints.

Managers investigated complaints and identified themes. The complaints' lead was the clinic manager and they were aware of their roles and responsibilities in relation to this. Patients could complain verbally or in writing; verbal complaints or concerns received were often dealt with quickly and informally. Written complaints received a response in writing, with an acknowledgment sent within two working days of receipt and a full written response within 20 working days wherever possible. Patients would be offered a meeting to discuss any potential solutions and would be kept informed of the progress of the investigation.

Good

Surgery

The clinic received very few complaints and managers told us those received were not usually related to surgery or treatment and could be dealt with quickly and to the patient's satisfaction. We discussed the only formal complaint received since the service opened in 2019 and were assured it had been dealt with appropriately.

Unresolved complaints could be escalated to the Cosmetic Redress Scheme, an independent service to which the clinic subscribed should a complaint require further intervention. It had not been necessary for them to utilise this service at the time of our inspection. The complaints' handling policy outlined the Cosmetic Redress Advisory Panel complaints' handling framework, how complaints should be recorded, response timescales, and information on the panel's role and remit.

All complaints and related information were stored securely; written information in a locked cabinet, and electronic information on the clinic's secure online system. Only the necessary staff had access.

Managers shared feedback from complaints with staff and learning was used to improve the service; there were detailed notes of discussion at team and clinical governance meetings and staff we spoke with confirmed this. The service could also demonstrate where improvements and learning were shared with other services, through external governance meetings and membership of national bodies.

Staff told us they felt confident to address or escalate any concerns within the service. We reviewed the service's patient complaints policy and procedure and receiving patient feedback policy. The documents gave relevant definitions relating to incident management and encouraged to remain calm and respectful. It directed staff to the complaints manager and gave comprehensive guidance around the complaints' management process.

Are Surgery well-led?

Good

Leadership

Leaders had the 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 service was led by the clinical director, who was a consultant plastic surgeon with a long NHS and independent hospital experience, and the registered manager who was the lead nurse. They were supported by the clinic manager. All had significant previous experience in their respective areas and understood the priorities of the service and any issues which may affect it. There was a clear organisational structure with defined lines of responsibility, for examples in terms of clinical governance, risk management, operational procedures and administration. All staff we spoke with were clear about their roles and accountabilities.

During our inspection, we saw the management team were visible, completely integrated within the staff team, supportive and had good working relationships with their staff. All staff we spoke with told us managers encouraged an open and honest culture and actively sought staff feedback and opinion. Staff were confident to offer constructive personal and professional opinions and frequently did so. Managers held regular staff meetings and communicated and engaged with staff regularly.

Good

Surgery

All staff we spoke with spoke highly of the management team and felt they were approachable and actively involved in all aspects of the service. Staff told us they were encouraged to develop their knowledge and skills and were supported to attend training courses.

The clinic director was a member of British Association of Aesthetic Plastic Surgeons (BAAPS) support board which offers business support services to plastic surgeon members, medical advisory committee (MAC) chair at a local independent hospital, and a trustee of the Cosmetic Practice Standards Authority (CPSA) for plastic surgeons, dermatologists, and non-surgical experts through the British Association of Plastic, Reconstructive and Aesthetic Surgeons (BAPRAS). Another surgeon was a programme director for aesthetic fellowship training and education through BAPRAS.

The service did not have a specific fit and proper person policy but the human resources and recruitment policies included processes to meet requirements of the regulations relating to directors and employees and gave appropriate definitions, details of checks to be completed, and information regarding where further information could be found.

We reviewed the service's human resources policies and staff records check and action lists for both employees and directors, which identified checks to be competed at the recruitment stage, details of induction, and processes to be followed in the event of misconduct or concerns being identified. In the staff files we reviewed, including that of the clinical director, we found all checklists were present and completed appropriately. However, staff records were stored in paper files and electronically and although we checked the service did hold and record all the necessary documents, it was not always immediately obvious where each piece of evidence could be found.

Vision and Strategy

The service had not developed a formal vision for what it wanted to achieve or a written a strategy to turn it into action. However, all staff were aware of the service's aims, which were focused on sustainability of services and meeting patient needs.

Managers told us they aimed to run a business where all staff felt valued, with a culture of mutual respect and teamwork. All staff spoke with enthusiasm about being part of the team and feeling valued with a common approach to exemplary customer service and nothing less than high standards of care.

Although there was no written vision at the time of the inspection, all staff told us the service's aim was to provide an excellent service for patients in a safe, caring, and modern environment. Managers aimed to make every patient feel well looked after and ensured their journey through the clinic was as safe and pleasant as possible; they provided a personal service with a small core of staff. All staff were aware and involved in plans for offering general anaesthetic in the near future and were working towards this by contributing their knowledge and experience in their own role and from roles held previously in other services. Managers were also planning to further expand the clinic service to include laser treatment in conjunction with or instead of invasive surgical procedures. These plans were referred to in meeting minutes.

Culture

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.

Good

Surgery

All staff we spoke with told us they felt respected, supported and valued. Managers told us they were always happy for staff to discuss, challenge and raise ideas. Staff corroborated this and said they always felt comfortable discussing ideas and raising concerns; they felt confident any issues would be responded to positively and dealt with appropriately. They told us they felt listened to and actively contributed to changes and developments within the service. They felt proud to work for the service and were committed to providing the best possible patient experience.

Consultants held surgical posts at local NHS teaching trusts and in independent hospitals and the team had developed with a culture of mutual learning and support.

The service had an equality, dignity and human rights policy in place and aimed to provide a supportive, caring and inclusive environment for patients to receive treatment and for staff to reach their full potential. Managers told us they were committed to ensuring equality, diversity and dignity of patients and staff. Managers encouraged feedback, and all external feedback from patients was responded to personally; we saw only positive comments about the culture of the service. Staff were encouraged to share their ideas and were given opportunities to learn and develop. Two members of support staff had recently left the service to pursue personal development goals and staff were proud the service had encouraged and provided motivation for this. Staff satisfaction was explored and discussed as part of day to day working, informal meetings, and the appraisal process.

The service considered and promoted the safety and wellbeing of staff. Access to the building was controlled remotely by reception staff and clinical areas were secured with keypads. There was a lone worker policy in place and managers told us they would complete regular welfare checks should a colleague be working out of hours at the clinic.

Mangers told us they took time to recruit staff who they felt would be the 'right fit' and shared the ethos of the service to provide a high standard of patient care. Clinic values were shared during staff induction and regularly through communication and discussions.

Governance

Leaders 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.

There was a defined governance structure within the service and staff at all levels were clear about their roles, responsibilities and accountabilities. Governance processes, such as audits, were completed regularly and further audits were still being developed following suggestions from staff and outcomes at other services. Managers were able to clearly articulate their plans and what they aimed to achieve in terms of development and performance.

The clinic shared quarterly clinical governance meetings with another, similar clinic. Within the service, there were quarterly Medical Advisory Committee (MAC) meetings where clinical governance and applications for practicing privileges were also discussed. We reviewed a range of meeting minutes and saw they were well attended. There was detailed discussion of relevant topics, such as best practice, risks and complications, infection control, compliance, case reviews, and sharing of lessons learned. All meetings had a set agenda and attendees took actions from the meeting to address any issues identified.

The service policies were all clear, comprehensive and easily accessible, and processes described were all relevant to the service.

Good

Surgery

We asked managers about the management of practicing privileges and fit and proper person checks; they told us of the list of requirements they had during recruitment and these were all present in the senior staff records we checked, in line with Schedule 3 of the Health and Social Care Act 2008 (Regulated Activity) Regulations 2014. However, staff files required better organisation so that documents were easy to find, and compliance checks could be carried out quickly and efficiently.

Management of risk, issues and performance

Leaders and teams used 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.

The service had a risk management policy and process in place, which we saw was thorough and reviewed regularly. Risks, actions, mitigations and designated responsibilities of staff were recorded clearly. We discussed risk management with managers, and they had comprehensive oversight of issues which accurately reflected those recorded. Risks included fire safety and evacuation, loss of essential utility supplies, staffing including use of bank staff, and annual service contracts for equipment that were due, to replace existing guarantees and warranties for equipment bought when the clinic opened in 2019. There was no formal risk register, but risks were managed well by the small clinic team. However, this might not continue to be a manageable process should the business expand. Risks were discussed in team meetings and actions to reduce risks were documented; these involved liaison with external services where appropriate.

Risks and performance were discussed regularly at clinical governance, MAC and team meetings and took into account issues highlighted by incidents, complaints and other occurrences. All staff were involved, could contribute, and were aware of actions.

The service had business continuity plans in place in case of loss of essential services and managers told us they had become much more focused on the need to plan effectively for unexpected events following a recent power cut that affected the service for several hours, and due to the impact of the COVID-19 pandemic on service provision.

The service had a planned programme of clinical and internal audit managed by a member of the team with audit and governance experience. The programme was detailed and enabled managers to effectively monitor and review the quality of care and clinical processes, and to identify where improvements were needed. Managers had clear oversight of audit processes and progression.

Information Management

The service collected reliable data and analysed it. Staff could find the data they needed, in easily accessible formats, to understand performance, and make decisions and improvements. The information systems were integrated and secure. Data or notifications were consistently submitted to external organisations as required.

The service subscribed to an external software provider and all patient records were digitised, except for paper operation notes that were scanned and added to patient records immediately after procedures were completed. Company documents and records, including staff and patient information and policies, were held electronically and on paper in secure files in an office fitted with a keypad, and located away from patient areas.

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Staff could easily access all the information they required in relation to patient care and clinic processes; all had access to the digital system using individual tablets and computers. Access was limited to the scope of their role within the service. We saw tablets were password protected and locked when not in use. Staff were able to communicate with each other throughout the single floor of the clinic by telephone or in person. All had completed training on information governance and were aware of data protection regulations. Patient records and clinic documents were stored securely.

The clinic had a website and employed a social media, and managers were responsible for ensuring all information was kept up to date. Information on the website relating to the clinic, its staff, and treatments offered was very detailed and enabled patients to complete thorough research and book consultations.

The service collected and monitored information regarding patient outcomes, and this was under continual development in preparation for expansion and changes to service provision. Patient feedback was a vital part of maintaining quality and improving services.

Engagement

Leaders and staff actively and openly engaged with patients, staff, the public and others to plan and manage services. They collaborated with partner organisations to help improve services for patients.

Managers and staff routinely gathered feedback from patients, and it was welcomed at all stages of their treatment journey. This was used to maintain quality and improve services. Feedback questionnaires were given to patients following post-operative review and the clinic subscribed to an independent feedback service which we saw was well utilised by patients who had attended. Managers responded personally to all comments received. We saw feedback provided was entirely positive, but even so, patient comments were used to make improvements. Managers told us they frequently received thank you cards and emails from patients.

Communications between the whole team were open and positive, with all staff feeling engaged and valued. All team members were actively involved in meetings and briefings.

The service engaged regularly with other organisations and similar service providers, including for the purposes of joint clinical governance and training. The clinical director was an active member of several external organisations specific to the service which allowed information sharing, discussions around best practice, and promoting service development.

Learning, continuous improvement and innovation

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

Staff of all levels were supported to learn and develop, and managers encouraged them to suggest further training they wished to pursue. Recent training had included the use of a specialist liposuction technique and the introduction of laser technology, although this was not yet in use at the time of the inspection. The ethos of the practice was to provide safe care above all else, and then the highest level of care to patients in a safe and modern environment. Managers told us they were always looking for techniques to help improve the patient experience and give the best possible result, these included non-surgical and aesthetic procedures alongside, or in place of, invasive procedures.

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The clinic used a wide range of technology to assist and improve service delivery and patient care, which included: the projection of patients' notes onto a screen during consultation to help with explanation and understanding; the use of individual issue electronic tablets to enable staff members to easily access records and documentation; and the electronic patient record system used at each stage of the consultation, treatment and follow-up process.

The lead surgeon was enrolled on the British Association of Aesthetic Plastic Surgeons (BAAPS) mentor programme to provide post-qualification plastic surgery training and worked closely with other surgeons in this field and had strong links, sharing good practice with another clinic within the region.

All staff were committed to improving services and we saw evidence of this during inspection and following review of clinical governance and staff meeting minutes. We discussed further examples of improvements with managers and they told us the clinic was working with an anaesthetic team to introduce safe and effective anaesthetic procedures including general anaesthetic. However, the clinic would not introduce anything until they had full assurance they would be safe and appropriate for the clinic, premises, equipment, staff, and their business model, in order to provide the best care for their patients.