Ziering London Clinic

Quality Report

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

Overall summary

Ziering London Clinic is operated by Edgbaston Medical Group Limited. The service has two overnight beds. Facilities include one main theatre, two clinic rooms used for hair transplant operations, consulting rooms, and a two-bedded recovery area and ward. The clinic offers cosmetic surgery such as breast enlargement and hair transplants, as well as non-surgical interventions.

We inspected this service using our comprehensive inspection methodology. We carried out the announced part of the inspection on 8 February 2018, along with an unannounced visit to the clinic on 1 March 2018.

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

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

Services we do not rate

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

We found the following areas of good practice:

- The service managed patient safety incidents well.
- 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.
- The service provided mandatory training in key skills to all staff and made sure everyone completed it.
- The service had enough staff with the right qualifications, skills, training and experience to keep people safe from avoidable harm and abuse and to provide the right care and treatment.
- The service planned for emergencies and staff understood their roles if one should happen.
- Staff gave patients enough food and drink to meet their needs.
- The clinic was submitting national data to the Private Healthcare Information Network (PHIN).
- The service made sure staff were competent for their roles. Managers appraised staff's work performance.
- Staff of different kinds worked together as a team to benefit patients. Doctors, nurses and other healthcare professionals supported each other to provide good care.

Summary of findings

- Staff understood their roles and responsibilities regarding obtaining informed consent.
- Staff cared for patients with compassion.
- Staff involved patients and those close to them in decisions about their care and treatment.
- People could access the service when they needed it.
- The service took account of patients' individual needs.
- The service treated concerns and complaints seriously, investigated them and learned lessons from the results, which were shared with all staff.
- The clinic had a vision for what it wanted to achieve and workable plans to turn it into action.
- Managers promoted a positive culture that supported and valued staff, creating a sense of common purpose based on shared values.
- The clinic had effective systems for identifying risks, planning to eliminate or reduce them, and coping with both the expected and unexpected. However, we did find that these needed to be updated more regularly.
- The clinic engaged well with patients and staff to plan and manage appropriate services, and collaborated with partner organisations effectively.

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

- The service did not always take all necessary measures to control infection risk well. We noted some areas were not always fully clean and staff did not always take all appropriate measures to prevent the spread of infection. The sinks throughout the service did not meet current clinical requirements, although these were due to be replaced in the near future.
- There were no locked doors between the reception of the clinic and the operating theatre, which may present a security risk.
- We noted some issues with the storage and audit of medicines. The emergency resuscitation drugs were not organised in a way that allowed for audit, with minor issues found. We found some ambient medications were past their expiry date and some medication left in the unlocked theatre room. Ambient room temperatures where drugs were stored were not monitored. No actions were documented when drug fridge temperatures were out of range. The medication fridge was not locked.
- Patient records were not always fully complete, although these had shown recent improvement.
- We were not always assured that patients were always discharged with an escort in line with the clinic's local policy.
- Not all policies referenced current clinical best practice guidance.
- The provider acknowledged that they needed to improve and widen existing audit activity in order monitor patient outcomes more effectively.The service was in the process of preparing to collect data in relation to Quality Patient Reported Outcome Measures (Q-PROMS), for example.
- No formal training was provided to staff on the Mental Capacity Act 2005 (MCA) or Deprivation of Liberty Safeguards (DoLS).
- Feedback indicated that patients were not always fully satisfied that they could find someone to talk to about their worries or their fears.
- At the time of inspection, the clinic was not a subscriber to the Independent Healthcare Sector Complaints Adjudication Service (ISCAS), but told us that they had made inquiries regarding this.
- Although all practicing privileges documents were found in place, these were not organised in a structured manner, making them difficult to review and for the service to audit effectively.

Following this inspection, we told the provider that it must take some actions to comply with the regulations and that it should make other improvements, even though a regulation had not been breached, to help the service improve. Details can be found at the end of the report.

Amanda Stanford

Summary of findings

Head of Hospital Inspection (North East & Cumbria)

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Surgery		Surgery was the only activity carried out in the service. Whilst we regulate cosmetic surgery services we do not have a legal duty to rate them.

Summary of findings

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Services we looked at
Surgery (cosmetic)

Summary of this inspection

Background to Ziering London Clinic

Ziering London Clinic is operated by Edgbaston Medical Group Limited. The service opened in 2014, providing hair transplants and non-surgical interventions. In February 2017, the clinic began functioning as a cosmetic surgery provider, providing operations such as breast enlargement and liposuction. It is a private clinic in London. The clinic accepts referrals from GPs, lead referrals from third party companies and self-referrals from patients living in London and internationally.

At the time of the inspection, a new manager, Kelly Jane Tivey, had recently been appointed and was registered with the CQC in September 2017.

The clinic also offers minor cosmetic procedures. We did not inspect these parts of the service as we do not regulate these procedures.

Our inspection team

The team that inspected the service comprised a CQC lead inspector, one other CQC inspector and four specialist advisors with expertise in theatre nursing, surgery, anaesthesia and infection control. The inspection team was overseen by Nicola Wise, Head of Hospital Inspection.

How we carried out this inspection

During the inspection, we visited the whole clinic. We spoke with eight staff including; registered nurses, health care assistants, reception staff, medical staff, operating department practitioners, and senior managers. During our inspection, we reviewed 15 sets of patient records.

Information about Ziering London Clinic

The clinic provides cosmetic surgery and is registered to provide the following regulated activities:

- surgical procedures
- treatment of disease, disorder or injury.

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

Activity (November 2016 to October 2017):

- In the reporting period November 2016 to October 2017, there were 312 episodes of care recorded at the clinic. All of these were privately funded.
- Of these, 4% of patients (13 in total) stayed overnight at the clinic.
- The ten most common surgical procedures performed at the clinic in the reporting period were as follows: breast enlargement (123), augmented mastopexy (15), mastopexy (nine), facial (eight), liposuction (seven), abdominoplasty (six), gynaecomastia (four), rhinoplasty (three), breast reduction (three) and otoplasty (two).

Three surgeons, two hair transplant doctors, one resident medical officer (RMO) and two anaesthetists worked at the clinic under practising privileges. The clinic employed

Summary of this inspection

one registered nurse, one healthcare assistant and one receptionist, as well as using bank and agency nursing staff. The accountable officer for controlled drugs (CDs) was Anjana Odedra.

Track record on safety

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

Services provided at the hospital under service level agreement:

Clinical waste collection

Confidential waste collection

Feminine hygiene waste collection

Cleaners

Fire alarm & lighting servicing

Fire extinguisher checks

Portable appliance testing

Air conditioning

Pest control

Gas boiler maintenance

Legionella risk assessment

Legionella sample results

Water cooler maintenance

Fixed electrical testing

Security procedure / details

Laboratory testing

Asbestos survey report

Anaesthetic machine servicing

Equipment servicing

Loan of beds

Hair beds

Ambulance services

Theatre lights

Bloods specimen testing

Supply of linen and provision of laundry

Summary of this inspection

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?

We do not currently have a legal duty to rate cosmetic surgery services.

We found the following areas of good practice:

- The service managed patient safety incidents well. Staff recognised incidents and reported them appropriately. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support.
- 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.
- The service provided mandatory training in key skills to all staff and made sure everyone completed it.
- The service had enough staff with the right qualifications, skills, training and experience to keep people safe from avoidable harm and abuse and to provide the right care and treatment.
- The service planned for emergencies and staff understood their roles if one should happen.

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

- The service did not always take all necessary measures to control infection risk well. We noted some areas were not always fully clean and staff did not always take all appropriate measures to prevent the spread of infection. The sinks throughout the service did not meet current clinical requirements, although these were due to be replaced in the near future.
- On the whole, the service had suitable premises and equipment and looked after them well. However, there were no locked doors between the reception of the clinic and the operating theatre, which may present a security risk.
- We noted some issues with the storage and audit of medicines. The emergency resuscitation drugs were not organised in a way that allowed for audit, with minor issues found. We found some ambient medications were past their expiry date and some medication left in the unlocked theatre room. Ambient room temperatures where drugs were stored were not monitored. No actions were documented when drug fridge temperatures were out of range. The medication fridge was not locked.

Summary of this inspection

- Patient records were not always fully complete, although these had shown recent improvement.
- We were not always assured that patients were always discharged with an escort in line with the clinic's local policy.
- At the time of inspection, the admission policy did not explicitly state that the clinic did not treat those under the age of 18 years.

Are services effective?

We do not currently have a legal duty to rate cosmetic surgery services.

We found the following areas of good practice:

- Staff gave patients enough food and drink to meet their needs.
- The clinic was submitting national data to the Private Healthcare Information Network (PHIN).
- The service made sure staff were competent for their roles. Managers appraised staff's work performance.
- Staff of different kinds worked together as a team to benefit patients. Doctors, nurses and other healthcare professionals supported each other to provide good care.
- Staff always had access to up-to-date, accurate and comprehensive information on patients' care and treatment.
- Staff understood their roles and responsibilities regarding obtaining informed consent. The provider followed guidance relating to the Royal College of Surgeons' professional standards for cosmetic surgery, which state that consent must be obtained in a two-stage process, with a cooling-off period of at least two weeks between the stages to allow the patient to reflect on their decision.

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

- Not all policies referenced current clinical best practice guidance.
- The provider acknowledged that they needed to improve and widen existing audit activity in order monitor patient outcomes more effectively. The service was in the process of preparing to collect data in relation to Quality Patient Reported Outcome Measures (Q-PROMS), for example.
- No formal training was provided to staff on the Mental Capacity Act (MCA) or Deprivation of Liberty Safeguards (DoLS).

Are services caring?

We do not currently have a legal duty to rate cosmetic surgery services.

Summary of this inspection

We found the following areas of good practice:

- Staff cared for patients with compassion.
- Staff involved patients and those close to them in decisions about their care and treatment.

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

- Feedback indicated that patients were not always fully satisfied that they could find someone to talk to about their worries or their fears.

Are services responsive?

Are services responsive?

We do not currently have a legal duty to rate cosmetic surgery services.

We found the following areas of good practice:

- People could access the service when they needed it.
- The service took account of patients' individual needs.
- The service treated concerns and complaints seriously, investigated them and learned lessons from the results, which were shared with all staff.

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

- At the time of inspection, the clinic was not a subscriber to the Independent Healthcare Sector Complaints Adjudication Service (ISCAS), but informed us that they had made inquiries regarding this.

Are services well-led?

We do not currently have a legal duty to rate cosmetic surgery services.

We found the following areas of good practice:

- The clinic had a vision for what it wanted to achieve and workable plans to turn it into action.
- Managers promoted a positive culture that supported and valued staff, creating a sense of common purpose based on shared values.
- The clinic had effective systems for identifying risks, planning to eliminate or reduce them, and coping with both the expected and unexpected. However, we did find that these needed to be updated more regularly.

Summary of this inspection

- The clinic engaged well with patients and staff to plan and manage appropriate services, and collaborated with partner organisations effectively.

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

- Although all practicing privileges documents were found in place, these were not organised in a structured manner, making them difficult to review.

Surgery

Safe	
Effective	
Caring	
Responsive	
Well-led	

Are surgery services safe?

The main service provided by Ziering Clinic London was cosmetic surgery.

Incidents

- In the reporting period November 2016 to October 2017, the clinic did not report any never events. Never events are serious incidents that are entirely preventable as guidance, or safety recommendations providing strong systemic protective barriers, are available at a national level, and should have been implemented by all healthcare providers.
- The clinic had a policy in place to guide staff on how to report any incidents. Staff we spoke with were aware of how they would report incidents. We saw evidence that incidents were reported using paper forms, which were supplemented by an additional form that graded incidents by severity and likelihood of harm. We saw that issues the inspection team picked up on the first day of inspection had been reported as incidents and action plans had been created as a result. A log of these incidents was also kept by the registered manager. Learning from incidents was shared with staff verbally and via email. We saw that incidents were discussed in the clinical governance meeting and medical advisory committee, both of which had been established in the autumn of 2017.
- Since the clinic had started offering a fuller range of procedures in February 2017, the service reported seven clinical incidents and two non-clinical incidents. Clinical incidents included implant failures or changes (three), missing equipment (one), a needlestick injury (one), a patient being discharged with insufficient medication (one) and a patient reporting being awake during surgery (one). Non-clinical incidents related to a delivery part going missing and money going missing from a staff member's bag. We saw an example of a detailed investigation into one of these incidents.
- No serious incidents were reported by the clinic between November 2016 and October 2017. The clinic's adverse incident policy referenced 'The Reporting of Injury, Diseases and Dangerous Occurrences Regulations' (RIDDOR) and stated that any relevant events should be reported to a central body. However, there was no information within the policy that specified what type of incidents fell into the category for RIDDOR reporting and no mention of serious incidents categorised as reportable to The National Reporting and Learning System (NRLS).
- Between November 2016 and October 2017, the clinic reported four surgical site infections. Patients generally left the clinic shortly after their procedures were completed and were given instruction regarding any wound/dressing care they may be required to do prior to any follow-up appointment. The clinic kept a log of all possible wound infections and swabs had been taken to ensure appropriate treatment regimes. These were audited on a quarterly basis.
- The duty of candour is a regulatory duty that relates to openness and transparency, and requires providers of health and social care services to notify patients (or other relevant persons) of certain 'notifiable safety incidents' and provide reasonable support to that person. This means providers must be open and honest with service users and other 'relevant persons' (people acting lawfully on behalf of service users) when things go wrong with care and treatment, giving them reasonable support, truthful information and a written apology. There were no incidents during the reporting time period that met the threshold for duty of candour. Staff that we spoke with were broadly aware of the duty

of candour requirements, with senior staff informing us that additional training in this area would be added to the upcoming clinical skills update in April 2018 to improve staff awareness.

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

- The clinic, unlike NHS trusts, was not required to use the national safety thermometer to monitor areas such as venous thromboembolism (VTE). However, services are required to have equivalent systems in place. The clinic did not use any clinical quality dashboards to monitor safety that were on display to the public but kept track of other data on their own spreadsheet, which was accessible to staff on the shared drive. The clinic reported no incidences of VTE in the reporting period. As patients rarely stayed overnight, pressure ulcers were not likely to occur.

Cleanliness, infection control and hygiene

- The provider had an Infection Prevention and Control (IPC) policy, drafted in June 2017. We saw that all staff were provided with annual training in IPC. The provider had developed an IPC work programme that detailed improvements to be made at clinic in this area in the coming year.
- Most areas that we inspected were visibly clean, including most equipment. On the second day of inspection, we noted a bloodstain on one of the theatre trolleys and dust on low and high shelving in the theatre. We saw that cleaning schedules and checklists were in place and completed on a daily basis. Deep cleaning of the theatre took place every two months. An IPC audit took place on a quarterly basis, with actions such as the ensuring bed curtains were dated for changing actioned by the provider in a timely fashion. Curtains were all clean and stain free.
- There was limited space in the operating theatre, which could potentially allow for contamination. During one operation, we observed that the trolley containing the surgeon's gown and gloves was positioned close to the scrub sink, which allowed contamination from water droplets. The theatre scrub sink did not meet current clinical guidelines as there was limited space to ensure sterility was maintained at all times and it had hand operated taps. The risk of infection and contamination had been added to the provider's risk register, along with the lack of a theatre scrub sink. The provider told us that the theatre scrub sink would be changed before the end of quarter one of 2018 and that this was priced and paid for, but they were still awaiting a date from the plumber to do this. We saw evidence of this on the second day on inspection.
- There were dispensers with hand sanitising gel situated in appropriate places around the clinic. Hand washbasins were equipped with soap, disposable towels and sanitiser, but basins were not compliant with clinical guidance as they did not have non-touch taps. This had been added to the provider's risk register. The provider told us that the basins would be replaced before the end of quarter one of 2018 and that this priced and paid for, but they were still awaiting a date from the plumber to do this. We saw evidence of this on the second day on inspection. Guidance for effective hand washing was displayed at the basins. Hand hygiene audit results showed compliance ranging from 90% in September 2017 to 100% for the months of October 2017, January 2018 and February 2018. We saw that issues with individual hand hygiene were discussed in clinical governance meetings and addressed as necessary with those involved.
- There was no separate room for the preparation of the trolley prior to operating or scrubbing. This took place in the operating theatre. Ventilation in the operating theatre met current clinical guidance as it allowed for 21 to 24 changes of air per hour, but three of the filters in the system needed to be changed. The provider told us that they were aware of this, and it had been added to the service's risk register. The provider informed us that the ventilation system was checked and serviced following the first day of inspection and that the same company planned to attend again to draw up a plan of works. Senior staff informed us that reconditioning was a priority as if the system broke down, they would struggle to replace the obsolete parts. We saw evidence of the plans of works to replace this on the second day on inspection.
- We noted that storage in the clinic was not ideal, with linen and patients' theatre gowns stored on open shelves in areas of high traffic. The sterile store room was also warm, with no record of ambient room temperature kept. We were therefore not assured that it complied with infection control regulations.

- The management of legionella had been added to the risk register by the provider. The action plan stated that regular water checks were completed and that renewal of the pipes would take place if required. We saw evidence of annual water quality checks being carried out by an external company. On the second day of inspection, we noted that two sinks that were not in regular use which presented a risk of legionella. The day following this inspection, the provider had added the running of these taps to the list of daily checks and created a record sheet for this purpose.
- Staff adhered to the bare below elbow dress code and we observed staff cleaning their hands regularly. We observed staff using personal protective equipment (PPE) such as gloves and aprons appropriately where indicated. However, on the first day of inspection, we did note that the surgeon wore his mask around his neck between surgical cases, which was against recommended IPC practice.
- Between November 2016 and October 2017, the clinic did not report any cases of MRSA. MRSA is a bacterium that can be present on the skin and can cause serious infection. We saw evidence in recent patient records that MRSA risk assessments were completed by a healthcare worker and that screening was carried out if appropriate. In the same period, there were also no incidents of MSSA (a type of bacterium that can live on the skin and develop into an infection, or even blood poisoning), E. Coli infection or Clostridium difficile (a bacterium that can infect the bowel and cause diarrhoea, most commonly affecting people who have been recently treated with antibiotics).
- Most of the equipment used was single-use. A service level agreement (SLA) was in place with a private company for the sterilisation of surgical instruments that were not single-use. Senior staff told us that there were no issues with this arrangement, with processes in line with national guidance such as the Department of Health Technical Memorandum on decontamination.
- We observed safe systems for managing waste and clinical specimens during the course of inspection. Staff used sharps appropriately; most of the containers were dated and signed when full to ensure timely disposal, not overfilled and temporarily closed when not in use. One sharps bin was observed to be full on the day of the first inspection but staff told us that this would be closed for disposal after the end of the theatre list that day.

Environment and equipment

- The provider told us that they had recently undertaken significant internal works on the building, including removing some partial walls, creating a recovery ward area, improving storage space and improving the aesthetic appearance of the clinic. The service acknowledged there was still work to be done within the clinic. We noted some minor issues with the staff facilities, which had been remedied by the second day of inspection. There were also no locked doors between the reception of the clinic and the operating theatre, which may have presented a security risk.
- A quarterly environmental audit was conducted to ensure that staff kept on top of actions needed to mitigate any risk. The premises were leased to two other providers and we saw copies of the service level agreements (SLAs).
- Piped oxygen was not used within the clinic, but senior staff told us that this would be reviewed as the clinic got busier. This had been added to the service's risk register. We noted that there were sufficient supplies of oxygen cylinders on both days of inspection, with this being stored appropriately. However, there was no evidence of regular checks of oxygen on the day of inspection. We found one empty oxygen cylinder on a trolley in recovery on the second day of inspection. The provider told us that the registered manager usually monitored this and following inspection, they had added a checklist to the front of the oxygen cupboard.
- All portable clinical equipment we checked had been recently serviced and labelled to indicate the next review date, but other portable items such as the TV and portable heater had not. The provider arranged for these appliances to be tested after the second day of inspection and provided evidence to confirm this. Disposable equipment was easily available and in date.
- Resuscitation equipment was available, with evidence of daily and weekly checks to demonstrate that equipment was safe and fit for use. However, we noted some issues on the day of our first inspection. The tamper proof seal on the emergency drug kit was

broken, although the seal indicated this should only be broken in the case of emergency. There were also only four ampoules of doxapram hydrochloride (a respiratory stimulant) in the emergency drug box, although the checklist stated there should be five. No quantities of drugs were mentioned in relation to some other drugs on the emergency drug checklist, making it difficult to ascertain what should have been present. The trolley in theatres were not well-organised, with equipment not stored in a logical and sequential way, with some items not intact within their sterile packaging. On the second inspection day, we also found an ampoule of local anaesthetic in the trolley that should have not have been there. We also noted there was no dantrolene (a muscle relaxant) available in the trolley.

- We saw that a control of substances hazardous to health (COSHH) assessment had been carried out in July 2017, with appropriate control measures put into place, on the whole. All items were supposed to be securely stored in a separate cabinet in the sluice room away from patients and staff, with a register in place to indicate what was stored on site. On the second day of inspection, we noted that some chemicals with a COSHH label were stored in an unlocked cupboard. Staff remedied this immediately.

Medicines

- There was a service level agreement (SLA) in place with a local pharmacy for the supply of drugs. Senior staff told us that they liaised with the pharmacist weekly and conducted monthly audits of any drugs in stock to ensure any unused items were returned and stock levels did not become too high. Any member of staff could email the pharmacist directly if they noticed stock levels of any drug were too low. We saw evidence that drugs were checked on a daily basis to ensure that they were in date. The way this was recorded had recently been changed for increased clarity. An electronic stock check sheet had been used previously, which staff found cumbersome. However, on the day of our first inspection, we found two drugs that had expired in January 2018. We raised this with the provider, who removed the drugs for disposal. On the day of the second inspection, we found no expired drugs, but that some medication had been left out (sodium bicarbonate and saline) in the unlocked theatre room. We also found naseptin cream which was partly used with no expiry date and three bottles of open 0.9% sodium chloride with no date of opening recorded.
- Medication fridge temperatures were monitored, although ambient room temperatures where medications were kept were not. We were not assured that effective room temperature controls were in place in the clinic. In the fridge temperature record, we also noted two occasions where the maximum temperature had been exceeded, but no actions had been recorded as a result. The medication fridge was not locked.
- We saw evidence of a medicines management audit completed in October 2017, which listed actions such as reminding doctors to sign the prescription signatory record. A further audit in February 2018, following our first inspection, stated that staff training in medicines management had booked in April 2018 and highlighted the importance of checking medication thoroughly.
- The clinic had obtained a controlled drug (CD) license from the Home Office in October 2017. We saw that CDs were still being transported from a central pharmacy store as direct supply had not yet been arranged. The clinic had drafted a risk assessment and plan for the transportation of CDs between sites whilst this was taking place. CDs were kept locked in a separate box within the main drug cabinet, with the keys kept separately. Although the main drug cabinet was not securely bolted to the wall due to building restrictions, it was within a locked space and there was security presence on site 24 hours a day. The home office had confirmed that they found storage arrangements to be suitable. We found that the systems for checking and managing the use of CDs were satisfactory.
- We looked at the medication records for 15 patients and found inconsistencies in the way that some drugs given during the course of the operation were recorded. All other medication records were signed and dated by both the prescriber and administrator. Prescription pads were stored correctly.
- There was an antibiotic prescribing policy in place which stated: 'One Health only provide antibiotics for true infections'. NICE guidance CG 74 states that an antibiotic should be prescribed where surgical site infections are suspected, with consideration of local

resistance patterns and the results of microbiological tests when choosing an antibiotic. However, we found that all patients were given a broad spectrum antibiotic following surgery, which was not in line with local policy or national guidance.

Records

- Information governance training was part of the annual mandatory update day for all staff working at the clinic, and 100% of permanently employed staff had completed this within the last year.
- Clinic staff used paper based patient records to record patients' consultation, assessment and operative record, as well as post-operative care and risk assessments. All patients having day surgery at the clinic were required to complete a pre-assessment medical questionnaire. This included questions about any recent surgery, medications, any treatment for any medical conditions, allergies, and if a female patient could be pregnant or breast-feeding. We saw these completed in all records we reviewed. A further consultation record was then completed with an advisor and then the surgeon who would be completing the operation. We saw allergies and results from blood tests were recorded. Paper records were later scanned electronically.
- Paper patient records were kept in a locked filing cabinet in a locked room. The provider had added the storage of records to their risk register due to the volume of notes left from the old provider at the premises. They had scanned header sheets for these and planned to move old records off site and archive them.
- We looked at 15 sets of patients' records. Although essential risk assessments had been completed, we noticed some inconsistencies. Some surgeons filled out different parts of the operative record, and we noted that these were not always signed and dated. In some records, not all the checklists or sections had been filled out, but had been in others – for example, the patient coordinator checklist, nine symptom checklist or MRSA checklist. In two records, we also saw that there were no nursing notes entered once a patient had been stepped down, despite each patient being on the premises for around two hours. We noted that more recent records usually contained different and more complete documentation to those that were older. The clinic explained that they had recently adapted and introduced standardised booklets and consent forms and were in the process of ensuring staff knew how to use these correctly. Notes were now routinely checked for completeness when scanned electronically. We saw that surgeons were reminded of the importance of clear and consistent documentation in the medical advisory committee (MAC) meetings.
- The provider showed us documentation audits that had been completed in January and February 2018. These mainly highlighted small issues such as identification labels not present on every page of the paper record, and identification checks not being completed. The documentation had been changed to include a prompt in response to this issue.
- The records included the procedure carried out and details of any implants used. Staff recorded the serial number of the implant in the patient's records and patients signed a consent form relating to the implant registry.
- A theatre register was kept, with details of all surgical procedures carried out in the theatre. All entries were clear and legible.

Safeguarding

- Staff we spoke with demonstrated an awareness of safeguarding procedures and how to recognise if someone was at risk or had been exposed to abuse. In the year prior to the inspection, the clinic had not reported any safeguarding concerns to the CQC.
- The clinic did not treat anyone under the age of 18. They had a policy for safeguarding patients from abuse, updated in June 2017. The policy referenced the Care Act (2014) but did not include any information on female genital mutilation (FGM). Following inspection, the provider informed us that FGM was referenced in a separate policy and added information regarding this to their safeguarding policy, too.
- The nominated safeguarding leads for the clinic were the registered manager and the nominated individual. All staff had completed baseline safeguarding vulnerable adults training. The registered manager had completed children's safeguarding level three training and the nominated individual was booked to complete

this in April 2018. Government guidance states that all staff working in healthcare settings should receive a minimum of level one training. All other staff had completed level one training in the last year. This was in line with minimum training requirements set out in 'Safeguarding children and young people: roles and competences for health care staff: Intercollegiate Document, Third edition: March 2014' as the clinic did not see people under the age of 18.

Mandatory training

- Mandatory training included: infection control, moving and handling, safeguarding, information governance, fire safety, equality and diversity, food hygiene, basic life support (BLS), complaint handling, conflict management and lone working. We saw evidence that staff had completed all of this training, either face-to-face at their annual update day, or online where appropriate.
- We saw evidence of an induction programme which differed in length and content, dependent on clinical role. There was a competency checklist for qualified nurses, with areas such as medication management and intravenous therapy listed. We also saw separate checklists that needed to be signed off prior to independent practice for areas such as venepuncture and surgical asepsis.
- There was a sepsis policy in place at the time of the inspection, dated October 2017. The provider told us that sepsis was covered as part of their mandatory training and that staff were encouraged to monitor signs of infection and sepsis during the procedure and before discharge, as well as monitoring for symptoms as part of the wound care process post-surgery.

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

- We saw evidence within the patient notes reviewed of risk assessments relevant to the patient's needs having been carried out. Between November 2016 to October 2017, 62% of patients had been assessed for the risk of venous thromboembolism (VTE). Most patients did not stay overnight at the service.
- Theatre staff used a surgical checklist based on the World Health Organisation (WHO) guidance. We followed a patient through their procedure and saw the WHO checklist completed. All 15 patient records we examined also contained completed WHO checklists. The provider completed an audit of 259 patient files in December 2017, which showed that 46 files (18%) were not fully compliant in terms of WHO checklist completion. Errors included minor issues such as the checklist being signed but no name printed alongside this, or where actions required had not been circled. Following the audit, staff had been reminded of the importance of accurate record keeping, via email and in a team brief.
- Surgical procedures carried out on-site were performed under local anaesthetic or total intravenous anaesthesia (TIVA), which is used for maintenance of general anaesthesia by intravenous infusion, without the use of inhalation agents. The anaesthetist was required to remain with the patient until the patient was awake and orientated after each procedure where TIVA was used. The anaesthetist was trained in Advanced Life Support (ALS).
- After each operation, the patient was moved to a recovery area for at least 90 minutes, before being stepped down to a ward area for up to four hours before being discharged. The provider's discharge policy stated that patients must wait a period of at least 60 minutes post-procedure after minor operations and for at least three hours following TIVA. The policy stated that each patient must leave the premises with a chaperone, unless agreed beforehand, with the patient signing a disclaimer. On the first day of our inspection, we noticed a patient leaving the clinic and crossing a busy road unescorted to enter a car where her escort was waiting. In the 15 sets of notes we reviewed, we also noted the following entry in one discharge summary: 'Patient discharged to the hotel. Awaiting daughter.' We were therefore not assured that patients were always discharged with an escort in line with the clinic's local policy.
- Patients' clinical observations such as pulse, oxygen levels, blood pressure and temperature were monitored in line with National Institute for Health and Care Excellence (NICE) guidance CG50 'Acutely ill-Patients in Hospital.' A scoring system based upon these observations known as a national early warning score (NEWS) was used to identify patients whose condition was at risk of deteriorating. Patient notes we examined

contained guidance for staff on the NEWS scoring system, and detailed the actions required. Staff we spoke with were familiar with using the NEWS tool and how to escalate concerns.

- Overnight stays were facilitated for those not fit or ready for discharge, those who elected to stay overnight, or for patients from further afield. This was not explicitly mentioned as an option in the provider's discharge policy, except for the following sentence: "if the patient needs to stay due to not arranging a chaperone a charge may be applied." We saw reference to overnight stays in the patient literature, but there was no explicit mention that this could be chosen as an option for surgeries that were normally day cases. The service confirmed that overnight stays were rare, with only 13 patients staying overnight between November 2016 and October 2017. No more than two patients would stay overnight at the facility at any time. Patients staying overnight were cared for by a nurse and resident medical officer (RMO). The RMO was trained in ALS.
- The clinic did not provide high dependency or intensive care. There were emergency crash alarms available in the recovery areas. In an emergency situation, the standard 999 system was used to transfer the patient to an NHS hospital. The clinic also had arrangements with two local private ambulance companies for less urgent transfers. In the year leading up to our inspection, there had been no such unplanned transfers to another hospital.
- The clinic told us that they had a strict admission criteria which allowed them to assess the risk of each patient physically and mentally, meaning they only elected to operate on fit and healthy people, due to the lack of intensive care facilities on site. We viewed the pre-admission criteria policy, which stated that any patients with a body mass index (It was not written down in the policy that the clinic did not accept patients under the age of 18, specifically, but it did state that: "It is essential that we obtain a copy of the patients' identification (passport or driving licence) prior to consultation. The litigation attached to consulting an under-aged patient is extensive not to mention the distress it can cause the patient directly. ID is to be photocopied and kept in the file."
- There were formal psychological assessment of patients in five of the 15 records we looked at. Staff told us that this element had only been added to the patient record recently. It is a requirement of the Royal College of Surgeons that the consultation identifies any patients who are psychologically vulnerable and they are appropriately referred for assessment. The provider informed us that

Nursing and support staffing

- At the time of inspection, the clinic directly employed one whole time equivalent (WTE) registered manager and one WTE receptionist, who shared front of house and administrative duties. There were also two WTE non-clinical surgical advisors who worked from home on days where consultations did not take place. Consultations usually took place one or two days per week, dependent on patient demand. On these days, the surgical advisors' role was to talk to patients about the company, costs and anything administrative, before they saw the operating surgeon. Clinically, they also employed one WTE theatre coordinator and one WTE healthcare assistant (HCA), who worked between the theatre and recovery.
- All other staff were currently employed via an agency. The provider told us that one operating department practitioner (ODP) worked the whole surgical list alongside the anaesthetist. In the recovery area, one nurse was used for half-day lists (lists of up to six hours in duration), with two nurses, or a nurse and a HCA, employed for longer lists. Senior staff told us that they used the same agency staff where possible, so that they were familiar with local protocols and procedures. We saw a comprehensive induction and competency checklist for agency staff.
- On the day of inspection on which a theatre list was running, we saw that staffing levels complied with Association for Perioperative Practice (AfPP) guidance, which stated that scheduled operating lists required a minimum of two scrub practitioners, one circulating staff member, one registered anaesthetic assistant practitioner and one recovery practitioner per patient. The provider told us that they had trialled having two recovery nurses present on days of theatre lists, but found this to be unnecessary. This was due to the short duration of operations undertaken and the staggering of theatre lists, meaning there was only ever one patient

requiring immediate one-to-one care by a nurse. All staff we spoke with in the theatre environment felt that there were adequate staffing levels to provide safe and effective care for patients.

- In the case of an elective overnight stay, an agency nurse would be used. In the case of an emergency overnight stay, the nursing and operating department staff who had taken part in that day's theatre list remained on call to return to the theatre in case of emergency. On the second day of inspection there had been heavy snow. We saw that staff involved in the previous day's theatre list had stayed overnight in a nearby hotel to ensure that they could return to the site in an emergency.
- The clinic was currently recruiting staff and planned to have recruited into all nursing vacancies by March 2018. The risk of cancellation of lists due to agency staff failing to turn up to work had been added to the service's risk register. Senior staff explained that the number of theatre lists they currently ran did not support a full complement of WTE staff, but they wanted to increase activity on site in the near future, once another premises had been secured. On the first day of inspection, we were told that six people had been recruited but that they were still looking to employ a scrub nurse, two ODPs and a recovery nurse.
- We observed the nursing handover of patients between different stages of recovery and found it to be comprehensive and clear, covering all necessary aspects of patient care.

Medical staffing

- Surgeons and anaesthetists worked under a practising privileges arrangement. The granting of practising privileges is an established process whereby a medical practitioner is granted permission to work within an independent hospital. The medical advisory committee (MAC) was responsible for approving practising privileges for medical staff. Medical staff with practising privileges had their appraisals and revalidation undertaken by their respective NHS trusts. There was a responsible officer who worked for the provider organisation who completed appraisals for those doctors without a substantive NHS post.
- One anaesthetist and one surgeon would work the entire theatre list on any given day. These medical staff were clinically responsible for the patients under their care, and were required to review their patients following the operation. We were told that all operating staff would remain at the clinic until the patient had left the premises. In the event of an overnight stay, a regular resident medical officer (RMO) was used, working 9pm until 8am. The RMO had also worked 7pm until midnight on occasions where longer lists took place to free up the anaesthetist for pre-midnight discharges, or upon request to provide the anaesthetist with a rest period.

Emergency awareness and training

- The clinic had a business continuity plan in place, drafted in February 2017. The clinic did not have an isolated power supply, but there was a back-up generator for emergency lighting and sockets and battery back-up power supply for each piece of equipment in theatres. There was a risk assessment in place for the event of power failure.
- Fire safety was part of the mandatory training cycle and all staff had received this training in the last 12 months. Staff we spoke with were able to describe what actions they would take in the case of an emergency such as a serious fire. Senior staff confirmed that the last fire evacuation drill had taken place in December 2017. All fire extinguishers at the building were within their service dates and we saw the annual fire risk assessment for the building.

Are surgery services effective?

Evidence-based care and treatment

- Since February 2017, when the clinic began providing a range of cosmetic procedures, 290 policies had been written and ratified via the clinical and medical director. We saw that some of the sample of policies we reviewed referenced appropriate National Institute for Health and Care Excellence (NICE) and Royal College guidelines, but not all policies referenced current best practice guidance. There were no specific NICE guidelines related to hair transplant available at the time of inspection.
- The clinic had not specifically audited their compliance with the Royal College of Surgeon's professional standards for cosmetic surgery. The provider told us that

all policies and procedures were written in line with guidance from the Royal College of Surgeons as well as the General Medical Council and CQC guidance and legislation.

- The clinic conducted some local audits relating to infection control, documentation and surgical site infection. However, the provider acknowledged that they needed to improve and widen existing audit activity and documentation in order to submit data more easily to the Private Healthcare Information Network (PHIN).

Pain relief

- The numeric rating scale (NRS) was used in the clinic, with patients asked to score their pain from zero to 10 each time their vital signs were taken. In this scale, zero meant no pain and 10 was extreme pain. We observed nursing staff in recovery asking patients about their pain and administering pain relief as necessary. The 15 sets of medical notes we reviewed showed that patients had been given regular pain relief after their operations.
- Due to the type of anaesthesia used, additional pain relief was required post-procedure. It was usual for patients to be discharged home with up to seven days of tramadol (a strong painkiller used to treat moderate to severe pain). We did not see any non-opioid painkillers routinely available for patients.

Nutrition and hydration

- Patients were screened to ensure they were not at risk of malnutrition. A tool based on the MUST (malnutrition universal screening tool) was used to identify the risk level of each patient and this was documented in each set of notes we reviewed.
- Staff followed The Association of Anaesthetists of Great Britain and Ireland (AAGBI) best practice guidance on fasting prior to surgery. Records showed checks were made to ensure patients had adhered to fasting times before surgery went ahead.
- The clinic provided water, tea and coffee to all patients. A coffee machine had been added to the clinic in 2017, specifically in response to patient feedback. They also had an arrangement with a local café, which allowed them to provide a range of meals to patients staying for a longer period to recover and overnight.

Patient outcomes

- In the reporting period November 2016 to October 2017, there were 312 episodes of care recorded at the clinic. In this time, there were five unplanned returns to theatre. These related to known implant risks and haematomas. As a result, the provider told us that they reviewed their diathermy kit to ensure this was of the best standard and was being used correctly. Diathermy is a surgical technique involving the production of heat in a part of the body by high-frequency electric currents, to stimulate the circulation, relieve pain, destroy unhealthy tissue, or cause bleeding vessels to clot.
- The clinic was supplying national data to PHIN as of August 2017, which they had back-dated to January 2017. However, the provider acknowledged that they needed to improve and widen existing audit activity in order to submit data more easily.
- The service was in the process of preparing to collect data in relation to Quality Patient Reported Outcome Measures (Q-PROMS), which had involved restructuring some of the documentation in use. These were currently sitting with the media team, awaiting the provider's branding to be added, and the service aimed to go live with these at the start of March 2018. The Royal College of Surgeons has requested providers of cosmetic surgery to submit Q-PROMs for cosmetic surgery procedures such as liposuction, rhinoplasty and breast augmentation. Q-PROMs are distinct from more general measures of satisfaction and experience, being procedure-specific, validated, and constructed to reduce bias effects. The data gathered from the use of Q-PROMs can be used in a variety of ways to empower patients, inform decision making and, where relevant, support quality improvement.
- On the first day of inspection, we noted that patients on the theatre list were from other places in the country, such as Wales or Northern Ireland. The operating surgeon told us that any issues after their operation would be followed up locally, for instance by clinicians in Northern Ireland. We raised this with the provider, who told us that patients would either be booked to come back to the London clinic 12 weeks post-procedure, or surgeons would fly out to review them. Wound care appointments would be carried out by other clinicians as necessary. Senior staff reported that some patients were reluctant to return for their

12-week review but that the clinic would try to accommodate them at weekends and stress that the surgical review was important in terms of implant warranty. Following the inspection, the provider added that some of these operations were on patients belonging to a third party clinic and that they were responsible for patient care during the operative phase only. They provided us with documentation that demonstrated patient follow-up locally.

Competent staff

- Staff we spoke with reported they received annual appraisals and opportunities for professional development. Senior staff told us that they attended conferences relevant to the field of practice. An external member of staff was responsible for appraising hair technicians. We saw evidence that all permanent staff had received an appraisal in the last 12 months.
- Senior staff told us that they ensured professional registration, fitness to practice, and validation of qualification checks were undertaken for all staff. However, one Disclosure and Barring Service (DBS) check was not in place for a hair technician at the time of our inspection. We were shown that one of these was in the process of being obtained and was in place by the second inspection day. A risk assessment had been undertaken by the service whilst this was underway.
- All consultants with practising privileges at the clinic had their GMC registration checked on an annual basis. Consultants were either appraised through their NHS trust and had to provide a copy of this to the clinic each year, or by the provider's own responsible officer. Doctors usually revalidated with the organisation where they carried out the majority of their clinical work. The clinic reported 100% completion rate of validation of professional registration for doctors working under practising privileges in the year prior to inspection.
- The provider informed us that surgeons only worked within their scope of practice and operated completely within their area of known practice and ability. Each surgeon kept a log book of their operations, which they used as part of their appraisal and revalidation process. Each surgeon was due to submit data annually, beginning in March 2018, relating to total number of all operations they had carried out, complaints, revision rate, returns to theatre, surgical site infection rates and general compliance and performance. As part of their appraisal process, surgeons completed 360 degree feedback reviews. The provider told us that each surgeon had to evidence competence and log book experience in a specific surgery type before being allowed to perform this type of surgery at the clinic.
- National guidance for patients states: "The surgeon must, as a minimum, be registered with the GMC and be fully insured to carry out the procedure in the UK. The Royal College of Surgeons (RCS) recommend choosing a surgeon who is on the GMC's specialist register in the area of practice relevant to this procedure." Two of the three surgeons carrying out the bulk of the cosmetic surgery procedures did not have specialist registration. The service were aware of this and future recruitment of surgeons was planned around them having specialist registration.
- Hair transplant technicians could assist in procedures under the supervision of the doctor. The doctor carrying out the surgery would lead the procedure; however, the technician was able to insert the hair follicle once the doctor had made the incision. At the time of inspection, there were no nationally agreed competency requirements for hair technicians but the provider demonstrated that they provided training to these individuals appropriate to their roles.

Multidisciplinary working

- Staff told us that they enjoyed working with their colleagues and were complimentary about the support they received from one another. We observed good working relationships between all grades of staff and all professional disciplines.
- The clinic asked every patient for their consent to share post-operative information with their GP. We saw that copies of discharge letters were included in some of the later patient records, where patients had indicated their permission. This was to ensure the GP was aware of the procedure and post-operative treatment recommended. The discharge letters also included contact details for the clinic, should another health professional require further advice about patients' care or treatment post-discharge.

Seven-day services

- The clinic was open six days a week. We saw that some theatre lists ran on a Saturday to offer more choice to patients. An on-call system operated for 24 hours after each operating list, which meant the same team would return in the case of emergency.
- Patients were able to contact staff at the clinic for support at any time. They were given a telephone number to call following their procedure, which was manned by a member of clinic staff 24 hours a day, seven days a week.

Access to information

- Staff were able to access the clinic's policies and procedures.
- Patient records were scanned electronically, as well as kept in paper copy on site. Staff were able to access records at any time. Blood tests and other diagnostic results were available to clinical staff as required.
- We saw that copies of discharge letters to GPs were included in some of the later patient records to ensure relevant information was shared between the provider and the patient's GP.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- There was a consent policy in place dated February 2017, which was in line with current guidelines. Formal consent was also sought for sharing of implant information and data collection. We saw signed and dated consent forms for these areas, and all surgical procedures undertaken, in all 15 records that we examined.
- We saw evidence that patients came in for an initial consultation appointment, where they met with an advisor and the surgeon who would perform their operation. At this appointment, all of the risks and benefits of surgery were discussed, as well as all relevant patient history. The Royal College of Surgeons' professional standards for cosmetic surgery states that consent must be obtained in a two-stage process, with a cooling-off period of at least two weeks between the stages to allow the patient to reflect on their decision. All records that we reviewed had a clear gap of at least two weeks from consultation to the surgery procedure. The provider's policy stated that any operation could be postponed free of charge if the patient was unsure about any aspect of their procedure. The patient reconfirmed their intention to go ahead with surgery by completing the consent within their surgical pathway on the day of surgery.
- The provider told us that they were looking into providing consent and capacity training to surgical advisors. Although they did not actively take consent, the provider recognised that their role touched on this aspect of patient care.
- The provider had a Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS) policy in place, dated November 2017. No formal training was provided to staff on MCA or DoLS. The provider reported that it was highly unlikely that patients lacking capacity would be treated at the clinic as all patients were 'screened pre-operatively regarding their suitability to surgery both physically and mentally.' Any patients who were regarded as lacking capacity would be referred back to their GP for more information and support.

Are surgery services caring?

Compassionate care

- We observed interactions between staff and three patients prior to, during and following a surgical procedure. Nurses and doctors introduced themselves to patients. Interactions between staff and patients were observed to be positive across the clinic. Staff had a caring, compassionate and sensitive manner. Patients present on the first day of inspection did not wish to speak directly with the inspection team so we were unable to gather direct feedback.
- There was a policy relating to privacy and dignity, dated December 2017. Staff were aware of how they would maintain the privacy and dignity of patients throughout the day of their surgery.
- The provider told us that patients were encouraged to give feedback via a patient satisfaction questionnaire. They had recently asked the receptionist to encourage patients to fill these out to increase the response rate. From the 71 responses received in the final two quarters of 2017, all patients reported that they would be

'extremely likely' or 'likely' to recommend the clinic to others for similar care and treatment. Staff also told us that positive feedback was often posted on their social media, which was then shared with the wider team.

Understanding and involvement of patients and those close to them

- The provider told us that they realised the importance of managing patient expectations prior to surgery. This ensured patients were realistic about the final outcomes of surgery. We saw evidence of this within patient consultation notes.
- The clinic offered patients as many consultations as necessary, either with the same surgeon, or an alternative, to ensure patients were happy with the procedure. Any additional consultations were offered free of charge. We saw that one patient had three consultations prior to surgery in our review of their notes.
- We saw information leaflets for patients and relatives explaining what to expect on the day of the procedure and afterwards. From the 71 responses received in the final two quarters of 2017, 12 patients were not fully satisfied that a member of staff had fully informed about the side effects of their take home medications. In response, the provider had edited their patient information to try and make this easier to read, and ensured their patient booklet contained all information pertaining to discharge.
- We saw evidence that treatment fees were discussed at the initial consultation appointment, with a written record made to document this. The provider told us that they did not offer any special discounts or offers relating to cosmetic surgery.

Emotional support

- Patients were offered the opportunity to have a friend or relative present during consultations, unless safeguarding concerns were raised in relation to this.
- Staff were aware of the importance of providing emotional support and advice. We observed positive interactions between patients and clinical staff. However, from the 71 responses received in the final two quarters of 2017, 28% of patients were not always fully satisfied that they could find someone to talk to about their worries or their fears.
- The service did not provide any formal counselling services to patients at any time, but would refer any patients requiring enhanced support back to their GP.

Are surgery services responsive?

Service planning and delivery to meet the needs of local people

- As the clinic provided private elective cosmetic surgery, admissions were planned in advance at times to suit the patients. The clinic was open six days a week, with approximately 10 theatre days per month at the time of our inspection.

Access and flow

- Patients could contact the clinic via email or telephone. There was a team of patient-booking staff based centrally, who responded to any initial patient enquiries. Patients considering surgical procedures would have a face-to-face consultation with a surgical advisor and the relevant physician. Following this appointment, subsequent consultations could be offered or the surgery could be booked.
- Patients for surgery arrived at the clinic before the start of the surgical list and a pre-operative assessment took place with the anaesthetist. A pre-operative checklist was completed and consent was obtained for the procedure.
- Delays to the theatre list could occur, but staff told us that patients were always informed of any delays. The clinic did not monitor average waiting times for theatre, so it was not clear if patients would normally have to wait for longer periods in the waiting area before their procedures.
- Between November 2016 and October 2017, the clinic reported no procedures had been cancelled for a non-clinical reason.
- Staff confirmed no unplanned surgery took place. If patients had an issue following surgery, they were provided with a phone number to contact a clinician to discuss this. In an emergency, the patient was directed to an acute hospital accident and emergency

department. For non-emergency issues, the patient would be reviewed by their surgeon. Any revisions to their surgical outcomes could be arranged as a planned episode of surgery.

- There were no reported delayed discharges as the majority of patients were day surgery or stayed one night. Patients were discharged home with post-operative care instructions, and pre-booked appointments were made for follow-up care either at the main clinic or at a location arranged by the surgeon.
- Staff at the clinic called the patient 48 hours after the procedure to check in with them and confirm the follow-up appointment dates. Staff were automatically prompted to make follow-up appointments on the electronic system.
- For hair transplant procedures, patients met with an advisor for a face-to-face consultation and hair assessment, with images of the area for transplant taken. The doctor responsible for the procedure then reviewed the patient files and images prior to the day of procedure. The patient met with the doctor prior to the procedure to discuss any concerns.

Meeting people's individual needs

- At discharge, each patient was given advice specific to the procedure undertaken, as well as information relating to pain relief or wound care.
- The clinic had step-free access and was located on one level, enabling disabled access.
- The provider's policy stated that only those patients who were mentally competent and able to give informed consent were offered treatment. No patients with learning disability or dementia were treated at the clinic.
- The provider had a chaperone policy in place, dated September 2017. It stated that any female patient who required a chaperone to be present would be provided with one, or could ask a friend or relative to be present. Details of the chaperone would be recorded in the patient's notes.
- When a patient booked in for a consultation, any enhanced needs would be flagged and an interpreter would be arranged if required. Senior staff reported that patients were informed they could not use family members to translate. They told us of one occasion where a consultation was rebooked with an interpreter from a local translation agency as they were not satisfied the patient could understand enough to consent to a procedure.
- The clinic informed us that they could provide patient information in any format, such as another language or braille. Senior staff told us that this could be facilitated 'within a matter of hours' by their marketing team in America. If a patient attended needing further information, extra time would be allowed for the information to be compiled in an alternative format. The patient would then be given additional time to review this and booked in for further consultation if required.

Learning from complaints and concerns

- Clinic staff tried to resolve any issues with patients informally prior to a written complaint being made. In the case of a formal complaint, the clinic had a policy for handling complaints and concerns. The policy stated complaints would be acknowledged within two working days and a full response would be made within 20 working days of receipt. Where this timeframe was not possible then a letter would be sent to the complainant to inform them of the revised schedule.
- At the time of inspection, the clinic was not a subscriber to the Independent Healthcare Sector Complaints Adjudication Service (ISCAS), but informed us that they had made inquiries regarding this.
- Between November 2016 and October 2017, 23 complaints had been received by the clinic. Of these, 13 were procedure related, four related to the product, three to the result and three to the overall experience. We saw the complaint tracker the service used and noted that appropriate actions had been taken in response to concerns raised. We saw one complaint investigation in detail, which investigated the patient's claims fully and identified learning points as a result.
- Complaints information and learning was shared with staff at clinic verbally and via email. The complaints tracker was available for all staff to view so they had visibility of both active and completed complaints. We also saw minutes from the clinical governance meeting where complaints were discussed. Staff told us of

changes resulting from patient complaints, such as improved food options, changing linen cleaners and improving aftercare information in order to send patients home with more written information.

Are surgery services well-led?

Leadership / culture of service

- The clinical director, registered manager and nominated individual were visible and easily accessible according to the staff we spoke with. Staff reported they felt supported by the leaders of the clinic and enjoyed working there. The nominated individual was a registered nurse by background and helped out with clinical work as and when necessary.
- We observed a good team attitude amongst the staff members. Staff were seen to be able to approach senior staff during and as part of their day-to-day work.
- Junior staff told us that they felt confident to raise any concerns with the manager or the doctors. There was an up-to-date whistleblowing policy, which outlined how to escalate any concerns.

Vision and strategy

- The provider was in the process of registering under a different name, One Health Hammersmith. They told us that their vision was to create a long-term business, which was safe and effective and provided both their patients and staff with the assurance of continued existence. Senior staff told us that the clinic aimed to grow the business, increasing the range of cosmetic procedures offered and doubling the current patient traffic. This would mean the clinic would be busy enough to employ full-time staff and provide greater continuity of care for patients. However, senior staff told us that the current building was not sufficient to be able to accommodate a bigger patient list and that they were in the process of acquiring a new set of premises to enable this growth to take place. The clinic had successfully been authorised to store blood products by the Medicines and Healthcare products Regulatory Agency (MHRA), in preparation for expanding the clinical work they undertook.
- Staff across the clinic were broadly aware of the vision and strategy, with knowledge of developments such as the recruitment of more permanent staff.

Governance, risk management and quality measurement

- The clinic had just introduced a monthly clinical governance committee into its structure in September 2017. We saw minutes from these meetings and saw that complaints, incidents and updates to policies and procedures were discussed. Learning from these meetings was shared verbally and by email.
- The medical advisory committee (MAC) had been set up in October 2017 to advise the clinic on matters relating to the granting of practising privileges, clinical standards, new and emerging professional guidance, the introduction of new treatments and capital investments. The MAC also ensured there was a process in place for overseeing and verifying doctor revalidation, continuing practice development and reviewing practicing privileges. Although all practicing privileges documents were found in place, these were not organised in a structured manner, making them difficult to review.
- The clinic provided us with a copy of their formal risk register, which was regularly reviewed by the management team. A risk register is a management tool that enables an organisation to understand its comprehensive risk profile. Although details of each risk and the level of risk was recorded, any mitigating actions were not time limited. Although actions had been taken in response to risks identified, no details of these updated actions were apparent on the copy of the risk register.
- The provider acknowledged that more work was required in terms of improving their clinical audit schedule.At the time of inspection, information regarding returns to theatre, list complications, implant complications and data protection queries were being collected. The clinic conducted some local audits, relating to infection control, documentation and surgical site infection. The clinic was supplying national data to PHIN as of August 2017, which they had back-dated to January 2017. However, the provider

acknowledged that they needed to improve and widen existing audit activity in order to submit data more easily. They were also in the process of restructuring documentation in order to take part in Q-PROMS.

Public and staff engagement

- Patients and relatives were asked to complete a provider feedback questionnaire about their experience. Patients were also able to provide feedback via the clinic website and email. The clinic told us that they also engaged with the public through their social media channels. Patients were able to add comments to their page. Senior staff told us they were in the process of developing a patient feedback tool for the website so they could share the changes they made based on patient feedback.
- Staff told us that communication was good across the clinic and they felt able to have their say. Regular staff meetings and email communication ensured that staff knew what was going on at the clinic. Senior staff told us that staff engagement was an area of focus for them, as they acknowledged they had not always got this right. The clinic was aiming to generate a monthly newsletter for staff, to provide them with company updates and any new policy or legislation information.

Innovation, improvement and sustainability

- The provider was in the planned to register under a new name, with the intention of creating a viable long-term business. Once a new building was procured, senior staff informed us that they planned to increase the number of procedures and frequency with which these could be offered to patients. The provider was responsive to any concerns raised by their patients or the inspection team.

Outstanding practice and areas for improvement

Areas for improvement

Action the provider MUST take to improve

- The service must ensure they take all necessary measures to control infection risk.
- The clinic must replace sinks and basins throughout the service and follow their infection control plan for the following year to ensure that the clinic meets current clinical guidance for surgical environments.
- The provider must continue to audit and improve the storage of medicines, including ambient and refrigerated medications, as well as those kept for the purpose of resuscitation.

Action the provider SHOULD take to improve

- The clinic should consider adding a locked door between the reception of the clinic and the operating theatre.
- The provider should continue to audit patient records to ensure these are fully complete and consistent.
- The service should ensure that patients are always discharged with an escort, in line with local policy.
- The provider should review their local policies to ensure they are in line with current best practice guidelines, including the adverse incident policy.
- The provider should consider reviewing their procedure for the prescription of antibiotics to bring this in line with local and national policy.
- The clinic should improve and widen existing audit activity, as planned.
- The provider should consider requiring future surgeons recruited to the clinic to have specialist registration.
- The clinic should consider providing staff with formal training on the Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS).
- The provider should continue to pursue subscription to the Independent Healthcare Sector Complaints Adjudication Service (ISCAS).
- The clinic should ensure that all items on their risk register are regularly reviewed and this document is updated.
- The provider should ensure that practicing privileges are stored in a centralised and organised manner to enable regular audit and review.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

The table below shows the legal requirements that were not being met. The provider must send CQC a report that says what action they are going to take to meet these requirements.

Regulated activity	Regulation
Surgical procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment d. ensuring that the premises used by the service provider are safe to use for their intended purpose and are used in a safe way; g. the proper and safe management of medicines; h. assessing the risk of, and preventing, detecting and controlling the spread of, infections, including those that are health care associated