Harley Health Village

Quality Report

64 Harley Street
London
W1G 7HB
Tel: 020 7631 4779
Website: www.harleyhealthvillage.com

Date of inspection visit: 15 January 2020
Date of publication: 20/03/2020

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

Ratings

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

Overall summary

Harley Health Village is operated by Linia Ltd. The service provides cosmetic surgery for privately funded patients over the age of 18 years of age.

The service is located in a multi-storey building, spread over the lower ground, ground floor and first floor. The service has six recovery beds on the ground and lower ground floors. The service has three admission and discharge rooms, which are also used for overnight stays. Facilities include two operating theatres, a consulting room, reception area and training/meeting rooms.

We last carried out an announced comprehensive inspection of the service in January 2017. At the last inspection, we did not have a legal duty to rate cosmetic surgery services when provided as a single specialty service.

We re-inspected this service using our comprehensive inspection methodology on 15 January 2020 in order to rate the service. Our inspection was announced, staff knew we were coming, to ensure that everyone we needed to talk to was available.

Summary of findings

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

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

Services we rate

This was the first time we are rating this service. We rated the service as good because:

- The service had enough staff to care for patients and keep them safe. Staff had training in key skills, understood how to protect patients from abuse, and managed safety well. Staff assessed risks to patients and acted on these assessments. The service kept detailed records of care and treatment. They managed medicines appropriately. Staff collected safety information and used it to improve the service. The service generally controlled infection risk well. Staff knew how to report patient safety incidents and could tell us about lessons learnt from them.
- Staff provided good care and treatment, gave patients enough to eat and drink, and gave them pain relief when they needed it. Managers monitored the effectiveness of the service and made sure staff were competent to carry out their role. Staff worked well together for the benefit of patients and supported them to make decisions about their care. Key services were available seven days a week.
- Staff treated patients with compassion and kindness, respected their privacy and dignity, took account of their individual needs, and helped them understand their care. They provided emotional support to patients and those close to them.
- The service planned care to meet individual patient's needs and made it easy for people to give feedback. People could access the service when they needed it.
- 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 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.
- Staff were overwhelmingly positive about the culture of the service. Staff were proud to work for the organisation and were committed to supporting their colleagues and meeting the needs of their patients. Managers promoted a positive culture where staff were valued and respected. Staff were supported and empowered by managers to raise concerns and suggestions for improvement.

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

- The risk register did not always highlight when the risks were last reviewed. Although we noted that the risk register was reviewed at the governance meeting. Following the inspection, the provider submitted an updated risk register which showed the issue had been addressed, and the updated risk register included the last review date.
- Not all of the staff we spoke with were able to articulate some of the national and professional guidelines that influenced their practice.
- We found an expired medicine and some out of date consumable items in the first aid box.

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

Nigel Acheson

Deputy Chief Inspector of Hospitals (London and the South East)

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Surgery	**Good** 	The service provided cosmetic surgical services for day case and inpatients together with related outpatient follow ups. We rated this service as good because it was safe, effective, caring, responsive and well-led. The service had enough staff to care for patients and keep them safe. Staff treated patients with compassion and kindness, respected their privacy and dignity and took account of their individual needs.

Summary of findings

Contents

Good

Harley Health Village

Services we looked at:
Surgery

Summary of this inspection

Background to Harley Health Village

Harley Health Village is operated by Linia Ltd. The service opened in July 2015. It is a private cosmetic service in Harley Street, London and primarily serves the communities of London and neighbouring areas. The service provides cosmetic surgery procedures to self-funded patients from across the UK. It also accepts self referrals from overseas patients. The service did not provide services to NHS-funded patients or patients under the age of 18.

The service provides a range of surgical cosmetic procedures including liposuction, breast augmentation, breast reduction, abdominoplasty and facelift surgery.

The service has had a registered manager in post since 1 July 2015.

The service also offers cosmetic procedures such as dermal fillers, peels, wrinkle reduction treatments. We did not inspect these services as they were out of scope.

Our inspection team

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

Information about Harley Health Village

Harley Health Village is operated by Linia Ltd and offers cosmetic surgery to private patients aged over 18 years.

The service is registered to provide the following regulated activities:

- Surgical procedures.
- Treatment of disease, disorder or injury.

During the inspection, we visited the reception area, the operating theatres, consulting rooms, recovery rooms and overnight rooms.

We spoke with 13 staff including registered nurses, health care assistants, reception staff, medical staff, operating department practitioners, and senior managers. We spoke with four patients. During our inspection, we reviewed 20 sets of patient records.

There were no special reviews or investigations of the service ongoing by the CQC at any time during the 12 months before this inspection. The service has been inspected once, and the most recent inspection took place in January 2017 which found that the service was meeting all standards of quality and safety it was inspected against.

Activity (March 2019 to December 2019):

- The service carried out 2,161 surgical cosmetic procedures. Recent data received during the inspection showed that 2,505 procedures were carried out between January to December 2019.
- There were 472 inpatient (21.8%) and 1,689 day case episodes of care (78.2%) recorded at the service; which were privately funded. The service did not provide NHS funded services.
- The most common surgical procedures carried out were breast augmentation (25.7%), breast implant removal and replacement (17.1%), liposuction (14.3%), rhinoplasty (11.4%) and mastopexy (8.6%), facelift (6.9%) and neck lift (5.7%).
- 51 surgeons and 21 anaesthetists worked at the service under practising privileges. A small number of regular resident medical officers (RMO) worked overnight when required. The service's employed staff consisted of 17 registered nurses, five care assistants, one ODP and nine other staff including

Summary of this inspection

administrative and receptionist. It also had access to additional nursing and support staff, through its own nursing bank. The accountable officer for controlled drugs (CDs) was the medical director.

Track record on safety

- No never events
- Seven reported clinical incidents which caused no harm but were outside of regulated activity.
- No serious injuries
- No incidences of service acquired meticillin-resistant Staphylococcus Aureus (MRSA),
- No incidences of service acquired meticillin-sensitive staphylococcus Aureus (MSSA)
- No incidences of hospital acquired Clostridium Difficile (C. diff)
- No incidences of hospital acquired Escherichia coli (E. coli)
- Five complaints

Services provided at the service under service level agreement include:

- Clinical and or non-clinical waste removal
- Interpreting services
- RMO provision
- Medical gasses
- Emergency intensive care provision
- Fire alarms
- Health and safety
- Human resources and employment
- Infection control
- Medical equipment maintenance and anaesthesia machine servicing
- Servicing and maintenance of the air conditioning in theatres
- Sterilisation of surgical instruments
- Staff training
- Servicing of coffee and water machines
- Air and water sampling
- Information Technology (IT) and e-mails
- General Anaesthetic machines and monitor medical maintenance
- Staff mandatory training, audit and advice line
- Theatre isolated power supply (IPS) and Theatre uninterruptable power supply (UPS) maintenance

Summary of this inspection

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?

Good

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

- The service provided mandatory training in key skills to all staff and made sure everyone completed it.
- Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it.
- The service controlled infection risks well. The service used systems to identify and prevent surgical site infections. They kept equipment and the premises visibly clean.
- The design, maintenance and use of facilities, premises and equipment kept people safe.
- 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 had enough staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment.
- The service used systems and processes to safely prescribe, administer, record and store medicines.
- The service used monitoring results well to improve safety. Staff collected safety information and managers used this to improve the service.
- The service managed safety incidents well. Staff recognised and reported incidents and near misses. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support. Managers ensured that actions from patient safety alerts were implemented and monitored.

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

- We found an expired medicine and some out of date consumable items in the first aid box.

Are services effective?

Good

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

Summary of this inspection

- The service provided care and treatment based on national guidance and evidence-based practice.
- Staff gave patients enough food and drink to meet their needs and improve their health.
- Staff assessed and monitored patients regularly to see if they were in pain, and gave pain relief in a timely way.
- Staff monitored the effectiveness of care and treatment. They used the findings to make improvements and achieved good outcomes for patients.
- The service made sure staff were competent for their roles.
- From January 2019 to December 2019, the service reported 100% of all staff had received an appraisal.
- Doctors, nurses and other healthcare professionals worked together as a team to benefit patients.
- Staff gave patients practical support and advice to lead healthier lives.
- Staff supported patients to make informed decisions about their care and treatment. They followed national guidance to gain patients' consent.
- Staff always had access to up-to-date and accurate information on patients' care and treatment. All staff had access to the patient's record that they could all update.

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

- Not all staff we spoke with were able to articulate some of the national and professional guidelines that influenced their practice.

Are services caring?

Good

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

- Staff treated patients with compassion and kindness, respected their privacy and dignity, and took account of their individual needs.
- Staff provided emotional support to patients, families and carers to minimise their distress.
- Staff supported and involved patients and those close to them in making decisions about their care and treatment.

Are services responsive?

Good

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

- The service planned and provided care in a way that met the needs of patients it served.

Summary of this inspection

- The service was inclusive and took account of patients' individual needs and preferences. Staff made reasonable adjustments to help patients access services.
- People could access the service when they needed it and received the right care promptly. Waiting times from referral to treatment and arrangements to admit, treat and discharge patients were in line with good practice.
- 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 learnt with all staff.

Are services well-led?

Good

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

- Leaders had the skills and abilities to run the service. They were visible and approachable in the service for patients and staff.
- The service had a vision for what it wanted to achieve and a written strategy to turn it into action, developed with input from staff.
- Staff were positive about the culture of the service. Staff were proud to work for the organisation and were committed to supporting their colleagues and meeting the needs of their patients. Managers promoted a positive culture where staff were valued and respected. Staff were supported and empowered by managers to raise concerns and suggestions for improvement.
- Governance and performance management arrangements were proactively reviewed and reflected best practice. 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.
- Leaders and teams used systems to manage performance effectively. They identified and escalated relevant risks and issues and identified actions to reduce their impact.
- The service collected, analysed, managed and used information well to support all its activities, using secure electronic systems with security safeguards.
- The service engaged well with patients and staff to plan, manage and improve services.
- The service was committed to continually learning and improving services.

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

Summary of this inspection

- The risk register did not always highlight when the risks were last reviewed. Although we noted that the risk register was reviewed at the governance meeting. Following the inspection, the provider submitted an updated risk register which showed the issue had been addressed, and the updated risk register included the last review date.

Detailed findings from this inspection

Overview of ratings

Our ratings for this location are:

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

Good

Surgery

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

Are surgery services safe?

Good

This was the first time we have rated this service. We rated it as **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 their mandatory training.
- The mandatory training included: infection control, health and safety, information governance, fire safety, resuscitation, equality and diversity and safeguarding. Staff had also received training on sepsis. Staff were required by the provider to complete the mental capacity act (MCA) and equality and diversity training every three years and while the information governance and moving and handling were to be completed every two years. Senior staff told us, for good practice and to ensure full compliance all clinical and non-clinical staff completed the training annually for their development even if it was not required.
- Staff understood their responsibility to complete mandatory training and told us they were given protected time to complete their training. Staff told us the mandatory training was scheduled on the days there were no scheduled surgical procedures, so all staff could attend the training. This process also ensured that staff completed all the training annually.
- The service set a target of 100% for completion of mandatory training. The service data showed an overall 100% compliance for all staff.
- Managers and the human resources (HR) team, monitored mandatory training and alerted staff when they needed to update their training.
- The medical staff with practising privileges at the service were required to provide annual assurance of mandatory training completion, which was monitored by the business manager and HR, with oversight from the medical advisory committee. The medical staff also completed the in-house mandatory trainings.
- Locum or temporary staff were required to provide evidence of mandatory training compliance from their employers before they commenced work.
- The mandatory training met the needs of patients and staff. Staff spoke positively about the training received. The staff training satisfaction audit carried out on the 5 June 2019 showed 99% staff satisfaction against the 11 standards audited.

Safeguarding

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

- The service had clear systems, processes and practices in place to safeguard patients from avoidable harm, abuse and neglect that reflected relevant legislation and national requirements.
- Staff we spoke with understood how to protect patients from abuse and were aware of the relevant

organisations to report to and their contact details. Staff knew how to identify adults and children at risk of, or suffering, significant harm and worked with other agencies to protect them. Staff knew how to make a safeguarding referral and who to inform if they had concerns.

- Staff received training specific for their role on how to recognise and report abuse. Safeguarding adult and child were part of the service's mandatory training and which included safeguarding adults and children1, 2 and 3. The medical and nursing staff were trained to level 3.
- The service had processes in place to check patients were over 18 years before undertaking cosmetic surgery through identification checks and referral letter and patients notes received from the patients GP or consultant.
- The service set a target of 100% for completion of safeguarding training. The overall safeguarding training compliance for all staff was 100%.
- Staff could give examples of how to protect patients from harassment and discrimination, including those with protected characteristics under the Equality Act.
- The service reported there had been no safeguarding referrals in the last 12 months.
- The business manager was the local safeguarding lead and had completed level 4 safeguarding adult training. Staff reported feeling supported to raise concerns. However, some clinical staff did not know who the safeguarding lead was, despite information being displayed in the clinical area.
- The service had not reported any safeguarding concerns to the CQC in the 12 months prior to the inspection.

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. Staff managed clinical waste well.

- The service areas were visibly clean and well-maintained with suitable furnishings such as wipeable chairs.
- Staff were responsible for cleaning the equipment and this was completed at the start and end of the shift and in between patients. They labelled equipment to show when it was last cleaned. Staff used green 'I am clean' labels on equipment to indicate that it had been cleaned and was ready for use.
- There was service level agreement in place for the decontamination and sterilisation of instruments in a dedicated facility off-site. The 2019 decontamination audit of the facility showed 100% compliance.
- The service carried out quarterly deep cleaning of the clinical service areas to prevent infection. This was evidenced in the records reviewed during inspection.
- The service had an updated infection prevention control policy in place that guided staff on infection control processes and procedures. Staff followed infection prevention and control (IPC) policies and procedures.
- The service IPC lead was the business manager, who had a clinical background and had completed additional training on IPC. The IPC lead supported and guided staff on IPC practice and queries in the service.
- Staff followed infection control principles including the use of personal protective equipment (PPE). The service provided staff with PPE such as aprons, visors and gloves, to prevent and protect people from a healthcare-associated infection. We saw that staff used these appropriately, this was an improvement from the last inspection. We observed that clinical staff adhered to the service 'arms bare below the elbow' policy to enable effective hand washing and reduce the risk of spreading infections.
- There was access to hand washing facilities and hand sanitiser in all areas. We observed staff applying hand sanitising gel when they entered clinical areas. We observed staff disinfected their hands between patient contact, in accordance with national guidance (National Institute for Health and Care Excellence (NICE) Infection prevention and control: QS61).

- There were posters displayed across the clinical areas on hand washing and hygiene which prompted the visitors and staff to use the hand sanitisers or wash their hands effectively.
- The service had hands-free sensor taps which enabled patients and staff to wash their hands without the need to turn the tap on and off, reducing the risk of them contaminating their hands. This was in line with the national guidance (Health Building Note 00-09: Infection control in the built environment).
- The service provided us with data on hand hygiene audits for the period of March 2018 to December 2019 which showed 100% compliance with the standards audited.
- Staff used audit to identify how well the service prevented infections. The 2019 infection prevention and control (IPC) audit showed 100% compliance with the standards audited these included equipment, personal protective equipment and waste management. An external IPC audit was carried out on the 27 October 2019 which showed that the service achieved 100% compliance with the 11 outcomes audited.
- The service carried out an external laboratory audit on the 22 August 2019 to assess the indoor air quality in the theatre. The result showed no concerns and the service met all areas audited.
- The service had also carried out other audits such as legionella and meticillin-resistant Staphylococcus Aureus (MRSA) swabs of the clinical areas which showed satisfactory results.
- Patients were screened for MRSA as part of their pre-assessment and admission process.
- There were contract arrangements in place to safely manage waste and clinical specimens. We saw clinical and domestic waste bins were available and waste was handled appropriately with separate colour-coded arrangements for general waste, clinical waste and sharps. There were waste segregation posters displayed advising staff on the right waste bin to use. We observed that general, sharps and clinical waste bags were changed frequently by staff. Staff used sharps bins appropriately and complied with the Health and Safety (Sharp Instruments in Healthcare) Regulations 2013. We observed that sharps containers were dated, signed when brought into use and not over filled.
- Staff worked effectively to prevent, identify and treat surgical site infections. The service had systems and processes in place to identify and prevent surgical site infections (SSIs). Staff were required to report any cases of suspected SSI to the IPC lead. Any suspected or identified cases were reviewed and discussed at the governance meetings. For the period of January 2019 to December 2019, the service reported two surgical site infections over 2,505 procedures performed.
- There was a spillage kit and a cleaning schedule in place for the clinic and environment.

Environment and equipment

The design, maintenance and use of facilities, premises and equipment kept people safe. Staff were trained to use them. However, we found some out of date medical consumable items in the first aid box.

- Access to the service was via the ground floor reception by means of an intercom buzzer system. Reception staff would call and escort patients from the waiting area to the clinical consultation room or admission rooms.
- The theatres were located on the ground and lower ground floor and there was a trolley that could be used for the evacuation of patients in the event of an emergency.
- The service had enough suitable equipment to help them to safely care for patients. The service had processes in place to ensure equipment was maintained and tested for electrical safety, demonstrating it was fit for purpose and safe for patient use. We saw that electrical testing of equipment had been carried out and the equipment had passed the test.
- The instruments, equipment and implants were in compliance with the Medicines and Healthcare products Regulatory Agency (MHRA) requirement.
- Patients could reach call bells and staff responded quickly when called.

- The service carried out an environmental and equipment audit for the period of 2018/19 which showed 100% compliance with the standards audited, these standards included building entrance, reception, theatres and recovery areas.
- We observed that the management of sharps was compliant with the Health and Safety (Sharp Instruments in Healthcare) Regulations 2013. The sharps bin audit for the period of 2018/19 showed 100% compliance.
- We observed that all Control of Substances Hazardous to Health (COSHH) items in the clinical areas were locked and labelled appropriately to prevent or reduce staff and patient exposure to substances that are hazardous to their health. This was in line with the Health Regulations 2002.
- The service passed the external generic function check test of the smoke evacuation unit carried out on the 1 June 2019, which meant they were operating in accordance with the codes, standards and design for providing a safe clinical area.
- The disposable equipment seen in the clinical areas was all in date and appropriately stored.
- There was appropriate surgical, anaesthetic and emergency equipment in the clinic including resuscitation equipment, oxygen, evacuation equipment, difficult airway equipment, emergency grab bags and defibrillator. The service had systems to ensure emergency equipment was checked daily, and during inspection we saw that these checks from January 2019 to January 2020 had been completed daily. We checked a range of consumable items from the resuscitation equipment and noted they were all in date. The emergency equipment and other equipment seen had all been serviced. However, we found a first aid box in the theatre area on the ground floor, which had sterile bandages, gloves and eye pads that had expired in November and December 2019. This was escalated to staff and removed from the clinical area immediately.
- The service had two back up generators in place that were activated in the case of power failure. The back up generators were tested and checked against the MHRA requirement every six months.

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.

- All patients had a face to face pre-operative assessment to assess their suitability for surgery to reduce risk and ensure their safety.
- Staff used a nationally recognised tool to identify deteriorating patients and escalated them appropriately. The service used the national early warning score (NEWS), designed to allow early recognition of deterioration in patients by monitoring physical parameters, such as blood pressure, heart rate and temperature. The 2019 NEWS chart audit showed that the service achieved an overall 100% compliance.
- The American Society of Anaesthesiologists (ASA) physical status classification system is a system for assessing the fitness of patients before surgery, with grade three indicating a patient with severe systemic disease, and grade four indicating a patient with severe systemic disease that is a constant threat to life. The treatment of patients of ASA grade three and above was not permitted and patients were referred to other providers. The service only carried out cosmetic procedures for low risk patients graded as ASA one (healthy) or two (mild systemic disease) in line with best practice and the local admission policy.
- All patients treated at the clinic had undergone a risk assessment using a recognised tool, during their pre-operative assessment and on admission, and staff reviewed this regularly, including after any incident. Staff completed, or arranged, psychosocial assessments and risk assessments for patients thought to be at risk of self-harm or suicide. The emotional and mental health screening and assessment of patients was carried out as part of the pre and peri-operative assessment, processes to identify psychologically vulnerable patients were in place. The service had a protocol for the psychological assessments for patients seeking cosmetic surgery. The protocol showed that the pre-assessment questionnaire had three psychological prompts under the patient's medical history which helped identified patients that may need psychological and psychiatric assessment or input. This was to ensure the patients were emotionally fit for the procedure and was in line with national guidance and best practice.

- Staff had access to the pre-assessment records including the risk assessments, which were documented in the patients' medical records and were available on-site on the day of admission.
- The booking office also checked the patients records before the surgery to ensure the admission criteria and pre-operative screening had been completed and met. For the period of June 2019, the service reported 100% compliance with the completion of pre-operative assessment and 98% compliance on the risk assessment in the patient pathway that had been performed or completed by the surgeons and anaesthetists.
- The service used the World Health Organisation (WHO) surgical safety checklist for patients throughout the perioperative journey, to prevent or avoid serious patient harm. The checklist was used to minimise safety risks, human errors and retained swab for patients having a cosmetic surgical procedure to prevent or avoid serious patient harm in the operating theatre. This was in line with national recommendations (NPSA Patient Safety Alert: WHO Surgical Safety Checklist). The WHO audit for the period of June 2018 to December 2019 showed 100% compliance. We observed two procedures and saw staff adhered to the WHO '5 steps to safer surgery' checklist, swabs were counted, staff asked if the patient had an allergy, patient identity was verbally confirmed and checked against the patient record.
- Staff knew about and dealt with any specific risk issues. The service had processes in place that ensured patients were assessed for their risk of developing complications following surgery. The service completed venous thromboembolism (VTE) risk assessments, used to identify patients at risk of developing a blood clot.From July 2018 to June 2019, the VTE audit showed 99% compliance with the assessment and recording of VTE in the service. The service reported there had been no reported incidence of deep vein thrombosis (DVT) since 2014. DVT is a blood clot that develops within a deep vein in the body, frequently in the leg.
- Staff shared key information to keep patients safe when handing over their care to others. Shift changes, team briefs and handovers also included all necessary key information to keep patients safe. We observed the theatre team brief which was attended by theatre staff including the surgeons, anaesthetists and nursing staff and discussion was detailed. Discussions had included patients' allergies, VTE, prophylactic antibiotics, pain management.
- The service had policies for emergency management of cardiopulmonary resuscitation, and accidents and major incidents that guided staff on the actions to take during these emergencies.
- The service had anaphylactic and other emergency medication available in the clinical area for use during medical emergencies. This ensured timely interventions and promoted patient safety.
- We noted that the consultants or RMO were always on site for escalation in case of medical emergencies on site.
- The nursing staff understood how to escalate any patient deterioration to the medical staff and felt well supported by the surgeon, anaesthetist and resident medical officer (RMO). Staff had received training in sepsis identification and management and knew where to find the sepsis protocol and guidance.
- The theatre staffing was in line with national guidance and a minimum of three theatre staff were rostered on duty five to six days a week. There were arrangements in place for an on-call team to be called into the hospital in the event of an unexpected return to theatre. This team included a scrub nurse, recovery nurse, health care assistant (HCA), RMO and ODP. Staff reported they rarely had cases of return to theatre or readmission in the service.
- The service had only a few patients that stayed overnight, and the overnight care was provided by a recovery nurse, healthcare assistant and RMO. The responsible surgeon and anaesthetist, who had performed the patient's procedure, were required to be available to attend the hospital within 30 minutes of being notified of any emergency. The service also had arrangements in place to ensure appropriate nursing and RMO cover when there were unexpected overnight stays.
- The service had a service level agreementwith the local NHS trust for the escalation and transfer of any patient who had deteriorated post-operatively and needed care and treatment that could not be provided in the service.

Staff had a dedicated contact number for the critical care unit's registrar at the local NHS trust. The service was located less than a mile from the NHS hospital which ensured patients could be transferred quickly in the event of an emergency. Staff told us they rarely had any patient transfers to the local hospital for critical care and the last one was around three years ago.

- Patients had access to a 24-hour telephone helpline, which was staffed by a registered nurse. Staff encouraged patients to phone the helpline for advice if they had any concerns following discharge from the service. We noted that the service also advised overseas patients to spend a few days in the country before they travel to ensure they were fit to travel.
- Staff had received training in the basic life support and advanced life support and felt competent to respond appropriately to any cardiac arrest situation. The service had resuscitation algorithms by the resuscitation trolley which also guided staff on the procedures to take during an emergency. In the event of a cardiac arrest, following skills and drills or an emergency call, staff would be required to complete an emergency incident form.
- The service had processes in place to ensure that patients who were unwell on the day of their surgery, did not have their procedure and that this was rescheduled for a later date to ensure their safety. Staff told us they had a cancellation the previous week as the patient arrived at the clinic unwell and presented with cold symptoms.
- The surgeons, nurses and patient co-ordinators contacted the patients following their discharge after 24 hours to ensure they were recovering well and there were no complications. This was in line with the 2019 guidelines from the Association Anaesthetists and British Association of Day Surgery Guidelines for day case surgery.

Nursing and support staffing

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

- The service had enough nursing and support staff to keep patients safe. The theatre staffing levels were in line with the Association for Perioperative Practice (AfPP) guidance, which stated that scheduled operating lists required a minimum of two scrub practitioners, one circulating staff member (floater), one registered anaesthetic assistant practitioner and one recovery practitioner per patient.
- Managers accurately calculated and reviewed the number of nursing staff needed for each shift in accordance with national guidance. The number of ODP and healthcare assistants matched the planned numbers. The staff rota was planned at least two to three weeks in advance and the theatre manager reviewed the surgical booking list a week in advance, for complexities of the cases to ensure sufficient time had been allocated for each procedure and the skill mix of staff met the patient's needs.
- The service was staffed with 30 substantive nursing and support staff which was sufficient to provide a safe service. This included; six receptionists, five scrub nurses, one ODP, seven recovery nurses, five HCAs, two administrative staff, two senior managers and a house keeper.
- During the inspection, we noted that the staffing levels matched the patient acuity. The service had one theatre list for four surgical procedures and an overnight stay. The admission area was staffed with two nurses and an HCA and while the theatre was staffed with two scrub nurses, a floater, one recovery nurse and an ODP.
- The service had low staff vacancy rates. During our inspection, there were three vacancies for: one scrub nurse, an ODP and one house keeper. At the time of the inspection vacancies were covered by bank staff. Managers did not use agency staff and requested staff familiar with the service. Staff told us that the service did not use agency nursing staff and only used their bank staff to cover any gaps in rota or sickness. Managers made sure all bank staff had a full induction and understood the service. The service data showed 57.6% bank usage and 0% agency staff for the period of March 2019 to December 2019.
- The service had low staff turnover rates and we noted that two staff had left the service in the last 12 months due to relocation and career progression.

- The service had low staff sickness rates. The overall sickness rate for the period of January 2019 to December 2019 was 0.8%. The service reported that all shifts had been covered in the last 12 months.

Medical staffing

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

- The service had enough medical staff to keep patients safe. There were 51 surgeons, 21 anaesthetists, and one resident medical officer (RMO) working under practising privileges at the hospital. The granting of practising privileges is an established process whereby a medical practitioner is granted permission to work within an independent hospital.
- The responsible surgeon and anaesthetist, who had performed the patient's procedure, were required to be available to attend the hospital within the 30 minutes time frame of being notified of any emergency. The service also had arrangements in place to ensure appropriate nursing and RMO cover when there were unexpected overnight stays.
- The medical advisory committee (MAC) was responsible for approving practising privileges for medical staff. We reviewed the last two MAC governance meetings which showed that practising privileges were reviewed at the meetings. Medical staff with practising privileges had their appraisals and revalidation undertaken by their respective NHS trusts. For those doctors without a substantive NHS post, there was a responsible officer who completed their appraisals quarterly and had oversight of their indemnity cover and occupational health checks.
- The business manager and HR department monitored registration and insurance requirements for all doctors on practising privileges. We saw evidence that the service had carried out appropriate checks on the medical staff with practising privileges, these included their registration, revalidation and indemnity cover.
- The Royal College of Surgeons (RCS) introduced a certification process for cosmetic surgeons on a relevant specialist register. This was not yet compulsory but regarded as best practice by RCS. The service data reviewed showed that 90% of their surgeons were on the specialist register which was in line with the RCS best practice.
- Managers could access locums when they needed additional medical staff. During our inspection, we noted that the anaesthetist called in sick that morning and the managers arranged for an anaesthetist to cover a within few hours. Staff called and advised the patients of the situation and asked them to arrive an hour later than their scheduled appointment time, this allowed the replacement anaesthetist to arrive and familiarise themselves with the theatre list.
- The medical staff matched the planned number. The theatres were staffed with a surgeon and anaesthetist and when there were patients admitted overnight or evening the RMO would be on shift.

  Doctors who failed to meet the standards expected by the service had their practising privileges suspended, removed or had supervised practice. For the period of February 2018 to February 2019, the service reported no medical staff with practising privileges have been suspended, removed or had supervised practice. However, during the inspection we noted that there had been a consultant who had their practising privileges suspended in December 2019 due to an allegation that had occurred somewhere else.

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.

- The service currently used paper records to document patient's assessment, care, consultation and treatment. The service planned to introduce and implement an electronic patient record (EPR) system in 2021. At the time of the inspection, we observed the senior managers had on-going conversations and negotiations with an EPR provider to ensure the new system would be customised to the service's needs. The senior managers told us they hope to set up the new EPR system in phases from the 1 July 2020 following their negotiations with the EPR provider and to complete the implementation process in June 2021.

- Patients records were stored securely on site, and all staff could access them easily. We reviewed 22 patient records and noted they were contemporaneous and entries were legible, signed and dated.
- Clinical assessments by nursing and medical staff were evident in the records reviewed. Clinical assessment such as VTE, NEWS scores, blood results, pre-operative assessments, emotional assessments, the patient's medical history, patient choices, care plans, allergies, smoking and alcohol status, vital signs, consent, and any ongoing risks and/or follow-up care needed and discharge summary to the GP were documented. The patient records audits for the period of June 2018 to November 2019 showed 100% compliance with all standard audited.
- All patient records reviewed had a document on the front page on General Data Protection Regulation (GDPR) which advised patients that their information may be shared with organisations such as the Private Healthcare Information Network (PHIN), CQC and NHS organisations.
- The service had a process in place which ensured that records in relation to breast implants were included in the national breast and implant register. The patient records reviewed included the procedure carried out and details of the 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. Patients were given information on the implants used and an Implant Identification card at the time of discharge. The patient's GP was sent a discharge summary that included the details of the surgery, implant or injectable used.

Medicines

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

- The service had an up to date policy on medicines management which advised staff on the management of medicines and controlled drugs. We observed and staff told us they had received training and assessment on medicines management.
- Staff followed systems and processes when prescribing, administering, recording and storing medicines to promote safety.
- Staff reviewed patients' medicines regularly and provided specific advice to patients about their medicines. We observed that discharge summaries detailed the verbal and written information provided to patients about the medicines they were given.
- There were effective processes in place for storing and managing medicines including controlled drugs (CDs) and emergency medicines. CDs were checked twice daily by two nurses and matched the CD records reviewed.
- Staff carried out daily checks on the resuscitaires equipment such as grab bags and the resuscitation trolley which contained medicines.We observed that the emergency medicines were in date and stored appropriately.
- Staff stored and managed medicines and prescribing documents in line with the provider's policy. The medicines and controlled drugs reviewed were arranged in a neat and organised manner and most were in date, we found an out of date gelofusine intravenous (IV) medicine that expired July 2019 which was escalated to staff and removed immediately.
- The service had planned and prepared for EU exit to ensure there were no issues with the supply of certain medicines due to national shortage.
- We checked 20 prescription and administration records and saw that they were accurate and completed fully with no missing administrations. Allergy statuses of people and venous thromboembolism (VTE) risk assessment outcomes were routinely recorded. We saw that as required drugs were given to patients when needed. Staff understood their responsibilities for ensuring prescription records were kept securely.
- We found medical gas cylinders were stored properly, in line with national guidance. Oxygen cylinders were full and in date. We saw that empty cylinders were stored appropriately and separately in a designated area.
- Staff followed current national practice and local policy to check patients had the correct medicines during their stay and discharge.
- The service had systems to ensure staff knew about safety alerts relating to medicines, so patients received

their medicines safely. For example, staff told us they were informed of the national recall of some batches of paracetamol in November 2019 as a precautionary measure due to fungal contamination.

- The service had a service level agreement (SLA) with a local pharmacy for the supply of medicines. The managers liaised regularly with the pharmacist to maintain appropriate stock levels. Staff reported good support from the pharmacist when they had to contact them for guidance or queries.
- To Take Home (TTH) medicines were pre-ordered and held in stock two to four weeks before patients were admitted, which ensured timely discharge and turnaround times.
- The medicines audit carried out for the period of June 2018 to December 2019 showed 100% compliance against the 32 standards audited.
- Staff did not prepare substances for injection in advance of their immediate use or administer medicines drawn up in a syringe by another practitioner, who was not present during the two surgical procedures we observed. This was in line with best practice.

Incidents

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

- Staff were able to recognise clinical and non-clinical risks and knew what incidents to report and how to report them. Staff raised concerns and reported incidents and near misses in line with the organisation's policy.
- The service had no never events in the last 12 months. Never events are serious patient safety incidents that should not happen if healthcare providers follow national guidance on how to prevent them. Each never event type has the potential to cause serious patient harm or death but neither need to have happened for an incident to be a never event.
- The service had no serious incidents in the last 12 months. Serious incidents are adverse events, where the consequences are so significant or the potential for learning is so great, that a heightened level of response is justified. In accordance with the national Serious Incident Framework 2015, the hospital reported there had been no serious incidents (SIs) which met the reporting criteria set by NHS England in the last 12 months.
- There were systems in place for the monitoring of surgical site infections and carrying out preoperative tests and assessments in line with the NICE guidelines.
- Staff had received training on duty of candour, they demonstrated an understanding of this and its impact to their practice. Staff were able to give examples of incidents when the duty of candour would apply. They were open and transparent and gave patients and families a full explanation if and when things went wrong. 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.
- Managers had received root cause analysis training and investigated incidents thoroughly. From the incident's records reviewed, we saw that staff, patients and their families were involved in these investigations. Managers shared learning about incidents and any national patient safety alerts with their staff. All incidents were discussed and incidents grading reviewed at the governance meetings, which were attended by the medical director and clinical leads.
- Staff received feedback from investigations of incidents via email, face to face and at meetings. Staff met to discuss the feedback and looked at improvements to patient care at the staff and governance meetings. Staff received email alerts following changes to any service policy or guideline as a result of any learning from incidents.

Good

Surgery

- There was evidence that changes had been made by the managers following staff feedback and incident investigations. For example, the service had installed an additional call bell panel in the staff area to ensure timely response to call bells. The service had purchased an extra anaesthetic machine and now had two back up machines with maintenance arrangements. There was an emergency call out service in place to mitigate the risk of in the event of an anaesthetic machine breaking down during a cosmetic surgery procedure.
- For the period of January 2019 to December 2019, the service reported there had been seven incidents, which were related to clinical and non-clinical incidents such as allergic reactions. Of the seven incidents, four were categorised as moderate risks and three were categorised as low risk. We reviewed two root cause analysis investigation reports. We found these to be detailed and included the outcome, human factor error, learning and an action plan.
- The service used a paper record system for reporting incidents. Nursing, support and medical staff we spoke with said they were encouraged to report incidents and felt confident to do so.

Safety Thermometer

The service used monitoring results well to improve safety. Staff collected safety information to improve the service.

- The NHS safety thermometer is an improvement tool to measure patient harm and harm-free care. It provides a monthly snapshot audit of the prevalence of avoidable harm in relation to new pressure ulcers, patient falls, venous thromboembolism (VTE) and catheter associated urinary tract infections. The service was not required to use the safety thermometer as it was a private healthcare provider. However, the hospital collected this information as part of their quality and safety performance monitoring and review process.
- Between January 2019 and December 2019, the service reported no falls or pressure ulcers. There was no reported case of venous thromboembolism (VTE) in the service.
- Patient safety information was regularly reviewed at governance meetings and shared with staff.

Are surgery services effective?

Good

This was the first time we have rated this service. We rated it as **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.

- Staff had access to and followed up-to-date policies and care pathways guidance to plan and deliver high quality care according to best practice and national guidance. We saw that staff knew where to access policies and procedures in both paper and electronic form.
- The policies and guidelines we reviewed reflected the latest professional standards and guidelines by the Royal College of Surgeons (RCS), NHS- Enhanced Recovery Programme and National Institute for Health and Care Excellence (NICE) guidance. We noted that the service had involved staff in the review of policies and protocols relating to theatre at their staff meeting to ensure they were fit for purpose and reflected best practice. However, some of the staff we spoke to were unable to articulate some of the national and professional guidelines that influenced their practice.
- We observed that staff followed the NICE guidance on the assessment and management of sepsis, urinary tract infection, venous thromboembolism (VTE) and the administration of intravenous (IV) fluid therapy. This meant that patient received appropriate care and treatment based on evidence-based practice.
- There were systems in place for the monitoring of surgical site infections and carrying out preoperative tests and assessments in line with the NICE guidelines. The pre-operative assessments of patients included the taking of a relevant medical history and discussion with the patient about their body image and emotions before any surgery was carried out. This was in line with the RCS professional guidance.

Nutrition and hydration

Staff gave patients enough food and drink to meet their needs and improve their health. Staff followed national guidelines to make sure patients fasting before surgery were not without food for long periods. The service made adjustments for patients' religious, cultural and other needs.

- Staff made sure patients had enough to eat and drink including those with specialist nutrition and hydration needs.
- Patients' dietary preferences were assessed and documented at the pre-assessment appointment and recorded in the patient's notes. Patients were given the food menu on arrival which included a range of choices including vegetarian, cultural, religion and vegan choices.
- Staff used a nationally recognised screening tool to monitor patients at risk of malnutrition. This was in line with the NICE QS15 :10 guidance.
- Patients waiting to have surgery were not left nil by mouth for long periods, in line with best practice. The patient records we reviewed showed that checks were done to ensure patients had complied with fasting times before their surgery went ahead. Patients were offered fluids immediately after they had recovered from surgery.
- Staff fully and accurately completed patients' fluid and nutrition charts where needed to ensure patients received sufficient food and drinks.
- Patients who experienced nausea or vomiting were prescribed anti-sickness drugs if required. We observed that nursing and medical staff asked patients if they felt sick and responded appropriately.

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 the patient pain as required.

- Staff assessed patients' pain using a recognised tool and gave pain relief in line with individual needs and best practice. We observed the anaesthetist and recovery nurse monitoring and recording patients' pain levels and gave additional pain relief to ease pain if required.
- Patients received pain relief soon after requesting it. Patients we spoke with told us that staff had asked if they were in pain and had administered their pain relief in a timely manner.
- From the patients' records reviewed, we saw that staff prescribed, administered and recorded pain relief accurately.
- Patients were followed up by staff 24 hours post discharge by telephone and their pain levels were discussed with advice given as necessary.
- The service carried out a pain audit for the period of 2018/19 which showed 100% compliance with the professional standards audited. The October 2019 patient satisfaction survey showed that 91% of patient commented their pain had been dealt with efficiently.

Patient outcomes

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

- Managers and staff carried out a programme of repeated local audits to check improvement over time. This included consent, infection control, infection rate, pain relief and WHO safety checklist. Outcomes for patients were positive and consistent. The service had achieved 100% in majority of their local audits.
- Managers used information from the audits to monitor improvements in patients' outcomes. They shared and made sure staff understood audit outcomes.
- The service participated in relevant local and national clinical audits. The service engaged with the Private Healthcare Information Network (PHIN) and collected and submitted data in accordance with the legal requirements regulated by the Competition Markets Authority (CMA).
- In line with the Royal College of Surgeons recommendations, the service collected and submitted data in relation to quality patient reported outcome measures (Q-PROMS). This involved asking patients to complete a standard set of questions to assess their health status before surgery, and again six months after surgery. This facilitated patient's own measurement of their health and health-related quality of life, and how

this had been changed by having surgery. The data gathered from the use of Q-PROMs was used to empower patients, inform decision making and support service improvement. In the Q-PROMS survey, patients were asked whether they felt better or worse after receiving surgical operations such as liposuction, breast augmentation and abdominoplasty. The results for the period of January 2019 to December 2019 showed that 81% of patients were very or somewhat dissatisfied with their body pre-operatively and while the others were very or somewhat satisfied with their image. The result showed that post-surgery, 98% of patients were very or somewhat satisfied with their body and health. The service also carried out the quality of life (QOL) survey regularly to assess the impact of long-term results, which showed positive outcomes.

- Patients completed a patient reported experience measures (PREMS) form on discharge, to assess their experience of care during their stay at the hospital. PREMs results were positive and the performance was reviewed at the governance meetings to identify themes and areas for improvement such as if patients' nausea was dealt with efficiently.

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.

- Staff were experienced, qualified and had the right skills, training and knowledge to meet the needs of patients. This included training and competency in administering sedation, airway management, oxygenation and resuscitation in line with the Academy of Medical Royal Colleges, 2013 guidelines on sedation practice for healthcare procedures.
- The surgeons had sufficient exposure to cosmetic surgery and had carried out the expected number of surgical procedures needed to retain their certificate, which was in line with the RCS guidance.
- Managers and the responsible officer supported medical staff to develop through regular, constructive clinical supervision of their work. There were processes in place to ensure that the surgeons, anaesthetist and RMOs had completed their appraisals and revalidation to ensure they had the knowledge, skills and competence for their practice. From the staff records reviewed we saw that the medical staff had a General Medical Council (GMC) licence to practice and 90% of surgeons were on the GMC specialist register.
- Data provided by the service showed that 100% of doctors with practising privileges at the hospital had an in-date appraisal at the time of the inspection.
- The service was a registered designated body that provided support to their medical staff with a regular appraisal and revalidation. For those doctors without a substantive NHS post the responsible officer completed their appraisals and had oversight on their indemnity cover and occupational health check, as required for the designated body by the GMC and NHS Revalidation Support Team.
- The service had measures in place to ensure all nurses and doctors were up-to-date and fit to practice Nursing and medical staff we spoke with were up-to-date with their professional revalidation, and their managers and colleagues had supported them with their revalidation.
- There were competency packs for all new starters and recovery nurses to complete to assess their clinical skills and competencies required to carry out their job. There was also a competency pack for medicines which all nursing staff were required to complete to assess their clinical skills on medicines management.
- Managers gave all new staff a full induction tailored to their role before they started work. All staff completed a local induction and orientation programme, which included mandatory and role specific training. Staff told us the induction and three months orientation for new starters was useful and well organised. Nursing staff were given a six weeks supernumerary period and were able to rotate between the theatres and admission areas which provided them with a range of experience.
- Managers supported the nursing and support staff to develop through yearly, constructive appraisals of their work. Managers identified any training needs their staff had and gave them the time and opportunity to develop their skills and knowledge. From January 2019 to December 2019, the service reported 100% of all staff had received an appraisal.
- Managers made sure staff received any specialist training for their role.

- Managers identified poor staff performance promptly and supported staff to improve through training or teaching sessions at staff meeting such as management of nausea.

Multidisciplinary working

Doctors, nurses and other support staff 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.
- Staff worked across health care disciplines and with other agencies such as GPs and NHS organisations when required to care for patients. There were systems in place to ensure that the patient's discharge summary and information on their breast implants was shared with their GP. This was in line with the RCS professional standard for cosmetic surgery.
- There were arrangements in place to ensure the surgeons and anaesthetist were available during the day and the resident medical officer available at night or out of hours for medical advice when needed.
- Staff we spoke with were aware of their roles and who had the overall responsibility for each patient's care.
- Staff referred patients for psychological and mental health assessments when they showed signs of mental ill health, anxiety or depression. We saw examples where staff had referred patients to a psychologist for assessments and support. We noted that staff also engaged with the patient's GP as part of their psychological and mental health assessment.

Seven-day services

- The hospital was open six days a week. Theatre lists ran mostly during the week but cosmetic surgery was also offered on Saturdays to offer more choice to patients when needed.
- Patients were able to contact staff for support, advise or if they had a query at any time. They were given a telephone number to call following their procedure, which was staffed by a nurse 24 hours a day, seven days a week.

Health promotion

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

- The service had relevant information promoting healthy lifestyles and support for patients.
- Staff assessed each patient's health during pre-assessment and admission and provided support for any individual needs to live a healthier lifestyle.
- Staff gave health promotion advice to patients on various topics which was evident in the patients' records we reviewed. This included alcohol, smoking cessation, healthy eating and care of self post surgery. Patients who had a liposuction procedure were given leaflets on what they should eat as part of their recovery process.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

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

- Staff understood the relevant consent and decision-making requirements of legislation and guidance, including the Mental Health Act, Mental Capacity Act 2005 and they knew who to contact for advice. Staff could describe and knew how to access the consent policy and get accurate advice on Mental Capacity Act.
- Staff understood how and when to assess whether a patient had the capacity to make decisions about their care.
- Staff gained consent from patients for their care and treatment in line with legislation and guidance. Staff made sure patients consented to treatment based on all the information available.
- Staff clearly recorded consent in the patients' records. Staff told us and from the records reviewed, we noted that the surgeons carrying out the cosmetic surgery explained the expected outcome and ensured patients understood the risk and outcomes before consenting for the surgery.
- There were systems in place to ensure the patients had a two-week cooling off period between when patients agreed to undergo cosmetic surgery and the surgery being performed in line with the RCS professional

standard. This was evident in the patients' records we reviewed and in the discussion, we had with staff and patients. The cooling off period ensured patients were able to reflect on the information received before making an informed decision to continue or not with the procedure.

- The service also followed best practice in obtaining a separate consent for anaesthesia, which ensured patients were fully aware of the risks of undergoing anaesthesia or sedation and had an opportunity to ask their anaesthetist questions.
- The service did not accept patients for cosmetic surgery that were deemed to lack capacity regarding treatment decisions.
- From January to December 2019, the consent audits showed 100% compliance with the standard audited by the medical director.

Are surgery services caring?

Good

This was the first time we have rated this service. We rated it as **good.**

Compassionate care

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

- We observed and patients told us that staff were discreet and responsive when caring for them. Staff took time to interact with patients and those close to them in a respectful and considerate way.
- Staff understood and respected the personal, cultural, social and religious needs of patients and how they may relate to care needs. Staff understood and respected the individual needs of each patient and showed understanding and a non-judgmental attitude when caring for patients.
- Patients said staff treated them well and with kindness. We spoke to four patients during the inspection and their feedback was positive. Some specific comments included "had a good experience and nurses were very patient", "good experience on all visits", "kind and efficient staff", "lovely receptionists", "friendly and respectful staff". Patients told us that staff were compassionate and have helped prepared them well ahead of their procedures.
- We saw staff introduced themselves by name and job title and that the surgeons and anaesthetist visited and introduced themselves before and after the patient's surgical procedures.
- Staff followed the service's privacy and dignity policy to keep patient care and treatment confidential. Patients told us that staff had maintained their confidentiality and dignity throughout their visit. Staff used chaperones during the clinic appointments and surgical procedures.
- The service carried out a patient survey to assess the patients' experience during their stay. From April to September 2019, the result showed that patients were positive about their outcomes and the service had achieved 92.4% compliance against the 12 outcomes audited. The service performed better than their target of 80% within this period. Specific comments had included, "Friendly staff and professional, "5 star service today", "I was in the best hands", "Everyone was professional and friendly", "You were all first class".

Emotional support

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

- 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. Staff gave patients emotional support and advice when they needed it.
- Staff supported patients with anxiety or those who became distressed in an open environment and helped them maintain their privacy and dignity. We observed two surgical procedures and saw nursing and medical staff offering reassurance to the patients to ease their anxiety and distress.
- Staff undertook emotional and mental health screening as part of the pre-operative assessment process to

identify psychologically vulnerable patients in line with best practice. This included a review of the patient's psychiatric history and a questionnaire about body image.

- We saw evidence of where staff had liaised with patients' GP, psychologist and psychiatrist in the assessment and support before and following the cosmetic procedures if they were concerned about a patient's mental health and wellbeing.
- Patients were assigned to a patient coordinator who liaised with the clinical staff and supported and navigated the patients through the cosmetic surgical pathway from consultation through surgical treatment and after discharge. Patients were given the patient coordinators contact details to contact them for any queries, support or information.

Understanding and involvement of patients and those close to them

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

- Staff made sure patients understood their care and treatment. They spoke with patients, families and carers in a way they could understand, using communication aids where necessary.
- We observed good instruction and interaction between the patient and the multi-disciplinary team during their procedures. Staff ensured the patients knew what was going on during the procedure and answered their questions.
- We spoke to four patients during inspection and they all reported not feeling rushed during discussion with staff, were involved in the decision about their care and staff had been patient when answering their questions. A patient commented that staff were very attentive and patient. We saw that staff gave written information to support information given verbally.
- Patients and their families could give verbal and written feedback on the service and their treatment and staff supported them to do so. Patients gave positive feedback about the service. Patients saw the same consultant for their pre-assessment and surgical procedure which ensured they were able to ask any follow-up questions and the consultants had informed knowledge about their care. The service data from April to September 2019 showed that 99% of patients commented they had a chance to ask the surgeons questions and while 91% had a chance to ask the anaesthetist questions. This was better than the service target of 80%.
- Staff supported patients to make informed decisions about their care. All patients were responsible for the full cost of their cosmetic surgical procedure and treatment. Staff discussed the cost and payment arrangement of the procedure in a sensitive manner during the patent's initial consultation.

Are surgery services responsive?

Good

This was the first time we have rated this service. We rated it as **good.**

Service delivery to meet the needs of patients

The service planned and provided care in a way that met the needs of patients served.

- Managers planned and organised services providing flexibility and choice, so they met the needs of the patients that accessed the service. The clinic was opened five days a week between 7.30am and 8pm and had the capacity to open on Saturdays to meet the patient's preference. Patients were offered different appointment times to meet their social and work-life commitments.
- Facilities and premises were patient centred and appropriate for the services being delivered. We saw that the service made provisions to meet patient needs through access to complimentary streaming TV services, magazines and newspapers. There was a comfortable seating area, hot and cold drinking amenities, and toilet facilities for patients and visitors in the service.
- The service's website contained information about the clinic, how to request an appointment, the cosmetic procedures offered, testimonials, parking arrangements and how to get to the clinic.
- The service offered a wide choice of procedures and choice of consultants, to meet the patients' needs. Each

patient was assigned a patient coordinator to help them with booking appointments and facilitating any questions they might have for the medical and nursing staff before or after their surgery. This ensured that patients had access to a flexible service with choice and continuity of care.

Meeting people's individual needs

The service was inclusive and took account of patients' individual needs and preferences. Staff made reasonable adjustments to help patients access services. They coordinated care with other services and providers.

- The clinic environment was spacious and had a relaxed and homely feel. There was wheelchair access to the clinic environment which was suitable for people with reduced mobility. The clinic did not have a lift however patients or their relatives with reduced mobility would have their surgical procedures and treatment on the ground floor theatre and recovery area.
- Staff understood and applied professional guidelines on meeting the information and communication needs of patients with a disability or sensory loss. The service provided a hearing loop system to patients who were hard of hearing to improve their experience and obtain informed consent.
- Managers made sure patients could get help from interpreters or signers when needed. There were arrangements in place for patients whose first language was not English and required translation services.
- Patients preferences and commitments were accommodated by staff and we noted that appointments were given to patients in a timely manner.

Access and flow

People could access the service when they needed it during the service opening hours. Waiting times from referral to treatment and arrangements to admit, treat and discharge patients were in line with good practice.

- Patients accessed the service through referrals by their GP and consultant. Patient were also able to complete an online booking form or contact the customer service team via telephone call or email for self-referral however a referral by their GP or consultant was still required for a surgical procedure. By contacting the customer service team directly this improved the patient's experience and addressed any questions they might have in a timely manner.
- The cosmetic procedures offered at the clinic included liposuction, breast augmentation, breast reduction, abdominoplasty and facelift surgery. From January to December 2019, the top seven most performed procedures included breast augmentation (25.7%), breast removal and replacement (17.1%), liposuction (14.3%), rhinoplasty (11.4%) and mastopexy (8.6%), facelift (6.9%) and neck lift (5.7%).
- Patients had timely access to consultations, treatment and after care. The service did not audit the waiting times from referral to surgical treatment as all the procedures were elective, and patients were able to choose their preferred dates. The scheduled surgical appointment took account of patient's availability and the minimum two weeks cooling off period between consultation and procedure. This 'cooling off' period was in line with the Royal College of Surgeons (RCS) Professional Standards for Cosmetic Surgery.
- The service carried out a waiting time audit from July 2019 to December 2019 to assess how timely patients were seen and admitted for their clinical procedures. The results showed 94% of patients were seen and admitted on time or before their scheduled procedure. The result showed that 6% of patients were not seen or admitted on time due to patients arriving late (3%) and the surgeons or anaesthetics arriving late (3%).
- We saw that patients could access the clinic for their cosmetic procedure on their preferred day and time to meet their needs and commitments. Procedure start times were staggered to minimise patient waiting times on the day of surgery.
- Managers and staff worked to make sure patients did not stay longer than they needed to. The average length of stay for day cases was four hours and less than 24 hours for the overnight stay patients.
- Managers kept the number of patients the service cancelled to a minimum. A last-minute cancellation by the service is defined as a cancellation for non-clinical

reasons on the day the patient was due to arrive, after they had arrived in hospital or on the day of their operation. From January to December 2019, the service reported zero cancelled procedures.

- From March 2019 to December 2019, there were 2,161 cosmetic surgical procedures recorded, of which 1,689 (78.2%) were day cases and 472 (21.8%) stayed overnight. The service saw an average of 10 patients per days and 216 patients in a month.
- From January 2019 to December 2019, the service reported 17 unexpected overnight stays. These mainly related to patients feeling tired, fatigue or no relative being available to pick the patient up.
- There were systems in place to ensure patients who did not attend (DNA) appointments were contacted by staff. For the period of January to December 2019, there were no reported DNA at the service.

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 learnt with all staff. The service included patients in the investigation of their complaint.

- There were systems and processes in place for the management of complaints. The service aimed to acknowledge all complaints within two working days and provide a full response within 20 working days. The service took an average of 21 days to investigate and close complaints. Senior managers told us one of the complaints took 25 days to complete, this was due to staff being on planned annual leave and the patient was updated about the delay in advance.
- The hospital received five complaints between January 2019 and December 2019.These were regarding providing identification document (ID) and orientation to the service. We reviewed three complaints and saw the complaints had been responded to in a timely and courteous manner. Actions were taken to resolve the complaints to the patient's satisfaction, which included offering an orientation booklet to all patients. Ensuring the admitting surgeons orientated the patients prior to their admission and sending a letter to all surgeons advising them they must inform their patients to bring a form of ID on admission under the PHIN regulations.
- Staff told us they informed patients they could give feedback and make a complaint via the clinic's website. Patients and their relatives could also make a complaint verbally or written, by face to face contact, email or by telephone. Patients we spoke with knew how to complain or raise concerns.
- The service clearly displayed information in patient areas about how patients or relatives could raise a concern.
- Staff knew how to acknowledge complaints and patients received feedback from managers after the investigation into their complaint.
- Managers investigated complaints and shared feedback with staff and learning was used to improve the service.
- From January 2019 and December 2019, there were no complaints referred to the ombudsman or ISCAS (Independent Healthcare Sector Complaints Adjudication Service).

Are surgery services well-led?

Good

This was the first time we have rated this service. We rated it as **good.**

Leadership

Managers at all levels had the right skills and abilities to run a service providing high-quality sustainable care.

- The hospital was managed locally by the medical director, who was also the registered manager and was supported by the theatre manager, business manager and compliance assistant. The business manager reported to the medical director and managed the administration, reception and housekeeping staff. The theatre manager also reported to the medical director and managed the theatre, ward and recovery staff.

- The medical director and other managers had received appropriate training for their role such as leadership, risk and safeguarding training. They attended the governance committee meetings including the medical advisory committee meeting.
- Staff spoke highly of their leaders, particularly the medical director and how approachable and supportive he was. Staff told us they had 'excellent visibility of their medical director' and had direct access to him and were able to raise issues or questions they had with him.
- The managers prioritised safe, high quality, compassionate care and promoted equality and diversity. Staff told us their managers encouraged cooperative and supportive relationships among staff and patients, so they felt respected, valued, and supported.

Vision and strategy

The service had a vision for what it wanted to achieve and workable plans to turn it into action, which it developed with input from staff and patients.

- The service's mission statement was, 'to deliver outstanding care to our patients, with compassion, kindness and respect, in the safest clinical environment, with the focus to customise the care to the unique needs of each individual patient, and to advance the field of medicine through education and audits'.
- The service aimed to provide first-class healthcare in a comfortable and welcoming environment, care for patients as they would care for their families and act as a team without hierarchical boundaries. The service also aimed to develop partnerships with their patients which was built on trust, integrity and mutual respect.
- The service's vision was 'to seek excellence in all endeavours, aspiring to provide premier services to our patients in a safe and patient-centred environment, and to nurture an environment in which health care professionals and staff can learn and thrive'.
- The hospital had a written strategy which focused on staff training and development, quality of care, expansion of service delivery and patients record. The service had a short and long-term plan to improve services through the introduction of electronic records and the expansion of the service by opening another cosmetic clinic that would provide cosmetic surgery and non-surgical cosmetic procedures. As part of the service's strategy to go paperless and implementing electronic patient and staff records, the staff records were now managed electronically. The managers had bought electronic tablets for staff to familiarise themselves with the computing system before the implementation of patient electronic records in 2021.
- Staff we spoke with knew the service vision, objectives and written strategy and told us this had been discussed at their staff and governance meetings.

Culture

Staff were positive about the culture of the service. Staff were proud to work for the organisation and were committed to supporting their colleagues and meeting the needs of their patients. Managers promoted a positive culture where staff were valued and respected. Staff were supported and empowered by managers to raise concerns and suggestions for improvement.

- There was strong collaboration and support across staff groups and a common focus on improving quality of care and people's experiences.
- Staff had a strong commitment to their jobs and were proud of the team working, and its positive impact on patient care and experience.
- Staff across all disciplines spoke highly of the morale, collaboration and culture of the service. Specific comments included, "friendly and inclusive", "family like environment", "best work place I have ever worked", "always happy to help each other", "never expected to be so included, they listen to me and take my advice". "The leaders of this clinic look after the staff financially and emotionally", "listening organisation"," leaders respect your opinion and if they can give you want you want or need- they will".
- Staff felt respected, valued and that they could approach any member of staff and challenge practice or behaviour if necessary. Nursing staff gave examples where they had challenged their colleagues on use of personal protective equipment.
- The service's culture encouraged openness, honesty and improvement. Staff told us they were able to raise issues or concerns they had with their managers

privately or during their staff meeting or monthly business meetings. Staff told us if they had any issues or concerns the medical director would arrange for an informal lunch or coffee to discuss and address the issue.

- Staff told us there was a no blame culture when incidents happened and gave examples where the team supported each other at team meetings and during supervision.
- The service had a zero tolerance for bullying and harassment from patients to staff or among staff and this was displayed in the clinic.
- The service celebrated staff's contribution in various ways through achievement awards, vouchers and incentives. The service organised annual Christmas and New Year parties for their staff and patients. We noted that at the last Christmas party which included a five-course meal, 90 patients and staff attended the event and 20 awards were given to clinical and other staff for their achievements such as leadership and customer service.
- The service celebrated staff birthdays by blocking out 30 minutes to celebrate with cake, flowers and finger foods like pizza. Staff spoke highly of this and how they looked forward to this as it made them feel special and valued by their colleagues.

Governance

Governance and performance management arrangements were proactively reviewed and reflected best practice. 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.

- The service gained assurance through various meetings such as the quarterly MAC, bi-monthly clinical governance and department meeting, team lead meeting and monthly business meeting. The medical director attended most of the governance committees, including the MAC meetings which he chaired.
- The monthly team lead and business meeting reported to the bi-monthly clinical governance and department meeting, and which in turn, reported to the medical advisory committee (MAC). This arrangement ensured an oversight on the clinical, staff and business performance.
- The MAC monitored patient outcomes and discussed items such as clinical governance issues, complaints, incidents, policies, infection prevention and control, business compliance, equipment, human resource issues and audits. They also advised the service about the granting, renewal, restriction, suspension and withdrawal of practising privileges.
- The MAC oversaw the renewing and granting of consultants' practising privileges and reviewed each consultant's application before these were granted. The practising privilege process in the hospital included a consultant interview, references, DBS clearance, scope of practice and approval of the MAC chair before privileges were granted.
- The MAC meeting was attended by surgeons, anaesthetists and managers. We noted that the suspension of a surgeon by the General Medical Council (GMC) following a GMC tribunal had been discussed at the MAC meeting and a decision was made to suspend the surgeon's practising privileges in light of the tribunal.
- We reviewed various governance meetings and noted they were well attended by senior managers and MDT staff and covered areas such as incidents, staffing, risk register, BREXIT, PHIN update, medicines and consumable stock, review of guidelines and policies, patient experience and medicines. Incidents, risks, complaints and audits were reviewed and discussed at the team lead, MAC and clinical governance and department meetings.
- Managers were required to carry out appropriate background checks such as an enhanced Disclosure and Barring Service (DBS), professional indemnity insurance, proof of identification, immunisation records and references check for all staff. We reviewed the staff files for six medical staff working under practising privileges and five nursing and support staff. We found that these pre-employment checks had been completed and evidence recorded in the staff files we reviewed.

- The service was visited bi-annually by the GMC to review the medical staff who held practising privileges and the last inspection in 2019 was reported to be satisfactory with no concerns identified.
- The service had 35 service level agreements (SLAs) with third parties which were monitored at the governance meetings and managed jointly by the service and provider. We reviewed the data provided by the service which showed the SLAs were up to date and meetings were held regularly with the third parties to review the services provided.

Managing risks, issues and performance

The service had systems to identify risks, plan to eliminate or reduce them, and cope with both the expected and unexpected.

- The service had The service's risk register included a description of each risk, with mitigating actions and assurances in place. The risk register reflected the risks found during the inspection. An assessment of the likelihood of the risk recurring, possible impact and those responsible for reviewing and monitoring were highlighted on the risk register. There was no evidence to show when these risks had been reviewed and the document updated to reflect any changes. However, minutes of the governance meetings showed that the risk register was reviewed regularly. Following the inspection, the provider submitted an updated risk register which showed the issue had been addressed, and the updated risk register included the last review date.
- We reviewed the service risk register during inspection. The risk register contained 38 risks which were categorised into five themes; safe, effective, caring, responsive and well-led. The risk register included risks such as needle stick injury, poor handover, Brexit, GDPR, medicines, sickness and absence, faulty equipment and staffing. The majority of the risks were rated as green, six were rated as amber and five were rated as red. Some of the risks rated amber and red had been on the risk register for less than two years.
- The service had systems in place for measuring performance and providing information to help staff and the MAC understand the service's performance and how risks were mitigated.

Managing information

The service collected, analysed, managed and used information well to support all its activities, using secure electronic systems with security safeguards.

- The service had clear performance measures such askey performance indicators (KPI), local and national audits which were reported and monitored. These included recording and reporting of data for all patients who underwent certain cosmetic surgeries to the Private Healthcare Information Network (PHIN), the national breast and cosmetic implant register and quality patient reported outcome measures (Q-PROMS). This was in line with the Royal College of Surgeons (RCS) standards.
- Data regarding patient outcomes and experience was routinely collected and monitored. The results from patient questionnaires were reviewed and used to improve service provision, where indicated.
- Staff had access to up-to-date, accurate information on patients' care and treatment. The patient's records were currently paper however the service was working towards all aspects of patient records being electronic by July 2021. Studies have shown that the change from paper to electronic records can improve patient safety and risk management, reduce errors and support better outcomes.
- The service had system in place to ensure data submitted to PHIN are coded in accordance with the surgical specialty associations to refine clinical terminology (SNOMED CT). We saw that the service was making plans to ensure surgical procedures will be coded in SNOMED CT. This will ensure an agreed, clinically relevant set of terminology, will be available within the new electronic health record systems to describe cosmetic surgical procedures to support improved communication and audit.
- Staff had received training on General Data Protection Regulations (GDPR) and information governance and were supported by the business manager, who was the Caldicott guardian. During the inspection we observed staff treated patient identifiable information in line with GDPR.
- Patient records were stored securely in a locked cupboard.

Engagement

Good

Surgery

The service engaged with patients and staff to plan, manage and improve services.

- Patient's views and experiences were gathered and used to shape and improve services. Patient feedback was sought from the initial consultation to the follow-up appointment after their surgical procedure. Patients could also post reviews of the service on a social media platform and search engine. We saw evidence that patient feedback was used to inform changes and improve service provision. For example, following patient feedback the service had re-furnished the reception area.
- Patient feedback was gathered in several ways including the patient survey, patient reported experience measures (PREMS), Q-PROMS and complaints. From April to September 2019, the patient survey audit showed that patients were positive about their outcomes and the service had achieved 92.4% compliance against the 12 outcomes audited. This was better than their 80% target. Feedback and concerns were discussed at governance meetings and used to drive conversations around improvements in service delivery and patient experience.
- The managers were based in the clinic which ensured their visibility and provided patients and staff with the opportunity to express their views and opinions.
- The service engaged with patients and staff through various means such as the annual Christmas event, the agenda included activities, awards and testimonial. The service also engaged with staff through emails, regular staff meetings and informal meetings. The staff meetings were planned in advance, on set days to facilitate staff being able to attend these meetings. Staff were also able to give feedback about the service or share their ideas or innovation to the managers privately or during their staff or monthly business meetings.
- Managers made sure staff attended team meetings or had access to full notes when they could not attend.
- The service carried out a staff training satisfaction survey on the 5 June 2019 which showed positive feedback and experience on the quality of the mandatory training received.

Learning, continuous improvement and innovation

There was a culture that focused on, continuous learning, innovation and improvement in the service to improve patient outcomes. Staff and management were committed to improving services by learning from when things went well and making changes in practice through shared learning, external reviews, promoting training and innovation.

- The hospital had short and long-term plans to improve services through the introduction of an electronic record system and expansion of the service by opening a new cosmetic surgery clinic in the UK.
- The service acted on patient feedback to improve patient's experience. For example, they had improved and streamlined the processes from the initial consultation and pre-assessment to the surgery to improve patient outcome and experience.
- The service had a theme of the month for staff based on patients' feedback with the aim to improve their practice and patients' outcomes. We noted the recent themes in the last 12 months had included topics such as communication, quality, leadership, conscientiousness, quality and safety. The theme of the month was displayed in the clinical areas for the staff, patients and visitors to see.
- The service had made improvements and taken note of the concerns raised at the previous inspection relating to staff compliance on the use of personal protective equipment (PPE) through staff training and monitoring of compliance through audits.

Outstanding practice and areas for improvement

Outstanding practice

- Leaders had an inspiring shared purpose, striving to deliver and motivate staff to succeed.

Areas for improvement

Action the provider SHOULD take to improve

- Include review dates on the risk register.
- Take prompt action to address the concerns identified during the inspection in relation to staff's understanding of professional guidance that influenced their practice.
- The service should ensure appropriate checks were in place to ensure medicines and medical consumable items were in date.