

CC Kat Aesthetics

Quality Report

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

Ratings

Overall rating for this location

Requires improvement



Are services safe?

Requires improvement



Are services effective?

Requires improvement



Are services caring?

Good



Are services responsive?

Good



Are services well-led?

Requires improvement



Summary of findings

Letter from the Chief Inspector of Hospitals

CC Kat Aesthetics is operated by CC Kat Aesthetics Ltd. Facilities include a theatre room, a recovery room with three beds, a treatment room and six consultation room. The service has no overnight beds.

The service provides cosmetic surgery, the focus at this location is consultations and minor surgery. Any major surgery that is required is performed at one of two local hospitals.

We inspected this service using our comprehensive inspection methodology. We carried out an unannounced inspection on 28 June 2019. Following the first inspection we raised some concerns with the provider. We also conducted an announced inspection of the service on 30 July 2019 so that we could observe surgery taking place and review the improvements that had been made. Following the second inspection we also raised some concerns with the provider which they submitted information on how they had reduced these risks.

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

We rated it as **Requires improvement** overall.

We found areas of requires improvement in relation to this service:

- At the time of our first inspection the service used a table top steriliser, according to government legislation this was not suitable for surgical procedures. We raised this with the service and they put appropriate measures in place to safely sterilise equipment.
- The service did not have effective checks of equipment in place at the time of our inspection.
- Staff had a lack of understanding about specific risks to patients such as venous thromboembolisms and sepsis. During the first inspection we found that patients were not being monitored appropriately for at risk of deterioration following surgery.
- During the inspection we found that the service did not have appropriate medicines in place to manage potential complications arising from the procedures. There were no guidelines on when to prescribe antibiotics. However, following the inspection we raised these areas of concern with the provider and they addressed all these issues.
- At the time of our inspection staff did not monitor the effectiveness of care and treatment.
- Leaders did not have all the skills and abilities to run the service.
- The service did not operate effective governance processes.
- Leaders and teams did not identify and escalate relevant risks and issues.
- The service did not collect data to improve the service.
- No staff survey was in place at the time of our inspection and the patient feedback forms were identified as an area for improvement.

However, we also found areas of good practice in relation to the service:

Summary of findings

- The service controlled infection risk well. The service managed safety incidents well and learned lessons from them.
- Staff provided good care and treatment, gave patients enough to eat and drink, and gave them pain relief when they needed it. The service had made improvements to ensure staff were competent for their roles. worked well together for the benefit of patients, advised them on how to lead healthier lives, supported them to make decisions about their care, and had access to good information.
- Staff treated patients with compassion and kindness, respected their privacy and dignity, took account of their individual needs, and helped them understand their conditions. They provided emotional support to patients, families and carers.
- The service planned care to meet the needs of local people, took account of patients' individual needs, and made it easy for people to give feedback. People could access the service when they needed it and did not have to wait too long for treatment.
- Leaders supported staff to develop their skills. Staff understood the service's vision and values, and how to apply them in their work. Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. Staff were clear about their roles and accountabilities.

Following this inspection, we told the provider that it must take some actions to comply with the regulations and that it should make other improvements, even though a regulation had not been breached, to help the service improve. We also issued the provider with one requirement notice that affected the service. Details are at the end of the report

Heidi Smoult

Deputy Chief Inspector of Hospitals Midlands Area

Summary of findings

Our judgements about each of the main services

Service

Rating

Summary of each main service

Surgery

Requires improvement



Surgery was the main activity of the hospital. We rated this service as requires improvement overall because the service required improvement in the areas of safe, effective and well led.

Summary of findings

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Requires improvement 

CC Kat Aesthetics

Services we looked at

Surgery

Summary of this inspection

Background to CC Kat Aesthetics

CC Kat Aesthetics is operated by CC Kat Aesthetics Ltd . This location opened in February 2019 and was previously operational at another location in Birmingham since 2008. The hospital primarily serves the communities of the Birmingham area. It also accepts patient referrals from outside this area.

The location had a registered manager in post since 2010.

The service was a small single speciality service that consisted of a small team of staff that worked across both surgery and outpatient services. The clinic offers on-site services ranging from skincare consultation, skin

treatments, injectable aesthetic treatments, laser treatments to a full range of aesthetic surgeries under local anaesthesia. Assessment for cosmetic surgeries are also conducted at the clinic with the surgeries (requiring general anaesthesia) carried out at two private hospitals around the Midlands.

The hospital also offers cosmetic procedures such as injectable aesthetic treatments and laser hair removal. We did not inspect these services as they are activities which are not regulated by the Care Quality Commission.

Our inspection team

The team that inspected the service on the first inspection comprised two CQC inspectors and a

specialist advisor with expertise in theatres. For the second inspection the team comprised of a CQC lead inspector and a CQC clinical fellow. The inspection team was overseen by Bridgette Hill, Inspection Manager.

Information about CC Kat Aesthetics

CC Kat Aesthetics provides cosmetic plastic surgery to people aged 18 years and over. No overnight beds are provided at the clinic.

It is registered to provide surgical procedures and treatment of disease, disorder and injury. The manager is registered with us to provide these services. The clinic has had a registered manager in post since 2010.

We have inspected this location three times since 2013. We made five compliance actions/requirement notices at the time of our last inspection in August 2017.

CC Kat Aesthetics is operated by CC Kat Aesthetics Ltd.

The main service is cosmetic surgery. The service had completed 122 surgeries from March 2018 to February 2019.

The clinic is set in a recently refurbished building and has two floors. It has a small car park to the rear of the property. The clinic has one theatre and five consulting/ treatment

rooms and is registered to provide the following regulated activities:

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

There were no special reviews or investigations of the clinic ongoing by the CQC at any time during the 12 months before this inspection.

Track record on safety:

- No never events.
- No clinical incidents .
- No serious injuries.
- Four complaints.
- No infections.

No services accredited by a national body.

Summary of this inspection

No services provided at the clinic under service level agreement.

Surgery

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

Are surgery services safe?

Requires improvement 

We rated it as **requires improvement**.

By safe, we mean people are protected from abuse* and avoidable harm.

*Abuse can be physical, sexual, mental or psychological, financial, neglect, institutional or discriminatory abuse.

Mandatory training

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

Staff kept up to date with their mandatory training. During our previous inspection of this service in August 2017 we found that there was no evidence to show that staff were trained and qualified to an acceptable level to keep people safe. There was no mandatory training programme in place and the provider did not keep mandatory training records. At the time of our first inspection to the service the service had an up to date mandatory training matrix. Clinical staff working at the service at the time of our first inspection visit had completed 78% of available mandatory training courses.

Five of the staff working with the patients had undergone sepsis training following our first inspection.

The mandatory training available to staff was comprehensive and met the needs of patients and staff. Training included; consent, conflict resolution, equality and

diversity, fire safety, health, safety and welfare, infection, prevention and control, information governance, moving and handling, safeguarding adults and children, prevent and GDPR.

Managers monitored mandatory training and alerted staff when they needed to update their training. At the time of our first inspection staff working directly with patients, 78% of mandatory courses had been completed.

Safeguarding

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

Staff received training specific for their role on how to recognise and report abuse. Six out of the seven clinical staff members working directly with patients had up to date level 1 safeguarding adults training. Five out of the seven clinical staff members had up to date level 1 safeguarding children's training. Five staff members had up to date safeguarding children's level 2 training, six out of the seven clinical members of staff had completed up to date Prevent training and one member of staff had completed up to date safeguarding adults level 3 training. Prevent training aims to help stop vulnerable people from being exploited and drawn into terrorism.

In accordance with the safeguarding children and young people: roles and competences for health care staff, intercollegiate document (March 2014). All non-clinical and clinical staff who have any contact with children, young people and/or parents/carers. Should be trained to level 2, the provider did not comply with this requirement.

Surgery

Staff showed an understanding of how to identify and report abuse. Staff were aware of areas of concern around safeguarding and could identify patients who they would flag as at risk.

Staff knew how to make a safeguarding referral and who to inform if they had concerns. Staff could tell us how they would make a safeguarding referral and who they would contact to raise a safeguarding.

Cleanliness, infection control and hygiene

The service controlled infection risk well. The service used systems to identify and prevent surgical site infections. They kept equipment and the premises visibly clean. At the time of our first inspection the service used a table top steriliser, according to government legislation this was not suitable for surgical procedures. We raised this with the service and they put appropriate measures in place to safely sterilise equipment.

All areas were visibly clean and had suitable furnishings which were clean and well-maintained. The service had a contract with an external cleaning company who came in to clean the premises.

During the first inspection to the service we found that clinical staff were responsible for cleaning equipment used in the surgical procedures and used a table top sterilising unit. However, legislation (Health Technical Memorandum (HTM) 01-01: Management and decontamination of surgical instruments (medical devices) used in acute care) states that the service should not be using a benchtop steriliser for surgical equipment. Following the inspection, we raised this as an area of concern with the provider and they responded by taking this steriliser out of use. At the time of our second inspection the service used single use instruments or instruments that had been sterilised by a local independent hospital.

Staff used records to identify how well the service prevented infections. The service conducted an infection prevention and control inspection checklist. The surgical equipment was all marked with when it had been sterilised and these stickers were used for the tracking of equipment and was used in patient notes.

At the time of our first inspection the service did not complete any hand hygiene audits. Following our second inspection the provider put plans in place to conduct hand hygiene audits every three months.

Staff followed infection control principles including the use of personal protective equipment (PPE). The service had a hand washing policy and an infection control policy. During the inspection we observed staff hand washing and scrubbing up in theatre. We also observed staff using appropriate PPE for the procedures.

Staff cleaned equipment after patient contact and labelled equipment to show when it was last cleaned. Staff told us the theatre was cleaned between cases, which we observed during the inspection, three times a week by an external company and there was a deep clean every six weeks. There was a theatre cleaning checklist that went into the patient records after their operation, in the notes we reviewed this was present and complete. In the dirty utility there was a file with cleaning checklists completed at the end of the day that were ticked and signed by staff.

Curtains in recovery were disposable and had the date marked when they were last changed. This was in line with best practice guidance.

Staff worked effectively to prevent, identify and treat surgical site infections. In the year before our inspection this service did not report any surgical site infections. The service submitted data to the BAAPS (British Association of Aesthetic Plastic Surgeons) Annual Audit of Surgical Complications. This is mandatory annual audit covering surgical procedures in both hospitals and the clinic.

Environment and equipment

The service did not have effective checks of equipment in place at the time of our inspection. However, the design and use of facilities and premises kept people safe. Staff managed clinical waste well.

The design of the environment mostly followed national guidance. The environment was not suitable for those with limited mobility. However, if the service received a referral for a patient with limited mobility then the surgeon would see the patient at another local hospital in the area. The new location offered a suitable waiting area for patients.

Staff carried out daily safety checks of specialist equipment. During the previous inspection of this provider we told them they should ensure equipment maintenance

Surgery

and servicing systems were more robust and update the available documentation. During this inspection we found the service did not have a log of when equipment was due/ had been serviced and instead relied on the equipment servicing companies to book the services. Following our first visit, we raised this as an area of concern and the service developed a log to enable them to see when equipment was due to be serviced. The service also had agreements with external companies to fix the machines if there were any concerns.

During the inspection we found some equipment was out of date such as oxygen masks and tubing which expired 2017 and a giving set which expired in 2015. Following the inspection, the provider put in place a monthly check of all the consumables.

During the inspection we looked at the checks of the resuscitation equipment, this was completed for April/May/ June of this year. However, there was no documentation of a check of the automated external defibrillator (AED). We also found that the Adrenaline 1:1000 had been ticked as checked even though the service had adrenaline 1:10 000.

The service had suitable facilities to meet the needs of patients' families. The service had a large waiting area and provided hot and cold drinks for visitors.

There were patient lockers available for the storage of their belongings while they were in theatre.

The service had enough suitable equipment to help them to safely care for patients.

Staff disposed of clinical waste safely. Clinical waste was stored safely whilst it was waiting to be collected. The service had a contract with an external company for the removal of clinical waste.

Assessing and responding to patient risk

Staff had a lack of understanding about specific risks to patients such as venous thromboembolisms and sepsis. The provider introduced systems to monitor patients following our first inspection.

At the time of our first inspection staff were not appropriately monitoring patients following surgery. This was raised with the service and at the second inspection staff were using a nationally recognised tool to identify deteriorating patients and escalate them appropriately. At our last inspection of the service in August 2017 we found

that the risks associated with anticipated events and emergency situations were not fully recognised, assessed or managed. We also found that the approach to assessing and managing day to day risks to patients were not fit for purpose. During our first inspection to the service we found that patients were not having physiological observations recorded post-surgery. This put them at risk of something going wrong and it not being recognised or addressed by staff. Following the inspection, we raised this as an area of concern and the provider then put in place an additional nurse to monitor patients in the recovery room post-surgery and a policy to support what should be checked and when it should be escalated. During the second inspection we found that staff were monitoring patients before, during and after their procedures and recording this in patient notes.

Staff used a nationally recognised tool to identify deteriorating patients and escalated them appropriately. Staff completed national early warning scores (NEWS) for patients who were undergoing surgery. This was to monitor the patients for any deterioration. All of the records we looked at contained NEWS recorded correctly.

The service would only operate on patients who were low risk at the clinic and anyone who was a medium/high risk would be seen at another local private hospital where the risk could be managed more safely.

Between the first and second inspections the service had secured a contract with a local company of anaesthetic doctors who could give telephone advice or who could visit the clinic to provide advice and expertise if a patient had deteriorated.

Staff had a lack of understanding about specific risks to patients such as venous thromboembolisms and sepsis. During the first inspection we found that staff did not perform any venous thromboembolism (VTE) assessments on patients. Following the initial inspection, we raised this as an area of concern with the provider and they responded to assure us that only patients assessed at low risk of VTE or bleeding would be deemed suitable for surgery at the clinic. Any patients at moderate or high risk would have their surgery carried out at other hospitals. On the follow up inspection we saw patients were being assessed for their VTE risk and information leaflets were being given out to patients following their surgery to inform them of what to look out for and what to do if they had any concerns.

Surgery

At the time of our first inspection staff had not received training in sepsis. However, before the second inspection, all clinical staff had completed an online course on sepsis. When we spoke to staff during the inspection they were not confident in how they would identify and carry out the initial sepsis assessments of patients. However, they said that they would escalate to the doctor of the day who would manage the patient.

Staff shared key information to keep patients safe when handing over their care to others. Patients had to give consent for the service to contact their GP. However, during the inspection, we observed staff giving patients information letters on what they had done which they could take to their GP if they wished.

Staffing

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

At the time of our first inspection the service did not have enough nursing staff to keep patients safe. The service only had two nurses employed who assisted the surgeon in theatre, this left patients in recovery post-surgery with an unqualified and untrained member of staff. Following the inspection, we raised this as a concern with the provider and they employed another nurse whose role it was to monitor patients in recovery.

Managers accurately calculated and reviewed the number and grade of nurses, nursing assistants and healthcare assistants needed for each shift.

The number of nurses all shifts on each ward matched the planned numbers. If any members of the team were off sick, then the manager told us they would use agency staffing to cover the gaps.

The service did not have any vacancies at the time of our inspection. The service had recently recruited an extra nurse who was due to start in August 2019 and recruited an extra nurse to cover recovery after we raised our concerns.

The service had low turnover rates. There had been one staff member leave in the year prior to our inspection.

The service had a low sickness rate. From March 2018 to March 2019 there was a 5% sickness rate across all staff working for the service.

At the time of our inspection the service had not used any agency staff and did not have any bank staff.

Following our first inspection, the service acquired a contract to have locum medical staff in the event of staff leave or sickness.

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.

Patient notes were comprehensive, and all staff could access them easily. In theatre there was a surgical log book. During the inspection we reviewed the records which were completed for each case and contained information on the date, patient name and number, procedure, start/end time, specimens taken, swab/instrument check, this was signed by a runner and scrub nurse.

Patients had information packs to take with them when they went home with leaflets on emergency contacts, signs/symptoms of VTE and sepsis information leaflet.

Records were stored securely. All patient records were scanned onto the computer system and then securely destroyed.

Medicines

During the inspection we found the service did not have appropriate medicines in place to manage potential complications arising from the procedures. There were no guidelines on when to prescribe antibiotics. However, following the inspection we raised these areas of concern with the provider and they addressed all the issues.

The service did not have appropriate medicines in place to manage complications arising from the procedures.

At the time of our inspection the service did not have any medications to manage toxicity of local anaesthetics. However, we raised this as an area of concern and the service put measures and medications in place.

Surgery

The service had 1: 10 000 adrenaline in place in case of an anaphylaxis shock. However, both the UK resus council and the algorithm started that for anaphylaxis 1:1000 adrenaline should be used, not 1:10 000 as was stocked. Their policy from the external company stated that an oral antihistamine was also a 'must' to have in stock although they did not have this.

Staff followed systems and processes when safely prescribing, administering, recording and storing medicines. Patients received a prescription the week before surgery which they were responsible for getting. Patients had instructions on when to take the medications as some of the medications needed to be taken the night before and some on the morning of the surgery. During the inspection we observed staff asking patients if they had taken their medications the night before and documenting when medications were taken before the surgery,

All records we looked at contained documentation of the amount of local anaesthetic that was given during surgery. Staff reported that if they gave additional medications e.g. ibuprofen in recovery this would be documented in a section for 'additional info' as there was not a specific prescription chart in use in the notes.

At the time of our inspection the service did not have any policy's or guidelines on when to prescribe antibiotics. We raised this as an area of concern and following the inspection the service put in place a guideline for the safe prescribing and use of antibiotics.

In the recovery room the medication cupboard was not locked, this could mean that medicines could be accessed by staff/people that should not have access to them. We raised this as an area of concern and during our second inspection we found the cupboard was locked and the key was held by a registered nurse.

Staff followed current national practice to check patients had the correct medicines.

The service had systems to ensure staff knew about safety alerts and incidents, so patients received their medicines safely. Patient allergies were clearly documented in patients records in all seven the records we looked at.

Incidents

The service managed patient safety incidents well. Staff recognised incidents and near misses and reported them appropriately. Managers investigated

incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support. Managers ensured that actions from patient safety alerts were implemented and monitored.

All staff knew what incidents to report and how to report them. The service had commenced their significant event/ adverse incident process in February 2019. Up to the point of our inspection there had been two incidents. One incident was around a reminder message being sent to the wrong patient and another was that a patient did not have their prescription sent.

Staff reported all incidents that they should report. The service kept a spreadsheet of records of complications all staff had access to this to add cases if required. There were no complications recorded for patients operated on at this clinic for 2018/2019.

The service had no never events prior to our inspection.

The service had not reported any serious incidents prior to our inspection. The service had also not had any clinical incidents.

Staff understood the duty of candour. They were open and transparent and gave patients and families a full explanation if and when things went wrong. The service had a duty of candour policy in place at the time of our inspection. Staff were aware of their need to be open and transparent with patients.

Staff received feedback from investigation of incidents, both internal and external to the service. We saw that incidents were discussed as part of the service's organisational meetings which were attended by all staff.

Staff met to discuss the feedback and look at improvements to patient care. Incidents were discussed during the practice governance meetings which occurred every quarter.

Managers investigated incidents thoroughly. Patients and their families were involved in these investigations.

Surgery

Are surgery services effective?

Requires improvement 

We rated it as **requires improvement**.

Evidence-based care and treatment

The service provided care and treatment based on national guidance and best practice. Managers checked to make sure staff followed guidance.

Staff followed up to date policies to plan and deliver high quality care according to best practice and national guidance.

The service had a minor operating theatre policy. This stated which patients could be seen at the clinic, pre-operative preparation, peri operative monitoring, anaesthesia guidance and discharge information.

The surgeon performed lock and glue procedures, this method reduces the risk of infection and meant that patients do not require a drain.

Staff routinely conducted psychological screening on patients, this is in line with best practice guidance to highlight patient expectations and motivations as well as identifying those who may require psychological support.

During our last inspection of the service in August 2017 we found that there was no safety procedure or instrument and swab count during surgical procedures. During this inspection we found that the service used the World Health Organisation (WHO) checklist during theatre. We observed that all staff were present during this and were actively involved in the process. We observed swab, sharp and instrument counts performed throughout procedure. Swabs were counted, crossed off the board and bagged during the procedure.

Nutrition and hydration

Staff gave patients enough food and drink to meet their needs and improve their health.

Staff made sure patients had enough to eat and drink. Especially those with specialist nutrition and hydration needs. The service had access to hot and cold drinks and snacks if required.

Pain relief

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

Patients received pain relief soon after requesting it. During the inspection we observed staff asking patients if they were in any pain and if they required anymore pain relief.

Staff prescribed, administered and recorded all pain relief accurately. Staff reported if a patient had additional pain during procedures they would be given more local anaesthetic and if the patient had pain in recovery they could be given ibuprofen.

Patient outcomes

Staff did not monitor the effectiveness of care and treatment.

During the previous inspection in August 2017 we found there was very limited monitoring of peoples outcomes of care and treatment. The provider was not developing a readiness to collect Patient Reported Outcomes Measures that the Royal College of Surgery (RCS) had deemed particularly important in cosmetic surgery, despite the clinic undertaking procedures that would apply. During this inspection we found there to be a lack of outcome monitoring for patients following their procedures. We raised this following our inspection and the service put in place the Royal College of Surgeons PROMS questionnaire. The service planned to carry out audits of these questionnaires beginning in October 2019.

The service did not participate in any clinical audits. During the previous inspection in August 2017 we found that there were no local audit programme, national benchmarking or participation in peer review or national audit programme. This continued to be the case at this inspection. Following the inspection, we raised this as an area of concern and the service put in place several audits. These included; surgical site infection audits, and completion of medical records audit.

There were no unplanned transfers of care from March 2018 to March 2019.

Competent staff

Surgery

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

Qualified staff were experienced, qualified and had the right skills and knowledge to meet the needs of patients. The nurse and the surgeon had worked together for a number of years and they told us this improved the efficiency of the service they provided. However, at the time of our first inspection the service did not have competent staff working in the recovery room. This placed patients at risk as they were not trained on how to monitor patients' for signs of deterioration. Following the inspection, we raised this as an area of concern with the manager and an extra nurse was employed to work in the recovery room to monitor patients.

At the time of our inspection three members of staff had been trained in intermediate life support. The service had booked a further six members of staff onto an intermediate life support course in September 2019.

Managers gave all new staff a full induction tailored to their role before they started work. The service had an induction checklist for new staff to the service. During the inspection we found that staff had completed this at the beginning of them working for the service.

Managers supported staff to develop through yearly, constructive appraisals of their work. Staff reported that they had recently undergone their appraisals, we saw this reflected in staff files we looked at.

Managers identified any training needs their staff had and gave them the time and opportunity to develop their skills and knowledge. Staff were given time away from the service to attend additional training and conferences.

Staff had the opportunity to discuss training needs with their line manager and were supported to develop their skills and knowledge. Staff reported that they had access to additional training and conferences when they required them. Managers made sure staff received any specialist training for their role.

Multidisciplinary working

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

Staff held regular multidisciplinary meetings to discuss patients and improve their care. The service held a morning huddle every morning to discuss all cases that day with all members of staff. They also had a theatre huddle with the members of staff involved with the care of patients pre/during/post-surgery. During the inspection we observed the theatre huddle and found it to be comprehensive for the day's surgeries planned. We also looked at the historic records of previous huddles and found them to be of a similarly high standard.

Seven-day services

The service ran Monday to Friday, out of hours patients had access to a phoneline to qualified staff if they had any concerns.

Patients were given a phone number to call out of hours or when the clinic was not open that they could access the surgeon or another qualified member of staff at another local private hospital if they had any concerns.

Health promotion

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

The service had relevant information promoting healthy lifestyles. Most patients who were visiting the service for surgery also visited another doctor onsite. This doctor discussed healthy lifestyles and other ways patients could maximise the results. During consultations we observed staff asking patients about smoking. Staff also told us that if patients had a high or low BMI then they were refused surgeries due to the risk.

During the inspection one patient came in whose blood pressure was high and they were deemed unsuitable for surgery that day. The patient was followed up by the surgeon and advised how they should proceed by visiting their GP.

Psychological wellbeing scores were calculated prior to agreeing to go ahead for surgery.

Surgery

Staff assessed each patient's health when admitted and provided support for any individual needs to live a healthier lifestyle. During one consultation we observed staff discussing exercise as an alternative to the surgery.

Consent and the Mental Capacity Act

Staff supported patients to make informed decisions about their care and treatment. They followed national guidance to gain patients' consent. Staff completed training on consent and the Mental Capacity Act.

Staff understood how and when to assess whether a patient had the capacity to make decisions about their care. This was assessed by the surgeon before consenting any patients for their procedures.

Staff gained consent from patients for their care and treatment in line with legislation and guidance. Consent for the treatment was gained from patients at their second appointment. On the day of the surgery patients were required to consent for the second time to ensure they wished to go ahead on the day. This was done in the recovery area, so patients consented to the procedure on their own.

The consent forms were appropriate and thorough. From the documentation we looked at patients were suitably informed prior to any surgery about the proposed surgery, benefits and risks. There was evidence that leaflets had been provided to patients.

All patient records we looked at had the two weeks 'cool of time' prior to surgery. This is in accordance with the General Medical Councils guidelines which state that patients should have a mandatory cooling-off period between the initial consultation and committing to the procedure.

Staff made sure patients consented to treatment based on all the information available. During the inspection we observed staff giving patients lots of information on their proposed procedures and giving patients time to ask questions and to think about their decisions.

Staff clearly recorded consent in the patients' records. In seven out of the seven records we looked at consent had been clearly documented.

Staff had completed training on the Mental Capacity Act 2005 and consent. Five out of the six clinical staff had completed this training at the time of our first inspection.

Are surgery services caring?

Good 

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.

Staff were discreet and responsive when caring for patients. Staff took time to interact with patients and those close to them in a respectful and considerate way. One patient told us they were talked to throughout the surgery and that it had helped with their nervousness.

Patients said staff treated them well and with kindness. One patient told us they were 'over the moon' with how the whole team had treated them.

Staff followed policy to keep patient care and treatment confidential. Staff closed curtains to protect patient's modesty during consultations.

Staff understood and respected the personal, cultural, social and religious needs of patients and how they may relate to care needs. Staff were focussed on the patient as an individual and took steps to ensure they were supported throughout the service.

Emotional support

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

Staff gave patients and those close to them help, emotional support and advice when they needed it. The service had access to a psychologist who they could refer patients to if required. During the inspection we observed staff supporting patients throughout their journey in the service and offering them support when needed.

Staff understood the emotional and social impact that a person's care, treatment or condition had on their

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wellbeing and on those close to them. In theatre there was a TV on the ceiling which patients could watch whilst they were undergoing procedures to distract themselves if required. Before one procedure we observed staff asking the patient if they would like the TV on or would like their eyes to be covered. There was also the option for music to be put on during the operation.

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 and those close to them understood their care and treatment. Staff told us they are very honest when discussing surgery and that the surgeon did not offer patients inappropriate surgery. One patient had written on a comment card that staff were, “friendly and informative, exactly what I needed to understand my options.”

We observed a phone call in which a potential patient had called to discuss the options available, they were guided through the options in a kind and easy to understand way. The potential patient was also advised of national organisations and the surgeon’s registration that they could look at before deciding to go ahead with the surgery.

Staff talked with patients, families and carers in a way they could understand, using communication aids where necessary. One patient told us they felt that the staff were in it for them and that they knew their end goal.

In theatre we observed good communication with the patient throughout the procedure by the surgeon and nursing staff. We saw the procedure was explained, reassurance given, and the patient asked about pain and observed steps were taken to minimise pain.

Patients and their families could give feedback on the service and their treatment and staff supported them to do this. Comment cards were available for patients in the reception area. There had been seven comment cards completed from February 2019 to June 2019. All rated the facilities, treatment and customer service as good or excellent.

Staff supported patients to make advanced decisions about their care. During the inspection we observed good communication with the patient throughout procedure by surgeon and nursing staff and that they fully explained the procedure.

Staff supported patients to make informed decisions about their care. During consultation for breast implants patients were shown and sent 3D images of what they may look like with the different sized implants, so they could make an informed decision on their care. One patient told us they had been informed of the complications of the surgery prior to consenting.

Are surgery services responsive?

Good 

We rated it as **good**.

Service delivery to meet the needs of local people

The service planned and provided care in a way that met the needs of local people and the communities served. It also worked with others in the wider system and local organisations to plan care.

Managers planned and organised services so they met the needs of the local population. Clinic opening times could be flexed to accommodate patients and staff worked one Saturday each month to see patients. Patients who required surgery that was outside the scope of what could be offered at this location were given appointments with the surgeon at local private hospitals where there was more support in case of any complications arising.

Facilities and premises were appropriate for the services being delivered. The service had moved location in February 2019. This building had undergone a renovation and was designed for the services offered.

The service had systems to help care for patients in need of additional support or specialist intervention. In the event of a patient deteriorating the service would dial 999 and the patient would be sent to an acute hospital. The service only conducted surgery on low risk patients and if anyone was assessed as high risk then the surgery would be completed in a local private hospital with more facilities to manage the risks.

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Managers monitored and took action to minimise missed appointments. Patients were sent a reminder letter to remind them of their appointment and to give them the opportunity to rearrange to a more suitable time if required.

Managers ensured that patients who did not attend appointments were contacted.

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.

Staff fully discussed with patients the treatment options available. Staff made sure patients understood all the options and the possible complications associated with them.

Consultations we observed were not rushed and all options were fully explored with patients. If patients wanted to discuss more than one surgery area then they would be booked in for a double appointment to give staff enough time to fully discuss the treatment.

The service had an agreement with a local NHS acute hospital to send samples removed from patients for histological examination and reporting. This was done based on clinical assessments and patients' requests.

Staff told us they turned away approximately 5% of patients as they were not suitable for surgery and that this was often due to high BMI (>30) and unrealistic patient expectations.

Staff understood and applied the policy on meeting the information and communication needs of patients with a disability or sensory loss. Staff told us if patients required additional support then they would seek it out for patients to enable them to access the service.

Managers made sure staff, and patients, loved ones and carers could get help from interpreters or signers when needed. The service had access to a language line if patients required an interpreter and staff told us they would also book a sign language interpreter if required.

Access and flow

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 national standards.

Managers monitored waiting times and made sure patients could access services when needed and received treatment within agreed timeframes and national targets. For cosmetic surgery there is a mandatory cooling off period of two weeks from appointment for patients to think about their decision to undergo the surgery. The service abided by the rules and booked patients in for a second consultation after two weeks had passed to book the patient in for the surgery if they still wished to go ahead. The service did not currently have a waiting list.

One patient told us that they were able to access appointments at a time to suit them.

Managers and staff worked to make sure patients did not stay longer than they needed to. Following surgery patients were monitored in the recovery area and when they were ready to go home they were discharged.

In the year prior to our inspection the service had 21 patients who did not attend their appointments.

Managers worked to keep the number of cancelled appointments and operations to a minimum. In the year prior to our inspection the service had not cancelled any operations.

Staff supported patients when they were referred or transferred between services. There was a tick box in the patient records for if they consented to the GP being informed.

Managers monitored patient transfers and followed national standards. In the year before our inspection the service had not had to transfer any patients to other hospitals during/following the procedures.

Learning from complaints and concerns

There was a process for people to give feedback and raise concerns about care received. The service treated concerns and complaints seriously, investigated them and shared lessons learned with all staff.

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Patients, relatives and carers knew how to complain or raise concerns. The service had had received four complaints from June 2018 to June 2019. We looked at the four complaints raised and did not see any themes.

The service did not clearly display information about how to raise a concern in patient areas. Staff told us that if a patient wished to complain then staff would print off the relevant information.

Staff understood the policy on complaints and knew how to handle them. Staff told us that all complaints were acknowledged within three working days and a response sent within 30 days. When we looked at complaint records we found this to be the case.

Managers investigated complaints and identified themes. The service had a contract with a private independent complaints advocacy service for which they would refer any patients who weren't happy with the complaint response given for an independent review. One of the complaints we reviewed was referred for an independent review.

Staff knew how to acknowledge complaints and patients received feedback from managers after the investigation into their complaint. All four of the complaints we looked at fed back to the patient after the investigation had been completed.

In one complaint we looked at there was evidence that the service had offered to meet with the patient and their family to discuss the concerns raised.

Managers shared feedback from complaints with staff and learning was used to improve the service.

could raise any ideas of concerns with them. The service also had a clear management structure with individuals taking on different lead roles such as safeguarding. However, there was a lack of knowledge around the safety and assurance systems in place to deliver a fully safe and effective service. During the inspection, we found a lack of risk management and monitoring of the effectiveness of the service.

Vision and strategy

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

During the previous inspection in August 2017 we found that there did not appear to be a set of values or strategy in place. The service had developed a vision to provide patients with a comprehensive range of treatments in aesthetic medicine and surgery and related specialties. Staff were aware of this vision.

The service had developed values which were to be a high performing practice and treat all patients with dignity and respect. They felt team work played a big part in the practice as they learnt from each other.

Culture

Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. The service promoted equality and diversity in daily work.

During the inspection staff told us they felt supported, respected and valued by the leaders in the service. The culture of the service was very centred on the needs and experiences of people who used the service. Staff working in the service felt proud to work for the provider and were all positive about their job.

The culture encouraged openness and honesty at all levels within the organisation, including with people who use services, in response to incidents. Staff were all aware of duty of candour and what they would do if there was an incident. Staff all told us they would feel comfortable raising any concerns they had about the service.

Are surgery services well-led?

Requires improvement 

We rated it as **requires improvement**

Leadership

Leaders lacked some skills and abilities to run the service. They were visible and approachable in the service for patients and staff. They supported staff to develop their skills and take on more senior roles.

Leaders had some skills to manage the service. Staff reported that the leaders were approachable and that they

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Equality and diversity were promoted within the organisation. Patients from a variety of backgrounds and countries were treated in the service. The service had an agreement with a local hospital for any patients who could not access the service due to the environment or their risk levels to be seen at local private hospitals.

Governance

The service did not operate effective governance processes. However, staff at all levels were clear about their roles and accountabilities.

During the previous inspection of this service in August 2017 we found that governance and assurance systems and processes were not robust or were completely absent from the service. During this inspection we found that the service did not have robust assurance systems around audit, monitoring of equipment, outcome measures or around risks to the service. Following the inspection, the service put in place a number of audits and began monitoring outcome measures. However due to the infancy of the systems we were unable to assess their effectiveness.

The service had clear lines of accountability and staff were aware of their roles within the service.

Leaders met with staff on a regular basis and shared learning with staff.

Managers made sure all staff attended team meetings or had access to full notes when they could not attend. Team meetings occurred quarterly at this service. We saw minutes from previous meetings which discussed complaints and surgical complications as well as other business matters. Staff also had a morning huddle in which any updates or information for staff to be aware of were discussed.

Management of risk, issues and performance

Leaders and teams did not identify and escalate relevant risks and issues.

During our previous inspection of this service in August 2017 we found that there was no effective system for identifying, capturing and managing issues and risks at team, directorate and organisational level. During this inspection we found that the service did not have a risk register for risks to the service.

Following the first inspection the service compiled a risk register which contained two risks of not being able to turn around instruments in time for lists as we have progressed to offsite sterilisation and the risk of non-compliance with CQC requirement for ILS resuscitation for medical staff. The service identified actions to be undertaken to mitigate these risks.

The service did not independently identify any of the risks that we found during our inspection. Staff working in the service were not focussed on the risks of the service or how these could be mitigated.

Information management

The service did not collect data to improve the service. The information systems were integrated and secure. Data or notifications were consistently submitted to external organisations as required.

The service did not collect data in relation to the effectiveness of the service. The service did not conduct audits or measure any patient outcomes at the time of our inspection. However, the service did review complaints and complications.

The service used paper records which were scanned onto the computer the same day. Staff were aware of how to access information relating to patients.

The service did not have any notifiable incidents in the year before our inspection which would require it to report to external organisations. However, staff were aware of what they would need to report and how they would report them.

Engagement

Leaders and staff actively and openly engaged with patients, staff, equality groups, the public and local organisations to plan and manage services. However, there was not a staff survey in place at the time of our inspection and the patient feedback forms were identified as an area for improvement.

Staff were actively involved in the planning of the service. The team met regularly to discuss updates to the service. However, the service did not conduct a staff survey so staff could not raise concerns in an anonymous way.

The service conducted patient feedback forms following treatment. However, the uptake of these forms was low and

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leaders identified this was an area for improvement. During the previous inspection in August 2017 we found that there was also low uptake of the patient surveys so the service had not improved since our last inspection.

Learning, continuous improvement and innovation

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

The surgeon working at the service met up with other local plastic surgeons to discuss issues in the area and any new ways of working.

All staff working in the unit were aware of changes in practice following our first inspection to our second inspection.

Staff working in the unit told us about different conferences they had been on and opportunities they had to develop while working at the service.

Outstanding practice and areas for improvement

Areas for improvement

Action the provider **MUST** take to improve

- The provider must ensure checks of equipment are in place and are completed.
- The provider must ensure the effectiveness of care and treatment is monitored. The provider should consider collecting data to improve the service.
- The provider must ensure governance processes are in place to monitor and improve the effectiveness of the service delivered.
- The provider must ensure risks and issues are identified and action plans put in place to address the issues.

Action the provider **SHOULD** take to improve

- The provider should ensure staff have an understanding about specific risks to patients such as venous thromboembolisms and sepsis.
- The provider should ensure its sterilisation of equipment is in line with government legislation.
- The provider should continue to ensure medication continues to be stored securely.
- The provider should ensure it has a staff survey in place.
- The provider should ensure patient feedback mechanisms are strengthened.
- The provider should continue to monitor staff mandatory training compliance.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Surgical procedures Transport services, triage and medical advice provided remotely	Regulation 17 HSCA (RA) Regulations 2014 Good governance • The provider must ensure checks of equipment are in place and are completed. • The provider must ensure the effectiveness of care and treatment is monitored. The provider should consider collecting data to improve the service. • The provider must ensure governance processes are in place to monitor and improve the effectiveness of the service delivered. • The provider must ensure risks and issues are identified and action plans put in place to address the issues.