The Pemberdeen Laser Cosmetic Surgery Clinic Limited

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Inspection report

The Cottage
Bostall Hill, Abbey Wood
London
SE2 0GD
Tel: 02045352010
www.pemberdeen.co.uk

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This report describes our judgement of the quality of care at this service. It is based on a combination of what we found when we inspected, information from our ongoing monitoring of data about services and information given to us from the provider, patients, the public and other organisations.

Ratings

Overall rating for this location	Requires Improvement
Are services safe?	Requires Improvement
Are services effective?	Requires Improvement
Are services caring?	Good
Are services responsive to people's needs?	Requires Improvement
Are services well-led?	Requires Improvement

Summary of findings

Overall summary

Following the lifting of restrictions on the regulated activity of surgery at this hospital location, we continued to have concerns about governance, risk management, and the ability of the provider to maintain the service. However, the new hospital manager had initiated improved practices. These were in the early stages and required significant development but indicated the provider's willingness to progress.

Our rating of this service improved. We rated it as requires improvement because:

- The service's clinical care and support functions were fulfilled by a transient, temporary workforce working under a range of different agreements. Staffing levels were arranged to meet patient's needs.
- Systems to maintain practising privileges for surgeons and consultants had improved.
- Appraisals provided no consistent assurance of competence, abilities or staff development.
- The service used equipment and control measures to protect patients, themselves and others from infection. The premises were visibly clean. However, a recent infection control audit had highlighted areas where infection control practice could be improved.
- Staff kept detailed records of patients' care and treatment. However, there was room for improvement in the consistency of risk assessments and monitoring. We were also not assured staff recorded all cosmetic implants on the clinic implant register.
- The service investigated incidents but there was limited evidence of learning being shared with staff.
- There was limited evidence of the service's ability to adapt to individual needs. There were no arrangements for language support and no practical application of guidance to ensure cultural or religious needs were met.
- The service manager had introduced effective governance processes that were adequate for the current levels of surgical activity. A senior management team (SMT) had been assembled to overview the processes and procedures at the clinic.
- Patients generally spoke positively about their experiences of care and treatment.

While there was still significant room for improvement, the hospital manager had implemented a range of new measures to return the service to compliance.

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Surgery	Requires Improvement 	See overall service summary.

Summary of findings

Contents

Summary of this inspection

Background to The Pemberdeen Laser Cosmetic Surgery Clinic Limited

The Pemberdeen Laser Cosmetic Surgery Clinic Limited is registered with the Care Quality Commission to provide the regulated activity of surgery.

This private hospital opened in 1985 and was registered to provide the regulated activity under a different location name. The hospital is situated in south east London. The hospital primarily serves the communities of the London and north Kent areas but also accepts patient referrals from the wider community.

The hospital carries out the following regulated activity: Surgical Procedures. The hospital provides a range of cosmetic surgery, including liposuction and abdominoplasty. Over 95% of procedures were for breast augmentation. The service offers cosmetic procedures such as dermal fillers. We did not inspect these services, as they do not come under the requirements of current regulations.

Except for the nominated individual, who is the hospital manager, all staff are employed on a temporary basis. This means the workforce is transient and works on a temporary basis under agency or locum agreements.

We have inspected the hospital location 19 times since its registration and under the former location name. The most recent inspection was in July 2021, during which we rated the provider inadequate overall and inadequate in safe, effective, and well-led.

We had previously suspended the provider's registration to provide surgery services due to concerns about safety and governance. At the time of this inspection, the provider had resumed these services under certain conditions. There was no registered manager in place. The nominated individual, who was also the hospital manager, told us in July 2021 that they planned to undergo the registered manager process. This had not been completed by December 2021. Their initial application had been rejected because of an error in the information submitted. The registration procedure was still in progress at the time of inspection.

We saw on this inspection the service had made improvements and we rated the provider as requires improvement overall and requires improvement for safe, effective, responsive and well led. Caring remained good.

How we carried out this inspection

We carried out a comprehensive unannounced inspection on 15 and 16 December 2021. Our team included a lead inspector, an inspection manager, one other inspector and two specialist advisors. We spoke with staff on site and members of the senior team remotely using video conferencing software.

You can find information about how we carry out our inspections on our website: https://www.cqc.org.uk/what-we-do/how-we-do-our-job/what-we-do-inspection.

Summary of this inspection

Areas for improvement

Action the service MUST take is necessary to comply with its legal obligations. Action a service SHOULD take is because it was not doing something required by a regulation but it would be disproportionate to find a breach of the regulation overall, to prevent it failing to comply with legal requirements in future, or to improve services.

Action the service MUST take to improve:

- The service must ensure accurate records of all surgical procedures undertaken.
- The service must ensure policies and procedures are tailored to the specific care provided, in particular safeguarding and chaperoning.

Action the service SHOULD take to improve:

- The service should ensure that at all times it is deploying staff with sufficient knowledge, training and experience to keep patients safe.
- The service should consider how they can improve governance and management systems as the service expands.
- The service should ensure that an audit programme is implemented to provide assurance of the standards of care and treatment.
- The service should ensure there is access to confidential translation services.

Our findings

Overview of ratings

Our ratings for this location are:

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

Requires Improvement

Surgery

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

Are Surgery safe?

Requires Improvement

Mandatory training

The service required staff working under temporary agreements to provide evidence of mandatory training.

The service was currently reliant on staff who worked under bank, agency, or locum agreements. The provider required all staff to maintain up-to-date mandatory training in their substantive post. The hospital manager maintained a record of each individual's training status on file. This reflected an improvement in governance from our previous inspections and meant there was greater assurance of staff competence.

The provider did not directly deliver mandatory training for temporary staff although the hospital manager had led discussions about future training the service could support. They had secured a new contract with an external training provider to ensure their own mandatory training remained current. They planned to roll this out to temporary staff in the future. However, there was currently no timeline for implementation.

The provider had a mandatory training policy that outlined 11 core subjects required of all staff. However, the policy provided a framework of responsibility for the hospital manager in delivering training to all staff. and it was unclear how the newly contracted training organisation would integrate into this policy.

The provider required staff to provide evidence of training in supporting patients with mental health needs and provided supplemental training where needed.

Safeguarding

Staff understood how to protect patients from abuse. Staff were required to maintain training on how to recognise and report abuse.

Staff were required to hold training specific for their role on how to recognise and report abuse. The provider required nursing staff to maintain training to at least level two and surgical staff to at least level three. The hospital manager was the designated lead for safeguarding and was trained to adults safeguarding level three. They had established links with a local authority team who delivered safeguarding training to new temporary staff as part of their induction.

Staff knew how to identify adults and children at risk of, or suffering, significant harm and worked with other agencies to protect them. The hospital manager was responsible for escalating concerns to the local authority and demonstrated a good understanding of this process.

Senior staff knew how to make a safeguarding referral. The policy noted the safeguarding lead was trained to level four. However, they were trained to level three and there was no named contact with more advanced training. The child protection and child safeguarding policy was comprehensive and provided staff with a clear escalation process. The policy was based on the Intercollegiate Document Safeguarding Children and Young People: Roles and Competencies for Healthcare Staff, which reflected best practice.

The chaperone policy indicated staff would reschedule appointments if a preferred chaperone was unavailable during a planned appointment. However, the policy did not explain a process for ensuring this risk was minimised or how chaperones could be arranged to meet individual or cultural preferences. The policy referred to lone working and home visits, neither of which were within the remit of the provider's services.

A policy was in place for the safe care of children on the premises, such as when they visited a relative on the ward. This was reflected in the chaperone policy. However, the policy went into detail of safeguards for children who needed intimate examinations by clinical staff when unaccompanied. The service did not provide care and treatment to children and the wording of the policy suggested it was not fully tailored to this specific service.

Cleanliness, infection control and hygiene

The service controlled infection risk variably. 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 premises visibly clean.

Minutes from the governance meeting of September 2021 reported on the infection control audit that had taken place. Actions were identified as: clinical waste and general waste is to be clearly differentiated by the use of yellow and black bags and removed and disposed of appropriately. Dust levels to be closely monitored. Hand hygiene notices to be placed above clinical sinks and in clinical areas. The service had acted on these recommendations.

The service performed variably for cleanliness. Clinical staff said they were satisfied with cleaning arrangements, including for periodic deep cleans. However, a routine maintenance check of beds in October 2021 found infection control risks caused by poor upkeep of some aspects of the beds. The maintenance inspection failed each item and required the provider to replace damaged parts. We found the service had acted on this requirement.

Staff kept cleaning rotas up to date and displayed these appropriately. Alcohol hand gel was available at the entrance and throughout the building. Staff marked privacy curtains with expiry dates, and all were all in date.

Staff used records to identify how well the service prevented infections. This included COVID-19 protocols such as pre-surgery testing for all patients. Staff used COVID-19 screening procedures designed to reduce the risk of an outbreak in the hospital. Procedures required patients to take a COVID-19 PCR test before their procedure. However, guidance given to patients was inconsistent. For example, staff told patients to take a test between 72 hours and seven days before a planned procedure. It was not clear why there was a four-day optional period in this timeline.

Staff followed infection control principles including the use of personal protective equipment (PPE). Staff followed enhanced measures to reduce COVID-19 risks, such as using surgical face masks when moving around the building.

Staff cleaned equipment after patient contact and labelled equipment to show when it was last cleaned.

Staff worked effectively to prevent, identify and treat surgical site infections. Staff noted infections in patient records and documented their action and follow-up. All documented infections were within expected thresholds of surgical risk.

The hospital manager told us the provider audited infection prevention and control standards.

Environment and equipment

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

Patients could reach call bells and staff responded quickly when called. A nurse was always available in the ward and staff said patients were never left without a member of staff nearby.

Staff carried out daily safety checks of specialist equipment. All items of equipment we checked had an up to date electrical safety check. The risk register was reviewed at the monthly quality, governance, risk and safety committee (QGRS). The risk register dated December 2021 showed that issues with environment and equipment were being assessed and actioned. Two items; fire safety and generator servicing had been progressed to 'compliant'.

The service had enough suitable equipment to help them to safely care for patients. Two resuscitation trollies were available in the hospital, one on the ward and on in the theatre. On the day of our inspection nurses broke the security seals and carried out a full stock check, including of items with a limited shelf-life. As the service was operating only one day a week, this meant the nurses followed best practice. Staff had completed previous documentation consistently in relation to stock checks.

Staff disposed of clinical waste safely and the provider had appropriate contracts in place for waste management.

Staff used an external service to decontaminate surgical instruments. Staff consistently documented reference numbers of surgical instruments in patient records and the paper monitoring system. This ensured a reliable audit trail in the event of a post-operative infection.

Assessing and responding to patient risk

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

Staff used the national early warning scores (NEWS) tool to identify deteriorating patients and escalated them appropriately. Staff used NEWS alongside other monitoring tools such as physical observations and fluid balance.

Staff completed risk assessments for each patient during pre-admission and reviewed them regularly. This included a review of each patient's medical history to ensure planned procedures were safe. Staff completed psychosocial evaluation assessments and risk assessments for patients to ensure they were suitable candidates for surgery.

Staff knew about and dealt with any specific risk issues. The team identified issues during the pre-assessment period using blood tests and checks for deep vein thrombosis (DVT) and venous thromboembolism (VTE). Staff documented instances of post-operative infections. These were within expected limits and staff took appropriate action in each case. We checked eight sets of notes that evidenced completion of surgical safety checklists for each patient.

Requires Improvement

Surgery

A resident medical officer (RMO) provided on-site cover when patients were in the hospital and the surgeon was not on duty. This enabled the service to provide overnight inpatient stays when needed, although this was a rare occurrence. The service had access to mental health liaison and specialist mental health support if staff were concerned about a patient's mental health.

Staff shared key information to keep patients safe when handing over their care to others. Escalation and emergency transfer protocols were in place for when patients deteriorated and needed specialist onward care.

Clinical staff maintained a presence on site after each procedure to provide care in the event a patient experienced a post-operative problem.

Staffing

The provider regularly reviewed and adjusted staffing levels and skill mix, and gave bank, agency and locum staff an induction.

The hospital manager calculated and reviewed the number and grade of nurses needed for each shift. All clinical staff worked under bank or locum temporary arrangements including practising privileges. The provider did not monitor sickness, vacancies, or turnover of staff due to the temporary nature of the team.

There was currently one surgeon carrying out operations. They carried out surgery one day a week. Four doctors formed the medical and surgical team; one surgeon, two anaesthetists, and one resident medical officer (RMO). This team provided care under practising privileges and each worked substantively for another service. The surgeon held General Medical Council (GMC) validation until 2024 and undertook annual appraisals with another independent hospital.

Two intensive care consultants provided anaesthetic services under practising privileges. The RMO ensured medical cover was available out of hours, including for urgent advice and review. They remained on site at all times a patient was in the ward following surgery.

The service currently relied upon two bank staff who were both scrub nurses, and two regularly booked agency nurses; one operating department practitioner and one recovery nurse. They were used regularly, providing some continuity of service.

The hospital manager made sure all bank and agency staff had an induction and understood the service. The newly implemented fit and proper persons checks (FPP) meant the service was now able to demonstrate professional accountability of its bank staff and medical staff with practising privileges. The service used a contracted background check service to ensure temporary staff obtained and maintained appropriate Disclosure Barring Service (DBS) checks. After reviewing personnel information we found that checks were taking place for identity, passport, DBS, professional registration, previous conduct, employment history, health conditions, mandatory training, reference checks and medical indemnity (for medical staff- surgeon, RMO and anaesthetists) were all being checked. Induction checklists had also been completed.

A dedicated team of substantive administration staff provided reception and other support functions when the service was in operation. The hospital manager arranged this in advance to ensure the hospital was fully functional on days surgery was planned.

A head of clinical services had just been appointed and was due to start in January 2022. This individual was a theatre nurse who would take responsibility for the operating theatre, compliance and outpatient activity.

Requires Improvement

Surgery

Records

Staff kept records of patients' care and treatment. Records were clear, up-to-date, stored securely and easily available to all staff providing care. we were not assured staff recorded all cosmetic implants on the clinic's implant register.

During our inspection we examined 10 patient records which were comprehensive, and all staff could access them easily. Patient records demonstrated good safety standards and staff documented delays and postponements to treatment when they identified risk. For example, a surgeon postponed a procedure when the patient's pre-treatment echocardiogram (ECG) was outside of acceptable standards. In another instance, the team postponed a treatment when it became clear the patient had not adhered to pre-surgical requirements for antibiotics. While this reflected good practice, there was room for improvement in the consistency of risk assessments and monitoring. In one record, the surgeon had signed a VTE risk assessment but had not completed the form. In another example, a surgeon had completed a record of consent but had not signed and dated the record.

Patient care pathways focused on safety and included a safer surgery checklist, anaesthesia chart, recovery charts and observations, a NEWS chart and an inpatient prescription chart. Staff used these recognised tools consistently and took appropriate action to address patient deterioration.

When patients transferred to a new team, there were no delays in staff accessing their records. For example, staff readily communicated with other healthcare professionals when patients received care from multiple organisations. Staff consistently completed post-operative notes and documented treatment follow up actions. Staff documented patient data confidentiality agreements and consent to share their data.

Records were stored securely with restricted access.

We were not assured the provider consistently recorded procedures on the clinic implant register. The only surgeon providing services carried out breast implant procedures. The procedure registry noted only six implants had taken place on site, which the surgeon disagreed with, and said they had carried out more than this. There was no monitoring or auditing system to confirm the true number. Despite this, senior clinical staff told us they were happy with clinical governance and safety arrangements. They said patient care was coordinated well.

Medicines

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

Staff followed systems and processes to prescribe and administer medicines safely. Patient pathway notes contained signed and data medicine administration details, including clearly documented allergies.

Staff completed medicines records accurately and kept them up to date. Nurses followed safe processes for managing controlled drugs (CDs). Two nurses carried out CD dispensing and both signed the CD log.

Staff stored and managed all medicines and prescribing documents safely. Nurses used a stock check system to ensure medicines remained available for patients. This reflected the sporadic nature of the service and reduced the risk that a required medicine had expired when needed. The hospital manager was responsible for re-ordering medicines following national standards.

Minutes from the governance meeting of September 2021 reported on a medication management and controlled drugs audit that had taken place. It was reported that storage and labelling was compliant and complete.

Requires Improvement

Surgery

Staff followed national practice to check patients had the correct medicines when they were admitted, or they moved between services. This included the prescribing of pre- and post-operative antibiotics. The surgeon provided prescription information to each patient's GP on discharge and kept them up to date with changes during routine follow-ups.

The provider's medicines management policy guided staff in safe practice. This included the use of temperature-controlled, secure storage and an effective stock taking system.

Incidents

Managers investigated incidents but there was limited evidence of learning. We were not assured the service reported all incidents.

Incidents were monitored through an incident matrix which was reviewed at monthly quality, governance, risk and safety committee (QGRS) meetings. There had been one incident in the last six months, since the arrival of the clinic manager, which had been appropriately investigated and reported on. The service had reported no never events and no serious incidents.

The provider had a duty of candour policy in place. This guided staff to be open and transparent if things went wrong.

Staff did not received feedback from investigation of incidents. The hospital manager said this did not routinely take place because of the bank and locum nature of the workforce.

Are Surgery effective?

Requires Improvement

Evidence-based care and treatment

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

The provider had up-to-date policies based on regulations. However, policies did not always reflect best practice and were not specifically tailored to the service. The provider had a portfolio of 42 policies that related to standards of patient care, safety, and the running of the service. While each policy had references to appropriate national standards, there was no audit trail of consultation or approval amongst the senior team.

There was also limited assurance the provider ensured staff were aware of each policy and some policies were incomplete.

The surgeon carried out a pre-surgical assessment and liaised with psychiatrists or psychologists to ensure surgery was appropriate in cases where patients were treated for a known mental health condition.

The quality, governance, risk and safety committee had carried out a leadership and management audit to check the provider's compliance with regulatory requirements. While the audit provided some insight into the provider's areas of improvement, there were no documented outcomes, no resulting action plan and no concluding narrative. This meant we were unable to establish the impact or outcomes of the audit.

Requires Improvement

Surgery

The senior team did have an awareness of their responsibilities in relation to national patient safety alerts and monitoring adherence to guidance issued by relevant organisations such as the National Institute for Health and Care Excellence (NICE), the Royal College of Surgeons of England (RCS) and the Association of Anaesthetists (formerly AAGBI).

This was a standalone service which did not have links with organisations for any networking or development based on relevant national guidance and evidence-based practice. There was no medical director or responsible officer (RO) in place and no medical advisory committee which meant that the clinical effectiveness function was currently a work in progress. A consultant surgeon had been approached and had agreed to take up the role of RO but had held off signing a contract of agreement. The same doctor had however, agreed to provide advice and was attending governance meetings.

Pain relief

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

Staff assessed patients' pain using a recognised tool and gave pain relief in line with individual needs and best practice. Staff prescribed, administered and recorded pain relief accurately. Staff consistently documented pain relief in patient records. We came to these findings from our review of a sample of patient records. However, the service did not carry out pain audits to check consistency of care or compliance with national standards. This meant assurance of practice was very limited.

Patient outcomes

Staff did not fully monitor the effectiveness of care and treatment. The provider did not have a system to use outcome findings to make improvements and contribute to good outcomes for patients.

The service did not participate in national clinical audits and had no alternative system to monitor patient outcomes. Patient records indicated post-operative complications occurred at an expected rate.

The surgeon recorded post-operative complications and infections and documented follow-ups and aftercare with patients. However, the provider had no system in place to cross-reference pre-operative discussions with clinical outcomes.

All surgery in the hospital was elective. However, staff did not monitor post-procedure outcomes for patients, such as hospital attendances or admissions. This meant there was no functioning system to evidence long-term impact and outcomes of procedures.

Competent staff

The service did not always make sure staff were competent for their roles. Managers did not appraise work performance or provide support and development.

The provider's understanding of staff's experience, qualification and knowledge to meet the needs of patients based solely on initial recruitment information. There was no ongoing process to check competency and provide support for development.

All clinical staff worked under bank staff, regular agency and practising privilege arrangements. While staff told us appraisals were supportive, documentation lacked detail to demonstrate the content. For example, one appraisal consisted solely of a tick box to note completion. There was no narrative or documented discussion and the member of staff said the appraisal had consisted of a phone call with the company director.

Requires Improvement

Surgery

The hospital manager gave all new staff an induction before they started work. Records indicated this was a generic process that relied on each individual's existing training and practices at their primary place of work.

The provider did not have a system in place to monitor performance and identify opportunities to provide support, training or development. There was no evidence that the service identified or provided specialist training or that staff undertook enhanced continuing professional development. This presented a risk because it meant staff did not have the opportunity to build on consistency of training and knowledge. The clinic manager told us a training contract with an external company was to be introduced.

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 worked across health care disciplines and with other agencies when required to care for patients. Staff demonstrated proactive communication with other healthcare professionals, including when referring or coordinating tests and follow-ups. The surgeon wrote to each patient's GP before surgery to ensure they were fully aware of their medical history. They repeated this after the procedure with details of the operation and after care.

Staff referred patients for mental health assessments when they showed signs of mental ill health or depression.

Health promotion

Staff supported patients to make informed decisions about their care and treatment. They followed national guidance and ensured that patients gave consent in a two-stage process with a cooling off period of at least 14 days between stages. They understood how to support patients.

The surgeon adhered to a 14-day cooling off period for all surgical treatments in line with national best practice. The surgeon discussed with each patient their reasons for seeking elective cosmetic surgery and took the time to understand their thought processes. This helped to ensure surgery was likely to be a positive experience for them and presented no risk of exacerbating an emotional or mental health issue.

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 gained consent from patients for their care and treatment in line with legislation and guidance. The surgeon obtained consent during the pre-operative assessment process and repeated it again before the surgery took place. They documented a clear explanation of the expectation and consequences of procedures with each patient in medical notes.

The provider required staff to keep up to date with training in the Mental Capacity Act although there was limited monitoring of this. Staff understood the relevant consent and decision-making requirements of legislation and guidance, including the Mental Health Act and Mental Capacity Act 2005 and they knew who to contact for advice.

The hospital manager said a consultant obtained consent at the first point of contact and the surgeon repeated this on the day of surgery. Clinicians offered a two-week cooling off period to enable patients to make an informed choice and the hospital manager said the provider offered flexibility on rescheduling. However, feedback from patients did not suggest this was consistent.

Requires Improvement

Surgery

The provider had a policy for mental capacity, consent, and making best interest decisions. This was up to date and reflected legislation and best practice.

Are Surgery caring?

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. Care was delivered by a small team whose members knew each other well and were accustomed to working together. The hospital manager said they were assured of the professional integrity of the team and everyone ensured they all provided compassionate, kind care.

Patients said staff treated them well and with kindness. One patient described staff as, “Nice”, and said their care had been, “Perfect.” However, the most recent patient audit included only nine individuals. This meant results may not have been fully representative.

The provider had a respecting and involving patients’ policy that was intended to provide guidance on standards expected of staff. While the policy directed staff in delivering care with equality and compassion, it did not provide clear expectations or standards of care. The policy referred to training as a tool to ensure adherence, but the provider did not deliver specific training to staff in this area. This meant we were not assured of performance in this area.

The privacy and dignity policy provided a more comprehensive structure of the provider’s expectations of care delivery. For example, it provided staff with examples of attention to detail they could use during care, such as asking each patient how they preferred to be addressed. The policy did not reference best practice standards or national guidance although the content reflected standards typically expected of staff.

Staff understood and respected the individual needs of each patient and showed understanding and a non-judgmental attitude when caring for or discussing patients with mental health needs. For example, the surgeon had postponed care for one patient who reported anxiety and fluctuating mood. This helped both parties gain assurance that surgery was an appropriate option for their needs.

Most patients received post-operative care in a private side room, which ensured privacy and dignity. Two side rooms could be shared, and staff used privacy curtains on such occasions.

Emotional support

Staff provided emotional support to patients. There was no evidence the provider worked to understand patients' personal, cultural and religious needs.

Staff gave patients and those close to them help, emotional support and advice when they needed it. Staff documented conversations with each patient in relation to consent and their expectations of treatment. The clinical team liaised with GPs to ensure they had an accurate psychological assessment to ensure surgery was appropriate. Staff demonstrated clear understanding of this specifically in relation to the emotional impact of cosmetic surgery.

Requires Improvement

Surgery

All procedures were elective and there were no processes in place to ensure staff identified needs around culture or religion. The provider indicated a basic understanding of this in the chaperone policy but there was no system in place to monitor adherence or learning.

Understanding and involvement of patients and those close to them

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

The surgeon completed a pre-operative questionnaire with patients as part of the consent process. This included a psychological assessment of the patient's ability to understand the proposed surgery. Staff documented such discussions in patient records and described how they managed expectations and ensured patients understood results that could be achieved.

The surgeon spent time with each patient to ensure they understood the potential for success of each procedure and the risks involved. This helped to manage expectations. However, we were not assured this process was effectively monitored. For example, a theme amongst patient complaints was dissatisfaction with the outcome of their procedure. It was not evident the provider consistently communicated with patients. One patient we spoke with described significant delays in undergoing surgery and said staff had not explained the reasons for this.

Are Surgery responsive?

Requires Improvement

Meeting people's individual needs

The provider planned the service to be inclusive but there was limited evidence this was consistent. There was a system for referring patients for psychological assessment before starting treatment, if necessary.

Staff made sure patients living with mental health problems received the necessary care to meet all their needs. They liaised with GPs and other appropriate professionals to ensure patients were fit for surgery through psychological assessments.

The hospital was accessible for patients or visitors with mobility needs. A lift was available in the building and no-step access to the ground floor via the front car park. this car park included a disabled parking area.

The provider did not have access to translators or signers when needed. We could not identify instances when such services should have been used. The provider's safeguarding policy noted relatives or friends of patients could be used to translate for them provided staff did not identify safety concerns. This presented a gap in service provision and potential unsafe practice.

The service operated two different websites, one for the registered name of the provider and another for the trading name of the hospital. The official website had limited information on the organisation, and we were unable to clearly establish why two websites were in use or how this improved services to patients.

Access and flow

People could access the service however, the process of referral to treatment involved a third party.

Requires Improvement

Surgery

Patients accessed the service through a separate business that acted as a brokerage and provided initial advice through a patient coordinator. The brokerage service then referred the patient to the service for care review and planning.

Surgical activity took place one day a week from 9am to 6pm and the hospital manager said the typical caseload was no more than four patients. However, we saw an occasion on which the surgeon had carried out eight consecutive procedures.

The hospital manager was responsible for overseeing surgery. For safety, procedures only took place when they were in the building and was documented in provider's contingency plan.

Patients did not typically stay overnight in the ward although staff could facilitate this if needed. Staff planned discharges early in the treatment process and reviewed this during the pre-operative stage. The surgeon carried out five planned post-operative follow-ups at ten days, six weeks, three months, six months and one year. However, some follow-ups required additional payment from patients, and it was not clear how well the provider explained this to patients in advance.

Learning from complaints and concerns

The service treated concerns and complaints seriously. The service was able to demonstrate that the backlog of complaints were now being meaningfully investigated.

The progress of complaints was monitored through a complaints matrix that was reviewed at monthly governance, risk and safety committee (QGRS) meetings.

Patient refunds had historically been a major source for complaint. However, payments and refunds were the responsibility of the brokerage that invoiced and referred patients into the service and so did not fall under the registration of the service. Before the clinic manager arrived, there was no understanding of who should take ownership of each complaint. Work had taken place to apportion responsibility for each.

The service was now able to demonstrate that complaints were being correctly and procedurally dealt with. The complaints log showed that the historical backlog of complaints were being actioned. All complaints were from before the clinic manager had joined the service in July 2021. Five unresolved complaints remained but all of them were now being investigated, monitored through the governance structure and were on the risk register. The complaints log was a basic aide memoir to keep a track progress with complaints. It lacked dates but showed that 10 of 15 complaints had been resolved, with a further five acknowledged and ongoing.

We requested a random sample of four complaints containing both resolved and unresolved complaints. All four sample complaints related to postoperative complications and were all historical from before the current clinic manager came in to post. They demonstrated that complaints were being meaningfully investigated and responded to.

The service had a website with very limited information about its services and no details of how to raise a complaint or access other policies which a member of the public may wish to see when deciding on using the hospital. The provider had a duty of candour policy based on national best practice guidance. The policy provided guidance for staff when dealing with complaints.

Are Surgery well-led?

Requires Improvement

Surgery

Requires Improvement

Leadership

Leaders had the skills and abilities to run the service. They understood and managed the priorities and issues the service faced.

The clinic manager had been employed by the service since July 2021 and described themselves as having a background of working in and developing challenging services. They gave examples to demonstrate this including healthcare consultancy, compliance and complaints management. They were contracted and employed by the service on a full-time basis. They reported to the owner/managing director who was based overseas and stated that they spoke on a daily basis.

The clinic manager saw their task as introducing a meaningful governance framework and reducing risk. They stated that previous leaders had brought clinical care but not structure. They described their work so far as constructing a senior management team, creating the clinical governance terms of reference (ToR) and having a working agenda each month. The clinic manager had insight and awareness of the issues the service faced.

At the time of this inspection the clinic manager provided leadership for the operating theatre based on their professional background as an operating department practitioner (ODP). If the clinic manager was not present the service stopped for safety reasons. This was written into the business continuity plan; a signed agreement between the clinic manager and owner/managing director, dated November 2021. We were given a recent example where the clinic manager had been absent, and the service had paused. A head of clinical services had been appointed and was due to start 4 January 2022. They had a background as a theatre nurse, and it was intended for them to take responsibility for managing the operating theatre and outpatient activity.

Vision and strategy

The service did not have a strategy to turn its vision into action at this present time.

There were no corporate or visionary values at present. This was described by the clinic manager as on the 'to do' list in the face of other priorities. The aspiration was to achieve good governance and meet compliance. The clinic manager stated there had been discussions with the owner/managing director about a strategy which had not been documented, therefore we were unable to review what the intentions were. The service was currently focused on managing reputational and compliance issues.

The owner/managing director told us they believed systems currently being put in place would meet the regulations and set them on course to build the business. We were told the strategy was to ensure this succeeds. However, this was not outlined in documentation.

The Clinical Quality, Governance, Patient Safety and Risk Strategy 2021 outlined the strategic aims and objectives of the clinic from a governance-based perspective. The document was clear in setting out governance priorities. However, in terms of accountability it referred to a chief executive having overall accountability and for effectiveness where there was not one. The clinic manager stated the document would be refined as time progressed.

Requires Improvement

Surgery

There was no strategy or 'roadmap' to plan for the future development of the service. The clinic manager stated they hoped to increase the number of surgery lists from one to three by mid-2022. However, there was no strategy to plan or assess how this model would work. This was in the context of key staffing positions being uncontracted. For example, on the governance group there were two freelance development consultants and one surgical consultant who could all leave at any time. Surgical activity was carried out by bank and agency staff who were currently committed to working one day a week. This model was adequate while the service had low activity levels. How this could be scaled up was not documented.

Culture

The service was currently working on reputational issues due to historically poor compliance with CQC standards. Developing a positive culture would take further time to achieve.

We were told there was a lot of culture to turn around which would take time. This was in the context of working on reputational issues due to historically poor compliance with CQC standards.

We observed good working relationships and camaraderie between staff. Staff spoke positively of their working relationships with each other and with the hospital manager.

This was a stand-alone service which did not have links with other similar services for any networking or development. The current leadership group were early on into their tenure and were yet to develop a culture or clear identity.

Governance

Leaders had introduced effective governance processes that were adequate for the current levels of surgical activity. How these arrangements would work when surgery occurred on more than one day a week was yet to be planned for or risk assessed.

The clinic manager had formed a senior management team, known as the quality, governance, risk and safety committee (QGRS). It currently comprised of four people; the clinic manager, the owner/managing director and two freelance development consultants who held the positions of interim director of risk and governance and interim risk and complaints lead. The freelance development consultant roles were one day a week and described in the business continuity plan as remote workers and accessible at other times. Duties included attendance at all QGRS meetings.

Its inaugural meeting was in July 2021 where the Clinical Quality, Governance, Patient Safety and Risk Strategy 2021 and terms of reference (ToR) were agreed. The ToR were dated June 2021 and stated membership, authority, frequency of meetings, responsibilities, management matters such as minute taking and review date of the ToR. The current context of the organisation, such as managing major reputational issues or constructing a governance framework from the ground up, was not mentioned in the ToR or QGRS strategy, so it did not fully capture the current situation. However, the document was adequate for the level of present activity.

The QGRS had a fixed agenda that consisted of: governance, incidents, quality performance, patient experience, appraisals, infection control, safeguarding, DBS, risk management, risk register, business continuity plan and policy ratification. Minutes showed that issues of safety and improvement were being assessed and actions agreed. Named members of the group took lead responsibility for each item. This meant that progress with complaints, action plans, theatre deep clean, arrangements for appointing a head of clinical services, audit outcomes and progress with regulatory compliance were all being meaningfully progressed.

The QGRS was the only decision-making body, so there was no other group to provide oversight of decisions or processes that were being agreed or acted on by the QGRS. For instance, there was no board, medical advisory committee (MAC) or other senior management meeting. This was not reflected in or mitigated against in the ToR. The owner/managing director's role in decision making or level of authority was not stated within the ToR or QGRS strategy. The clinic manager told us they had raised the need for a wider management structure, but it remained on the to do list in the face of other priorities.

There was no medical director or responsible officer (RO) in place. We were told by the clinic manager that a consultant surgeon had been approached and had agreed to take up the role but had held off signing a contract of agreement, although the same doctor had agreed to provide advice and was attending QGRS meetings. The clinic manager said that because of the contractual agreement not being in place he did not want to overstate this consultant's role. Surgeons that had previously been working at the service with practising privileges had removed themselves from the list as reputational risks had grown.

Management of risk, issues and performance

Leaders had introduced meaningful systems to identify and manage risks and reduce their impact. Work was being prioritised on the basis of risk and safety and further work was needed in some areas.

Since the appointment of the current clinic manager, systems had been put in place to manage risks and demonstrate progress with meeting standards of quality and safety. This was described by the clinic manager as the largest concern upon his arrival. Systems were newly implemented and still a work in progress but appeared meaningful in identifying and dealing with issues of risk and performance.

The clinic manager described safety as the overarching principle of the service and reputational damage as the biggest risk to service continuity. They stated they had control over what procedures were undertaken. We were given the example where surgery was cancelled, and the surgeon wanted to undertake laser surgery instead. This was refused on the basis of lack of policy and safety procedure.

There was a risk register, which was reviewed at the monthly quality, governance, risk and safety committee (QGRS). December 2021's version showed risks were assessed by their likelihood, impact and risk, and were RAG rated (red, amber and green colour coded). Controls to manage risks and future action needed were stated for each item. The register currently contained 25 items. Two items; fire safety and generator servicing had been progressed to 'compliant' while others remained ongoing such as WHO safer surgery compliance and review of all policies.

The service had produced a 'CQC key lines of enquiry audit tool' which monitored progress with improvement, risk mitigation and service development for the well led domain. It was reviewed at the monthly QGRS and demonstrated progress of each through several embedded documents in areas such as clinical governance, fit and proper persons and incident management.

Audit plans were agreed at QGSR. The service had so far carried out audits on infection prevention and control, patient experience and patient records, medication management and controlled drugs. October minutes for the QGRS reported that the audits took place on 15 September 2021, with outcomes and actions reported in to the QGSR. The clinic manager stated he would like to have an audit calendar in place, but this was still in the planning stage with other work taking priority.

Incidents were monitored through an incident matrix which was reviewed at QGRS. Complaints were monitored through a complaints log that was reviewed at QGRS.

Regarding oversight of patient safety alerts and notifications from organisations such as the Central Alerting System (CAS) and the National Institute for Health and Care Excellence (NICE), the clinic manager was unsure about how this was processed or who took responsibility prior to his arrival. Some were described as arriving in the post and we were provided with an email from the Medicines and Healthcare products Regulatory Agency (MHRA) regarding a medicine recall dated December 2021 to demonstrate this. However, processes were currently unclear and described as work to be done among other priorities.

Regarding contract oversight, the clinic manager stated there was no contract management framework at present although a baseline assessment had been carried out. Contract renewals were done on an 'as and when' basis. Contracts to provide instrument sterilisation and firesafe checks had been renewed while servicing and generator checks were all up to date. Services such as cleaning, maintenance and water safety were all provided by up to date contracts. All consumables and implants were supplied by an approved medical supplier who assured quality of product. We were also provided with test certificates from the same contractor dated September 2021 to show that all surgical equipment such as liposuction unit, ventilator and electrosurgical unit had been tested and verified for performance in accordance with the manufacturer's specifications.

Regarding financial oversight, the clinic manager stated that they did not have sight of the finances but financial demands and spend were regularly discussed with the owner/MD informally and at QGRS meetings. They were confident the money was there to safely sustain the business. For instance, the head of clinical services post was a substantive post agreed with the owner/MD with a 60k cost. The owner/MD stated they were confident that the business was financially resilient. If issues arose, they stated they ensured sufficient funding was provided.

Information management

Staff could find the data they needed, in easily accessible formats, to understand performance, make decisions and improvements.

Patient records were in paper form from the point of admission into the service. Retained records were archived in accordance with the records retention policy, which followed the NHS Records Management Code of Practice. The monthly QGRS had discussed the retention of records and placing records into electronic storage. Work around archiving remained ongoing.

The clinic manager expressed a desire to purchase an online reporting system for incidents and complaints which were currently paper based systems. Current levels of activity meant both could be easily managed this way.

The clinic manager stated that patient records belonged to the service and the consultant never held their own patient records.

The one incident that had occurred since the clinic manager had been in post related to an information governance breach, where sensitive personal information had been wrongly shared with someone other than the patient. Upon investigation it was found that this was a breach by a third party. Appropriate action had been taken that included seeking advice from the Information Commissioner's Office.

Engagement

Requires Improvement

Surgery

Engagement with patients, staff, equality groups, the public and local organisations was currently limited.

The workforce was currently made up of bank, agency, freelance development consultants and a small number of medical staff employed on practising privileges. The hospital manager maintained regular contact with staff through the course of attending meetings, arranging shifts and surgical days. However, there was no forum in which staff had the opportunity to meet and build working relationships. There was a speaking up policy and speaking up was part of the induction process. The clinic manager stated the policy would have more traction as staff numbers grew.

There were currently low numbers of patients accessing the service and engagement with patients took place in this context. The service was a stand-alone organisation with no networking within the wider healthcare community apart from the clinic manager's own connections.

Learning, continuous improvement and innovation

Leaders had a good understanding of quality improvement methods and the skills to use them.

Reputational risk was identified as a major risk to business sustainability and service improvement was key to managing this. The clinic manager stated that a sustainable business meant building on a safe reputation rather than simply attracting work. The clinic manager stated he had made this clear to the owner/managing director about how to grow the business, who was clear about wanting to keep going. One service priority was to attract new surgeons and increase the current level of activity. They were confident the money was there to improve and safely sustain the business and hoped to have two or three surgery lists by mid-2022.

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	Regulation 17 HSCA (RA) Regulations 2014 Good governance We were not assured staff recorded all cosmetic implants on the local implant register and there was no monitoring or auditing system to confirm the true number. Policies did not always reflect best practice and were not specifically tailored to the service.