Aesthetic Beauty Centre LLP

Aesthetic Beauty Centre - Newcastle-upon-Tyne

Inspection report

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

Ratings

Overall rating for this location	Inspected but not rated
Are services safe?	Inspected but not rated
Are services well-led?	Inspected but not rated

Summary of findings

Overall summary

Aesthetic Beauty Centre – Newcastle-upon-Tyne is operated by Aesthetic Beauty Centre LLP. The service is registered to provide a range of surgical and cosmetic procedures under local anaesthetic or sedation to fee paying patients over 18 years old.

The service is situated in a large detached house which has been converted into a clinic, that is wheelchair accessible to ground floor level (but without ramps) and is located conveniently for access to local public transport networks, but also has on street parking.

There is a downstairs reception room and waiting room, a consulting room and unisex toilet. On the first floor there was a theatre, pre-theatre room, shower/toilet room, clean and dirty utility, and recovery room, together with a room used by staff for administrative purposes.

We inspected this service using our responsive inspection methodology following information we received from the provider that confirmed they would recommence regulated activities from 01 July 2020. We carried out a short notice announced inspection on 27 July 2020 along with virtual interviews on-line with staff on 28 July 2020.

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

The main service provided by this location is Aesthetic Beauty Centre – Newcastle upon Tyne. Where our findings on Aesthetic Beauty Centre – Newcastle upon Tyne – for example, management arrangements – also apply to other services, we do not repeat the information but cross-refer to the Aesthetic Beauty Centre – Newcastle upon Tyne service level.

Following this inspection, we identified areas where the provider must make improvements. Details are at the end of the report.

Services we rate

We had not previously rated this service which was registered in October 2010. As this was a focussed responsive inspection, we looked at specific areas and did not cover the whole domains on key questions.

Therefore, we inspected but did not rate the service.

We found the following issues, where the service provider was not meeting regulations:

- The recovery environment did not meet infection prevention and control best practice in line with national guidance. This had been identified at previous inspections in September and December 2019 and again in January 2020. At this inspection there had been some improvements made to the environment, but these remained insufficient to provide adequate infection prevention and control practice.
- The provider had stopped decontamination of their own surgical instruments but had not been able to provide CQC with a copy of a contract or service level agreement to ensure surgical instruments were decontaminated in line with regulations.

Summary of findings

- Previous inspections had identified patient risk assessments were not always completed and updated in line with best practice. We found this had not improved at this inspection.
- Previous inspections had identified operation notes were not recorded on appropriate documentation for their purpose. Due to this it meant notes were difficult to find and not easily legible. At this inspection we found current patient records given to CQC by the provider were not always updated from consultations which had place up to a year ago and legibility remained very poor.
- There were no environmental risk assessments and no risk assessments carried out for new equipment. There was equipment stored in clinical areas and the provider had not recognised this as a risk. A new external staircase had been built but staff had not recognised the need to carry out a risk assessment.
- Previous inspections identified policies within the service did not reflect the environment or accurate processes used within the service. At this inspection we found a new policy and procedure manual had been produced but the old policies remained in place and there were still policies where roles and the environment were not accurately reflected. New patient pathway documentation referred to policies that did not exist or remained unchanged.
- Previous inspections had identified there was no audit of pre-operative risk assessments to ensure these were thorough and complete. At this inspection we found that although staff told us they had carried out records audits, patient pre-assessment documentation was still not fully completed, signed or dated even though patients were booked for surgery.
- Previous inspections identified the leadership team were unable to demonstrate full understanding of their responsibilities in carrying out or managing regulated activities and meeting the standards required by the HSCA regulations. At this inspection we found this had not improved. Some responsibilities had been delegated to a business consultant including the creation of a new policy and procedure manual, but the leadership team were still unable to demonstrate a full understanding of their roles and responsibilities as providers of a healthcare service.
- The provision of out of hours care was not robust. At previous inspections we were not assured a patient who required urgent treatment, when the surgeon was operating at other locations, would receive care from medical professionals with the appropriate skills and competence. Although the provider assured us there was an agreement in place with a local NHS trust, the formal document to confirm these arrangements could not be provided to us.
- There was out of hours cover provided at another facility where procedures were carried out under practising privileges. However, patients did not stay at the facility overnight following procedures.

However:

- The provider had addressed some areas of infection prevention and control. These included replacement of the sink in the theatre, provision of a handwashing sink in the recovery room, and washable hard flooring in clinical areas.
- Medicines were stored securely and correctly.

Following this inspection, we were not assured the provider had taken sufficient action to comply with all of the Health and Social Care Act (HSCA) 2008 Regulations (2014) and there was an ongoing risk of harm to patients undergoing cosmetic surgery procedures at this location.

We issued two fixed penalty notices on 29 July 2020 for failure to notify CQC as required under the Regulations 12 and 15 of the Care Quality Commission (Registration) Regulations 2009. These were paid by the provider on 13 August 2020

We issued a notice of proposal to cancel the registrations of the provider and registered manager on 25 August 2020. The provider submitted representations to appeal the notices on 22 September 2020. The representations were not upheld and a notice of decision to cancel the registration of both the provider and the registered manager was issued on 12 October 2020.

Summary of findings

The provider appealed to the first-tier tribunal in November 2020 against both notices, however, withdrew the appeal on 30 June 2021. Therefore, the notice of decision to cancel the registration of the provider and registered manager took effect on 12 July 2021.

Ann Ford

Deputy Chief Inspector of Hospitals (North)

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Surgery	**Inspected but not rated**	Are services safe? Care premises, equipment and facilities were unsafe. Staff did not have knowledge of appropriate regulations or apply national guidelines to ensure patients were safe at all times. The service did not have the correct equipment, or knowledge of regulations to keep patients safe. The service did not control infection risk well, although staff kept most equipment and the premises visibly clean. Staff did not always complete and update risk assessments for each patient to remove or minimise risks. Staff did not always keep detailed records of patients' care and treatment. Records were not always clear, or up to date. However: Staff stored and managed medicines well. Are services well-led? The leadership team were unable to demonstrate full understanding of their responsibilities in carrying out or managing regulated activities and meeting the standards required by the HSCA regulations. Leaders did not run the service well. They did not use reliable information systems including organisational policies and processes for staff to follow. Not all staff understood the service's vision and values, and how to apply them in their work. Processes were not always focused on the needs of patients receiving care. Leaders did not operate effective governance processes throughout the service. Staff were not always clear about their roles and accountabilities. Staff told us they were committed to improving services continually. However, leaders lacked insight and knowledge of regulations to make sufficient improvements.

Summary of findings

Leaders and teams did not identify or escalate all relevant risks and issues or identify actions to reduce their impact. There were insufficient plans to cope with unexpected events.
The service did not provide care and treatment based on national guidance and evidence-based practice. Managers did not check to make sure staff followed guidance.
The provider failed to manage the expectations of patients. However, they engaged well with patients and staff felt respected, supported and valued.

Summary of findings

Contents

Summary of this inspection

Background to Aesthetic Beauty Centre - Newcastle-upon-Tyne

Aesthetic Beauty Centre – Newcastle upon Tyne is operated by Aesthetic Beauty Centre LLP. The service opened in 2010. It is a private independent cosmetic surgery service in Newcastle upon Tyne, Tyne and Wear. The service primarily serves the communities of Tyne and Wear. It also accepts patient self-referrals from outside this area.

The service also offers cosmetic procedures such as dermal fillers and laser hair removal. We did not inspect these services.

The service has had a registered manager in post since 2010.

Aesthetic Beauty Centre – Newcastle upon Tyne provides the following regulated activities:

- Diagnostic and screening procedures
- Surgical procedures
- Treatment of disease, disorder or injury.

However, all the regulated activities above were subject to a condition that the provider must only undertake minor surgical and cosmetic procedures under local anaesthesia as detailed in its statement of purpose for service users aged 18 or over at this location.

We have inspected this location three times in the past 12 months and at each inspection CQC took enforcement actions.

We inspected this location in September 2019 and imposed conditions to prevent the provider from carrying out surgical procedures requiring local anaesthetic or sedation until 4 January 2020. The provider appealed this decision and CQC were required to attend a tribunal where the panel ruled conditions would be extended until 4 April 2020.

We re-inspected the service at the provider's request in December 2019 and in January 2020 and although the provider had made some changes, we found these were insufficient to provide adequate patient safety and the conditions remained unchanged.

We planned to carry out a full comprehensive inspection in March 2020, prior to the conditions expiring. However, CQC conditions were overtaken due to government restrictions on all independent health providers during the Covid-19 pandemic. The provider assured CQC, in line with government restrictions, they would remain dormant until 01 July 2020. The provider agreed to inform CQC two weeks prior to re-commencing services to allow sufficient time for a full comprehensive inspection before the first patients were seen and procedures were booked. We maintained engagement and monitoring activity with the provider and staff provided lists of consultations which showed the service had recommenced prior to 01 July 2020.

We carried out this responsive, focused inspection to ensure improvements to patient care and safety had been made.

Summary of this inspection

How we carried out this inspection

We carried out this responsive, focused inspection to ensure improvements to patient care and safety had been made. Our inspection was unannounced (staff did not know we were coming) to enable us to observe routine activity. The team that inspected the service comprised a CQC lead inspector, a CQC inspection manager, and two specialist advisors; one of which was a plastic and cosmetic surgeon, the other specialist advisor had expertise in independent health service theatre management and infection prevention and control. The inspection team was overseen by Sarah Dronsfield, Head of Hospital Inspection.

During the inspection, we visited the theatre, patient waiting and recovery rooms and main reception. We spoke with three staff including the lead doctor, lead nurse, and a secretary. We also spoke with a business consultant employed by the provider to support governance of the service. We spoke with 15 patients who had attended for consultations or procedures during the reporting period January to July 2020. During our inspection, we reviewed eight sets of current patient records.

No patients were present during the inspection.

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

Areas for improvement

The service must record and complete all patient risk assessments and update them in line with best practice. Regulation 12 Safe Care and Treatment

The service must ensure surgical instruments are decontaminated in line with regulations. Regulation 15 Premises and equipment

The service must ensure equipment used to transport contaminated instruments meets requirements. Regulation 15 Premises and equipment

The service must ensure all patient consultation notes are updated from previous consultations with clear legibility. Regulation 17 Good Governance

The service must ensure all patient pre-assessment documentation is always fully completed, signed and dated on every occasion. Regulation 12 Safe Care and Treatment

The service must ensure policies and procedures accurately reflect current practice, roles and the environment. Regulation 17 Good Governance

The service must ensure all new patient pathway documentation includes relevant and appropriate references to policies and current national regulations, guidance and best practice. Regulation 17 Good Governance

Summary of this inspection

The service must ensure the leadership team are able to demonstrate full understanding of their responsibilities in carrying out or managing regulated activities and meeting the standards required by the HSCA regulations. Regulation 17 Good Governance

Our findings

Overview of ratings

Our ratings for this location are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Surgery	Inspected but not rated	Not inspected	Not inspected	Not inspected	Inspected but not rated	Inspected but not rated
Overall	Inspected but not rated	Not inspected	Not inspected	Not inspected	Inspected but not rated	Inspected but not rated

Inspected but not rated

Surgery

Safe	Inspected but not rated
Well-led	Inspected but not rated

Are Surgery safe?

Inspected but not rated

This was a focused inspection and looked at the following areas only:

Cleanliness, infection control and hygiene

The service did not control infection risk well, although staff kept most equipment and the premises visibly clean.

We found that the provider failed to provide documented evidence of the service level agreement (SLA) regarding the management of decontamination and sterilisation with a third-party provider. As part of this inspection we requested this. We had been informed during routine engagement and at a previous inspection this was in place. However, the provider had only been able to produce a letter written by the provider and addressed to the third party dated 19 February 2020. During our onsite inspection staff said they were unable to contact the third-party provider because the person was on leave. However, they also told us during interview they had not followed this up and did not have a copy of the SLA.

The policy and procedure manual referenced a decontamination procedure which would take place on site. Staff told us this was a plan for the future to convert rooms to a decontamination suite. This did not reflect the current practice; therefore, we could not be assured which decontamination and sterilisation process staff were following.

We found the provider failed to ensure the new recovery chair was cleaned and ready for use. We saw peeling labels and tape on the frame which posed an infection risk. When questioned staff did not identify this as a concern.

Staff kept equipment and the premises visibly clean. Staff had developed checklists to ensure items of equipment and clinical areas were cleaned and we found these had been completed.

Environment and equipment

The service did not have the correct equipment and staff did not have knowledge of appropriate regulations or apply national guidelines to ensure patients were safe at all times. The provider did not ensure that the premises and equipment used to deliver care and treatment met service users' needs.

The operating room was located on the first floor of the premises. There was a staircase but no lift for patients to use. Staff told us they would not be able to provide surgical procedures for patients who could not climb the stairs although there was no written policy regarding this.

Inspected but not rated

Surgery

The provider did not demonstrate an understanding of the importance of risk assessments for the environment and equipment in relation to the new patient recovery chair, storage of equipment in the patient recovery room, stairs, or the new emergency exit at this location. We found there was insufficient planning to mitigate risks to patients and patients could be exposed to the risk of harm.

However, at previous inspections we had found flooring in some clinical areas was carpeted and did not meet infection prevention and control regulations. At this inspection we found the carpet had been replaced with non-carpeted washable flooring.

Assessing and responding to patient risk

Staff did not always complete and update risk assessments for each patient to remove or minimise risks.

During the inspection, we looked at eight patient records. We found these records did not contain suitable and sufficient risk assessments to effectively manage patient risk. Four patients had attended for consultations in February and March 2020 and were booked for surgery at a service in Liverpool. Staff provided theatre lists showing patients were booked for surgical procedures in August 2020. However, there was no evidence these risk assessments had been reviewed and updated at each consultation. We spoke with six patients who confirmed they had had further consultations with the doctor meaning that patient records should have been updated. In addition, we could not see evidence of all the consultations in the records we reviewed or in the lists provided to CQC.

We found that the patient disclaimer had not been signed by the doctor in six of the eight records we reviewed.

We saw a National Early Warning Score (NEWS) scoring sheet within the patient pathway documentation provided to inspectors but policies did not identify how or when staff would act upon patients at risk of deterioration. During interviews, clinical leads gave differing accounts of how or when they would act should a patient's condition deteriorate. We found there was insufficient planning and understanding of this risk assessment tool to remove or minimise risks to patients should the service resume surgical procedures.

The policy and procedure manual referenced a decontamination procedure which would take place on site. When questioned about this, staff told us this was a plan for the future to convert rooms to a decontamination suite. This did not reflect the current practice. Therefore, we could not be assured which decontamination and sterilization process staff were following.

We found staff failed to ensure the new recovery chair was cleaned and ready for use. We saw peeling labels and tape on the frame which posed an infection risk. When questioned staff did not identify this as a concern or recognise why this was an infection risk.

Records

Staff did not always keep detailed records of patients' care and treatment. Records were not always clear, or up to date.

Staff told usthey did not document or record initial and virtual consultations with patients in line with professional standards. Therefore, there was no evidence of appropriate patient selection, in terms of inclusion or exclusion for the environment.

Inspected but not rated

Surgery

Prior to this inspection, staff told us they had produced new patient pathway paperwork, and this would be used for all new patients using the service. However, we found old paperwork still in use in all eight records we reviewed.

These records were all for patients who had been booked

for surgical procedures in the following month. Writing and diagrams of the procedures to be carried out were not clearly documented, and not always signed and dated by the lead doctor in line with professional standards.

During our inspection staff told us they always gained patient's consent for all procedures carried out. However, we spoke to 15 patients and were told by three patients they were unsure if they signed a formal consent form during their consultation. Patients we spoke with could not tell us if they had received a copy of their consent in line with the Royal College of Surgeons Consent: supported decision-making (2016). In addition, we were unable to identify where formal consent for the procedure was documented in all of the patient records, we reviewed.

Records were filed at the location the patient was last seen at and were easily available to all staff providing care.

Medicines

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

We saw medicines were stored securely and staff checked stock to ensure use by dates were not exceeded.

Are Surgery well-led?

Inspected but not rated

Leadership

The leadership team were unable to demonstrate full understanding of their responsibilities in carrying out or managing regulated activities and meeting the standards required by the HSCA regulations. Leaders did not run the service well. They did not use reliable information systems including organisational policies and processes for staff to follow.

There was a history of breaches in regulation and patient safety concerns. We inspected this location on 27 September 2019, and again on 09 December 2019 and 02 January 2020. Following these inspections, CQC issued reports identifying areas where Aesthetic Beauty Centre had failed to comply with HSCA Regulations 12(1), 15(1) and 17(1).

We used our urgent enforcement powers under section 31 and imposed conditions on 04 October 2019 until 04 January 2020. The provider appealed this decision. However, at appeal the conditions were further extended by the care standards tribunal until 04 April 2020. These conditions had expired in April due to the COVID pandemic national guidance and the provider confirmed they would be following this guidance and would not be re-starting services until 01 July 2020.

Staff did not notify CQC in a timely manner that they had recommenced regulated activities following Covid-19 restrictions and they were no longer a dormant service.

Inspected but not rated

Surgery

Prior to our inspection of 27 and 28 July 2020 CQC had not inspected the Newcastle location since the urgent conditions were imposed and expired. Therefore, we had been unable to make an up to date judgement on the safety of services since our previous inspection in January 2020 when we had serious patient safety concerns.

However, we also found that two patients (one in June and one in July 2020) had undergone procedures which required excision and local anaesthetic whilst the service was dormant and whilst the lead Doctor had conditions on their professional registration.

Due to the continued breaches of regulation, the concerns we identified and the lack of improvement by the provider since our first responsive inspection in 2019, CQC took enforcement action and issued two fixed penalty notices on 29 July 2020 for failure to notify CQC as required under the Regulations 12 and 15 of the Care Quality Commission (Registration) Regulations 2009. We also issued a notice of proposal to cancel the registrations of the provider and registered manager on 25 August 2020.

The provider submitted representations to appeal the notices on 22 September 2020. The representations were not upheld and a notice of decision to cancel the registration of both the provider and the registered manager was issued on 12 October 2020.

The provider appealed to the first-tier tribunal in November 2020 against both notices, however, withdrew the appeal on 30 June 2021. Therefore, cancellation of the registration of the provider and registered manager took effect on 12 July 2021.

We found the senior team, including the registered manager continued to be unable to demonstrate full understanding of their responsibilities in carrying out and managing regulated activities and meeting the standards required by the HSCA regulations.

Staff failed to ensure the new policy and procedure manual (PPM) was fit for purpose and was specific and related to the service that was provided at this location.

We found staff had failed to ensure written documentation had improved in the service, despite conditions being imposed on the provider's registration in October 2019, four responsive inspections, reports and action plans.

Throughout engagement meetings we had discussed the importance of robust documentation of all patient consultations in line with professional standards.

During the inspection staff continued to ask CQC for advice and stated "if we make that change would that make you happy". This demonstrated limited understanding of their own responsibilities as required by the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 or of changing practice to improve safety for patents.

We asked the provider to formally notify CQC of the definitive list of procedures which they planned to undertake at the clinic locations. Staff advised us on 29 June 2020 they would send this in the updated statement of purpose, however when we received the updated documents on 07 July 2020 the information requested was missing. Despite repeated requests this has still not been provided to us.

Staff failed to provide documented evidence of the service level agreement (SLA) regarding the management of decontamination and sterilization of surgical instruments with a third-party provider. We were informed during routine engagement and inspection this was in place.

However, we were only provided with a letter from the provider addressed to the third party and dated 19 February 2020. During our onsite inspection staff told us they had been unable to contact the third-party provider because the person was on leave. However, staff also told us during interview they had not followed this up and did not have a copy of the SLA.

The policy and procedure manual referenced a decontamination procedure which would take place at the Newcastle clinic site. When questioned about this, staff told us this was a plan for the future to convert rooms to a decontamination suite. This did not reflect the current practice. Therefore, we could not be assured which decontamination and sterilization process staff were following.

This further demonstrated to us that the provider did not understand their roles in meeting the regulations and they did not take action to ensure breaches of regulation were addressed.

Vision and Strategy

Not all staff understood the service's vision and values, and how to apply them in their work. Processes were not always focused on the needs of patients receiving care.

Staff provided updated statements of purpose on 07 July 2020. However, these did not include the procedures which were planned to be undertaken at the Newcastle location. We had made this request a number of times during engagement and inspection interviews. Staff failed to provide these.

The updated policy and procedure manual (PPM) provided to us stated that the doctor would use the Bupa Schedule to categorise procedures. However, this was not reflected in the interview with the lead doctor. We could not be assured the doctor was following the Schedule to categorise procedures and therefore they would not be following their own policy.

Governance

Leaders did not operate effective governance processes throughout the service. Staff were not always clear about their roles and accountabilities.

Staff had not ensured they had effective systems in place to assess and monitor the quality of care for patients

Staff informed us due to the COVID 19 pandemic they would not be carrying out any activity at either Aesthetic Beauty Centre location. Due to this assertion we informed the provider on 08 June 2020 that we would treat Aesthetic Beauty Centre as a dormant service. We requested staff advise us two weeks prior to recommencing any regulated activity. In response to the dormancy letter staff told us they planned to recommence activity on 01 July 2020.

Staff provided records that showed staff carried out a consultation at Newcastle on 05 June 2020 and a procedure on 30 June 2020 whilst dormant.

Not all pre-assessment documentation was fully completed or legible. We saw eight patient records since activity was recommenced on 01 July 2020. We found the pre- assessment documentation was not fully completed in all but one record, and the disclaimer had not been signed or dated by the lead doctor in six out of eight records. In addition, staff had told us during engagement meetings that new documentation was ready to be used in patient records. We saw no new documentation had been completed for any of the patients who had recently attended for consultations and had been booked for surgery the following month.

Inspected but not rated

Surgery

We found the new policy and procedure manual (PPM) was not fit for purpose or specific to the services provided.

Written policies and procedures were brief and contained no references to best practice or national standards. There was no review date for the manual or policies included within it, although staff told us these were planned for annual review. However, there was no documented evidence of such a plan. The review process of the PPM had limited clinical oversight. In addition, the document was not individualised to the service as we found inappropriate references to a "victim" and "rescuer" in the resuscitation policy.

We found there was confusion as to the role of the PPM between the lead nurse (who was also the registered manager) and the lead doctor. Staff had informed us through engagement the PPM was in place and being used. However, we found not all staff we spoke with were aware of it. In addition, the lead doctor told us the PPM was linked directly to the old versions as background evidence. Also, staff told us the new PPM had not been ratified, therefore, it was not clear which policies staff at the Aesthetic Beauty Centre LLP were working to. We had identified during multiple inspections the previous policies were not appropriate for the services provided.

Key elements such as the safer surgery checklist and national early warning score (NEWS) within the new patient pathway documentation were not underpinned by an associated policy. This meant that there was no understanding of actions expected by staff. Every action such as a checklist or task should be backed up by an associated policy which is linked to best practice and national guidance. In relation to the NEWS in the patient record score the provider had identified that a NEWS score of 7 or more would trigger a call for 999. However, there was no evidence of a deteriorating patient policy. This led us to believe staff continued to have limited understanding and learning of the risks within their standalone locations, in particular on the occasions when there would only be two clinical members of staff to manage unexpected patient deterioration despite there being two patients in the previous year that had deteriorated.

Staff failed to ensure there was a documented process for how incidental findings would be reported or communicated. The service undertakes mole removal, however, there was no policy or procedure should histology be returned with a malignancy. During interview the lead doctor described a process, however, agreed it was not documented. They gave several iterations of what would happen and advised they had not had to do this for 6 years. However, immediately following our inspection and before the lead doctor's interview we found histology of a lesion had been undertaken a few weeks earlier.

Managing risks, issues and performance

Leaders and teams did not identify or escalate all relevant risks and issues or identify actions to reduce their impact. There were insufficient plans to cope with unexpected events.

The service did not provide care and treatment based on national guidance and evidence-based practice.

Managers did not check to make sure staff followed guidance.

We found staff failed to ensure all pre-assessment documentation was fully completed and clearly documented.

Staff failed to ensure key elements (safer surgery checklist and NEWS) of the new patient pathway documentation were underpinned by an associated policy. This meant that there was no understanding of the detail expected by staff.

Inspected but not rated

Surgery

Staff failed to ensure there was a documented process for how incidental findings would be reported or communicated. The service undertook mole removal, however, there was no policy or procedure should histology be returned with a malignancy.

Staff failed to mitigate risks to patients and staff. During our discussions with patients we were told the lead doctor had driven patients to and from a clinic in the North West in their private car for surgical treatment. The risk assessment staff provided stated:

“adequate motor vehicle insurance cover provided i.e. for personal business use”.

However, the car insurance certificate staff provided identified they had not adhered to their own risk assessment. The certificate stated:

“Limitations as to use, use for social, domestic and pleasure purposes (including commuting) EXCLUSIONS: Use for business purposes”.

There was no evidence that the risk assessment residual rating had been appropriately assessed, as staff had rated the above as low risk, yet staff did not meet the requirements of the assessment. In the event of an accident the doctor’s car insurance may have been null and void.

Engagement

The provider failed to manage the expectations of patients. However, they engaged well with patients and staff felt respected, supported and valued.

Staff provided lists of patients as requested by CQC. All had attended for consultations or procedures between January and July 2020 and we contacted patients from these

lists. We spoke with two patients who were expecting to have their surgeries in at another location in the North East and two patients who were expecting to have a procedure under general anaesthetic in Newcastle. The provider did not have the facilities at the Newcastle location to undertake a general anaesthetic and the lead doctor did not have practicing privileges at any other services in the North East.

Seven patients we spoke with said they had been surprised they could not have their surgery locally. Two patients said staff had told them this was because there were building works ongoing and a further three patients said they were told there were better facilities at a different location. One patient told us the provider’s website showed there were locations in other areas and following their consultation they understood procedures may be carried out elsewhere.

Patients we spoke with said they had completed

post-operative questionnaires following their procedures and felt positive about their experiences.

Staff we spoke with said they enjoyed working for the service and felt very much a part of the team.

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
Diagnostic and screening procedures Surgical procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment

Regulated activity	Regulation
Diagnostic and screening procedures Surgical procedures Treatment of disease, disorder or injury	Regulation 15 HSCA (RA) Regulations 2014 Premises and equipment

Regulated activity	Regulation
Diagnostic and screening procedures Surgical procedures Treatment of disease, disorder or injury	Regulation 11 HSCA (RA) Regulations 2014 Need for consent

Regulated activity	Regulation
Diagnostic and screening procedures Surgical procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance

This section is primarily information for the provider

Enforcement actions

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
Diagnostic and screening procedures Surgical procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment We issued two fixed penalty notices on 29 July 2020 for failure to notify CQC as required under the Regulations 12 and 15 of the Care Quality Commission (Registration) Regulations 2009. These were paid by the provider on 13 August 2020 We issued a notice of proposal to cancel the registrations of the provider and registered manager on 25 August 2020. The provider submitted representations to appeal the notices on 22 September 2020. The representations were not upheld and a notice of decision to cancel the registration of both the provider and the registered manager was issued on 12 October 2020. The provider appealed to the first-tier tribunal in November 2020 against both notices, however, withdrew the appeal on 30 June 2021. Therefore, the notice of decision to cancel the registration of the provider and registered manager took effect on 12 July 2021