Staianoplasticsurgery Ltd

# Staianoplasticsurgery

## Inspection report

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## Overall summary

We carried out an announced comprehensive inspection on 15 February 2018 to ask the service the following key questions; Are services safe, effective, caring, responsive and well-led?

**Our findings were:**

**Are services safe?**

We found that this service was not providing safe care in accordance with the relevant regulations.

The impact of our concerns is minor for patients using the service, in terms of the quality and safety of clinical care. The likelihood of this occurring in the future is low once it has been put right.

**Are services effective?**

We found areas where the service was not providing effective care in accordance with the relevant regulations.

The impact of our concerns is minor for patients using the service, in terms of the quality and safety of clinical care. The likelihood of this occurring in the future is low once it has been put right

**Are services caring?**

We found that this service was providing caring services in accordance with the relevant regulations.

**Are services responsive?**

We found that this service was providing responsive care in accordance with the relevant regulations.

**Are services well-led?**

We found that this service was not providing well-led care in accordance with the relevant regulations. We have told the provider to take action (see full details of this action in the Requirement Notices at the end of this report).

The impact of our concerns is minor for patients using the service, in terms of the quality and safety of clinical care. The likelihood of this occurring in the future is low once it has been put right.

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the service was meeting the legal requirements and regulations associated with the Health and Social Care Act 2008.

**Our key findings were:**

- The systems to keep patients safe and safeguarded from abuse needed improving. We identified several areas including arrangements for child safeguarding, recruitment and ongoing staff checks, legionella, equipment, unforeseen medical emergencies and management of safety alerts that were not sufficiently well established.

# Summary of findings

- We found the premises appeared well maintained and visibly clean and tidy however, audits undertaken in relation to infection control were not sufficiently detailed to fully identify potential risks.
- Patient information was well documented and routinely audited to support the delivery of safe care and treatment.
- The provider had arrangements for the safe management of medicines.
- Incidents were used to support learning.
- The provider had established a good network within the private healthcare sector for advice and support if needed. We saw that the principal Consultant had undertaken training to update knowledge and also carried out training for others. However, the provider had not clearly identified core training needs of clinic staff and evidence of regular staff appraisals for all staff were limited.
- We found the provider had not adequately assessed the risks for the removal of lesions in the absence of routinely sending samples for histology.
- The provider monitored outcomes for patients in terms of satisfaction with the outcome of their surgery. Feedback was positive. Patient feedback through CQC comment cards and the provider's own surveys also showed patients were happy with the service received and that they felt involved in decisions about their care.
- There was limited evidence of clinical improvement activity such as clinical audit undertaken.
- The provider had effective systems for obtaining consent and patient information was well documented.
- Services were provided that were responsive to the needs of the population served. This included timely and flexible services.
- There was a complaints process in place and complaints seen were appropriately managed, although information about how to complain was not clearly displayed to patients.
- There was clear leadership to support the running of the service. Staff felt supported and worked well as a team. However, governance arrangements did not adequately identify and address all areas of risk.
- Following our inspection the provider sent an update of actions they were taking to address the issues identified during the inspection.

We identified regulations that were not being met and the provider must**:**

- Ensure effective systems and processes are established to ensure good governance in accordance with the fundamental standards of care.
- Ensure appropriate recruitment checks are in place for all staff employed and where relevant registration with professional bodies are routinely monitored.
- Ensure appropriate provision to ensure staff receive appropriate support, training, supervision and appraisals for the duties they are employed to perform.
- Ensure care and treatment is provided in a safe way to patients.

You can see full details of the regulations not being met at the end of this report.

There were areas where the provider could make improvements and should:

- Review safeguarding arrangements to ensure these are adequate to safeguard children who may come into contact with the service.

# Summary of findings

## The five questions we ask about services and what we found

We always ask the following five questions of services.

**Are services safe?**

We found that this service was not providing safe care in accordance with the relevant regulations.

We have told the provider to take action (see full details of this action in the Requirement Notices at the end of this report).

- We found areas where improvements must be made relating to the safe provision of treatment. Although the provider had some systems and processes in place to keep patients safe some of these were not always sufficiently effective or embedded. This included risks in relation to child safeguarding, recruitment and ongoing staff checks, legionella, unforeseen medical emergencies and the management of routine safety alerts.
- There were however effective systems in place for the management of vulnerable adults and staff demonstrated an understanding of these risks.
- We found the premises were mostly well managed, information to deliver safe care and treatment was available and for the safe management of medicines. Incidents were used to support learning.
- We found the premises were visibly clean and tidy, although audits undertaken were not sufficiently detailed to fully identify potential risks.

The impact of our concerns is minor for patients using the service, in terms of the quality and safety of clinical care. The likelihood of this occurring in the future is low once it has been put right.

**Are services effective?**

We found areas where the service was not providing effective care in accordance with the relevant regulations (see full details of this action in the Requirement Notices at the end of this report).

- The provider had established a good network within the private healthcare sector for advice and support if needed.
- The provider monitored outcomes for patients in terms of satisfaction with the outcome of their surgery. However, there was limited evidence of any clinical improvement activity such as clinical audit.
- We found the provider had not adequately assessed the risks for the removal of lesions in the absence of routinely sending samples for histology. The provider also did not have systems for monitoring results were returned for all issue samples taken.
- The provider had effective systems for obtaining consent.
- The provider had not clearly identified core training needs of staff and evidence of regular appraisals were limited.

The impact of our concerns is minor for patients using the service, in terms of the quality and safety of clinical care. The likelihood of this occurring in the future is low once it has been put right.

**Are services caring?**

We found that this service was providing caring services in accordance with the relevant regulations.

- Positive feedback was received from patients through the CQC comment cards and the providers own in-house patient satisfaction surveys. Patients described staff as helpful, friendly and caring.
- Patients were involved in decisions about their care and treatment. They were given time and opportunities to ask further questions.
- Staff respected and promoted patients' privacy and dignity.

# Summary of findings

**Are services responsive to people's needs?**

We found that this service was providing responsive care in accordance with the relevant regulations. We found one area where improvements should be made which related to the displaying of the complaints process so that it was easily accessed by patients if needed.

- The provider understood the needs of its patients, and provided flexibility with appointments.
- The provider had made reasonable adjustments to make the service accessible to all patients.
- The service had systems in place for handling complaints and concerns. These we saw were appropriately managed.

**Are services well-led?**

We found that this service was not providing well-led care in accordance with the relevant regulations. We have told the provider to take action (see full details of this action in the Requirement Notices at the end of this report).

- The provider had a clear vision to provide high quality care and staff were aware of this vision.
- There was clear leadership and governance arrangements which supported the running of the service however, governance arrangements did not adequately identify and address all areas of risk.
- There was a supportive culture and staff felt valued and able to raise issues or concerns if needed.
- Staff were supported by a range of policies and procedures that were reviewed regularly.
- Feedback from patients was sought to help drive improvement.

The impact of our concerns is minor for patients using the service, in terms of the quality and safety of clinical care. The likelihood of this occurring in the future is low once it has been put right.

# Staianoplasticsurgery

**Detailed findings**

## Background to this inspection

Staianoplasticsurgery registered with CQC in February 2014 to provide the regulated activities of diagnostic and screening procedures and surgical procedures. It is a private consulting clinic which predominantly carries out pre-surgery and post-operative consultations for patients considering and undergoing plastic surgery. The principal consultant specialises in breast and body contouring procedures. Post operative dressings and some minor procedures (under a local anaesthetic) are also carried out on site. Procedures requiring a general anaesthetic are carried out at various local private hospitals. The service is available to people over the age of 18 years.

The service is located in a converted house in Edgbaston, Birmingham that has been adapted to provide medical services. The service has established links with another consultant to see patients who live closer to London at a clinic in Harley Street under the Staianoplasticsurgery banner. However, no patients have yet been seen in London and the viability of this arrangement is under evaluation.

The service is open for appointments Monday, Tuesday, Thursday and Friday 9.30am to 4.30pm and on a Wednesday 9.30am to 7pm.

The principal consultant is the registered manager. A registered manager is a person who is registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have a legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated regulations about how the service is run.

Other staff who work at the clinic include a second consultant plastic surgeon, a nurse, a health care assistant, a clinic manager, a secretary, a front of house / administrator and IT support.

As part of our inspection we also asked for CQC comment cards to be completed by patients prior to our inspection. We received 29 completed comment cards where patients and members of the public shared their views and experiences of the service. Patients spoke highly of the service, they described staff as professional, helpful and friendly. They told us that they felt they felt listened to and would be happy to recommend the service to others.

The inspection was led by a CQC inspector who had access to advice from a specialist advisor (Consultant Plastic Surgeon).

Before visiting, we reviewed information we hold about the service such as any notifications, the provider information return and other information received.

During our visit we:

- Spoke with a range of clinical and non-clinical staff (including the principal consultant, the clinic manager and secretary).
- Reviewed how treatment was provided.
- Reviewed comment cards where patients and members of the public shared their views and experiences of the service.
- Reviewed documentation made available to us for the running of the service.

To get to the heart of patients' experiences of care and treatment, we always ask the following five questions:

- Is it safe?
- Is it effective?
- Is it caring?
- Is it responsive to people's needs?

# Detailed findings

- Is it well-led?

These questions therefore formed the framework for the areas we looked at during the inspection.

# Are services safe?

## Our findings

**Safety systems and processes**

The service had systems to keep patient safe and safeguarded from abuse but there were some areas where these needed to be improved.

- The provider had policies and procedures in place covering adult and child safeguarding to provide support and guidance to staff. The policies contained contact details for relevant agencies responsible for investigating safeguarding concerns. All staff had received training in safeguarding vulnerable adults however, only one doctor had undertaken child safeguarding or child protection level three training. The staff explained that they did not see or treat children or had come across any safeguarding issues but would raise these with a doctor if they had any concerns. Staff told us they worked closely with a psychologist who they would refer patients to if they were concerned about the vulnerability of a patient. Although the provider did not knowingly treat patients under the age of 18 years there were no systems and processes in place for verifying the patients identification or date of birth. Following the inspection the provider advised us that they had introduced a new policy and systems for checking identification and had sourced safeguarding training for staff.
- Notices were displayed which advised patients that chaperones were available if required. There was a chaperone policy in place. Staff who acted as a chaperone were trained to do so and had undergone a DBS check. (DBS
- The provider carried out staff checks prior to employment, however these were not consistently completed for all staff. We reviewed the personnel file for one new member of staff and found appropriate checks were in place. However we also reviewed files for three clinical members of staff and found gaps in those checks. The provider also did not have a system for checking professional registration was kept up to date where relevant.
- We looked at the systems to manage infection prevention and control. We observed the premises to be visibly clean and tidy. Cleaning was carried out by an external cleaning company. There were cleaning schedules and monitoring systems in place for the cleaning of the premises. Staff told us that equipment used for minor procedures carried out on the premises were all single use. Staff had access to a range of infection control policies and procedures. Personal protective equipment such as disposable gloves and aprons and spill kits for the cleaning of bodily fluids were available to staff. The service undertook monthly infection control audits however these were basic.
- We found the premises appeared well maintained and had arrangements in place for the safe removal of healthcare waste. Risk assessments were in place in relation to health and safety, fire and the control of substances hazardous to health (COSHH). We saw records in relation to the maintenance of fire equipment, weekly alarm checks and evacuation processes. COSHH safety sheets were available for products used and kept on the premises. The provider carried out routine flushing of water systems but this did not include taps situated on the top floor. No formal legionella risk assessment to identify potential risks and other action required to mitigate them had been undertaken. Following the inspection the provider advised us that they had contacted an external agency to arrange for a formal legionella risk assessment.
- Equipment, including clinical equipment appeared well maintained. We saw evidence of electrical safety testing that had been undertaken in the last 12 months. However, calibration checks were not undertaken for appropriate clinical equipment to ensure it was in good working order.

**Risks to patients**

There were systems to assess, monitor and manage risks to patient safety but there were some areas where these needed to be improved.

- Staff felt there were sufficient staff to enable them to deliver the service. Most of the staff worked part time and were happy to work flexibly. Holidays were planned in advance and staff avoided taking leave at the same time. Although staff had their own roles and responsibilities they were familiar with each other's roles to enable them to provide cover.
- There was an induction process for new staff tailored to their role. We saw a recent example which set out areas to be covered over a period of six weeks and sign off once completed.

# Are services safe?

- We saw evidence of professional indemnity arrangements in place.
- The provider had not undertaken adequate risk assessments to ensure effective arrangements to manage emergencies on the premises. The provider did not hold emergency equipment such as a defibrillator or oxygen at the premises. Emergency medicines consisted only for those used in the case of anaphylaxis during minor procedures. No risk assessments had been carried out to assess the need for emergency equipment or emergency medicines not routinely stocked. However, patients who attended the clinic came for elective surgery (non-urgent or emergency treatment). Staff told us that would call for an ambulance in the event of an emergency. We were unable to verify staff were up to date with basic life support training as no records were available.
- A first aid box was also kept on the premises.
- Patients who had undergone a procedure at the clinic were given written post-operative instructions with phone number to call in the out of hours.

**Information to deliver safe care and treatment**

Staff had the information they needed to deliver safe care and treatment to patients.

- Individual care records were written and managed in a way that kept patients safe. The care records we saw showed that information needed to deliver safe care and treatment was available to relevant staff in an accessible way.
- Patients were required to complete a form when they first attended which provided details of past medical history, medications, allergies and details of the patients usual GP.
- Patients received consultations and treatment with the same doctors which supported the continuity of care.
- The provider had systems for sharing information with staff and other agencies to enable them to deliver safe care and treatment. Information was routinely shared with the patients NHS GP. A patient could opt out of having their information shared with their GP but not if they decided to undergo treatment. There were protocols in place for sharing information with the psychologist with the patient's agreement.
- Patient information was stored electronically on a password protected remotely accessed system. Paper records were also available and these were stored securely in locked facilities. A risk assessment had been completed for the transfer of records between the clinic and hospital sites.

**Safe and appropriate use of medicines**

The provider had reliable systems for appropriate and safe handling of medicines.

- The provider maintained a limited stock of medicines on site. Medicines stocked were logged and monitored on a monthly basis to check they remained in date. These were kept securely.
- Patients medicines and allergies were checked prior to any care and treatmentand any medicines used were documented within the patients records. Any prescribing was carried out by the doctors only.
- There was evidence of actions taken to support antimicrobial stewardship. The provider advised us that microbiological samples were taken as appropriate when prescribing antibiotics. However there was no specific antibiotic prescribing policy for the clinic.
- The provider did not hold stocks of prescription stationery. Private prescriptions were sent directly to a local pharmacist if needed.

**Track record on safety**

The provider had some systems for monitoring safety in the service.

- There was a range of risk assessments in place in relation safety issues which underwent regularly reviewed. These covered most areas, although we identified some gaps such as risks associated with legionella and unforeseen medical emergencies.
- There were established processes in place for the management of incidents.

**Lessons learned and improvements made**

The provider learned and made improvements when things went wrong.

- Staff understood their duty to raise concerns and report incidents and near misses. There was a standard reporting form for this and systems for reviewing and investigating incidents.
- We saw that there had been three significant events reported and investigated in the last year. Lessons learnt were shared across the staff team at staff meetings and

action was taken to improve safety in the service. We saw one example where an unknown person had entered the premises. Following the incident staff told us that they had put in tighter security arrangements in place.

- Staff were aware of the requirements of the Duty of Candour and told us that a culture of openness and honesty was encouraged. However, they had not had any incidents where this had applied.
- The provider advised us that they had systems which enabled them to inform patients about information and alerts relevant to procedures they had undergone. The provider also made use of social media which it monitored to dismiss any myths or answer questions. The provider spoke about issues arising from breast implants which they shared with patients. However, the provider had not formally signed up or had formal processes to receive routine safety alerts such as those from the Medicines and Healthcare products Regulatory Authority (MHRA) and Central Alerting System (CAS).

# Are services effective?

(for example, treatment is effective)

## Our findings

**Effective needs assessment, care and treatment**

We discussed with the provider how they kept up to date and made use of evidence based guidance and standards. The provider advised us that they had a good network of clinicians they worked with at the private hospitals with allied specialties. If patients were unhappy with care or treatment they would offer a second opinion with another consultant.

There was a registration form which was completed by patients unknown to the service which enabled staff to obtain details about a patients past medical history, medicines and allergies to support care and treatment.

The provider was able to show us evidence of sepsis guidance. However we found the provider had not adequately assessed the risk in relation to the excision of skin lesions. Tissue samples were not routinely sent for histology. The provider also did not have systems for monitoring results were returned for all issue samples taken.

**Monitoring care and treatment**

The provider advised us that patient feedback was their main system for monitoring the service and improving outcomes for people. Feedback seen was very positive. For example in the provider's patient survey 91% (70 out of 77) patients said they were happy or very happy with the results of their surgery. The provider offered revisions of procedures if patients were not entirely satisfied with the outcome. The provider shared with us a report of complications and infections following procedures and how these had been managed.

There was little evidence of quality improvement including clinical audit. The provider carried out monthly audits of patient notes to check the completeness of information.

**Effective staffing**

We reviewed information available relating to staff having the skills, knowledge and experience to carry out effective care and treatment.

- Two doctors worked from this location. The principal consultant was a plastic surgeon who had previously worked in the NHS and now worked exclusively in the private sector. The second doctor worked as a consultant in the NHS and privately. Both had undertaken additional qualifications in plastic surgery. The provider had also established links with a plastic surgeon in London where patients could be seen under the Staiano Plastic Surgery banner.
- All staff had access to a range of on-line training. At the time of the inspection the provider had not clearly identified core training requirements or had effective systems for monitoring that staff were up to date with training. Only one member of the clinical team had undertaken child safeguarding training. The provider was also not able to demonstrate that any staff had received basic life support training.
- Training updates undertaken by clinical staff were not available at the clinic for us to view during our visit. However, following the inspection the principal consultant sent us evidence of training they had attended to keep up to date and training they had themselves provided to others.
- There was an induction process for new staff which included key areas that they needed to complete to carry out their role.
- We saw evidence to confirm that the two doctors working from the Birmingham clinic undertook annual appraisals. This is the mechanism by which doctors demonstrate their fitness to practice. For other staff we saw little evidence of regular appraisals. The only appraisal available was for a member of staff who had since left the service. We were advised that two of the staff were self-employed and others were either bank staff or only worked on an ad hoc basis. Staff we spoke to explained it was a small team and that they regularly spoke on an informal basis.

**Coordinating patient care and information sharing**

The provider worked together with other health and social care professionals to deliver effective care and treatment.

- The provider had clear protocols for referring patients to specialists or other services. The provider had established a network of specialists locally and within the private hospitals.
- The provider routinely shared information with the patients usual NHS GP. The patient was able to opt out of this if they just had a consultation but not if they decided to go ahead with a procedure.

# Are services effective?

## (for example, treatment is effective)

- Patients were also given opportunity to see a psychologist where appropriate with regard to their treatment.
- The provider had effective arrangements for following up patients who had undergone care and treatment. Patients received routine follow up appointments immediately following surgery but were never discharged from care and were able to return at any time for a free consultation.
- The provider had a policy in place for sending tissue samples taken at the clinic, to a private laboratory, but did not maintain any systems for monitoring samples sent to ensure they were not lost and returned in a timely manner.

**Supporting patients to live healthier lives**

The provider identified those who needed additional support as part of their care and treatment. Patients body mass index and smoking status was discussed during consultation. If patients needed support in relation to their health needs they would refer them back to their GP.

The provider advised us that the aim of what they did was to improve the wellbeing of patients through improving their self-esteem. They were able to give examples where they had advised and waited for patients to lose weight before surgery to help achieve a better result. Referrals were also made to a psychologist to provide additional support if needed.

Patients were provided with written aftercare advice following surgical procedures. These included contact details as to who to get in touch with should the patient have any concerns in and out of clinic hours.

**Consent to care and treatment**

The service obtained consent to care and treatment in line with legislation and guidance. The provider carried out only elective (non-urgent) procedures.

- The provider had systems for seeking consent for surgical procedures. For any major surgery the provider operated a two stage consent process. Patients received an initial consultation which enabled them to discuss the procedure. They were also given a minimum of two week cooling off process before signing a consent from. The provider encouraged patients to consult with them as many times as they wanted before making a final decision.
- The provider was able to give examples where surgery had not gone ahead as planned where it was considered not to be in the patients best interest and to allow further time for consideration.
- Information was clearly provided in advance to patients about the full cost of consultations and treatments before any decisions were made.
- The principal consultant demonstrated an understanding of the requirements of legislation when considering consent and decision making for patients who may lack mental capacity. They advised us that they would seek further information from the patients GP and if necessary a second opinion if they had concerns regarding capacity. There was a policy in place for best interest decisions.

# Are services caring?

## Our findings

**Kindness, respect and compassion**

Staff treated patients with kindness, respect and compassion.

- Our conversations with staff indicated that they were sensitive to patients' personal, cultural, social and religious needs.
- Patients received timely support and information. Patients were encouraged to consult as many times as needed before and after treatment and without obligation.
- Patients were able to request a chaperone during an examination and were made aware through notices displayed in the premises. This was usually undertaken by the nursing staff.

As part of the inspection we asked for CQC comment cards to be completed by patients prior to our inspection. We received 29 completed comment cards, all were positive. Patients were very complimentary about the service they had received and the way they were treated by staff. Patients described all staff as professional, friendly, helpful and caring and said that they put them at ease.

We also received positive feedback directly from 28 patients who had used the service through the CQC website and telephone number.

The provider continuously monitored patient satisfaction with the service through the use of surveys at set points in the patient journey. We looked at the results for the previous 12 months.

Following the initial consultation patients were invited to rate the service on as scale of one to ten as to whether they would be likely to recommend the service to a friend (with ten being the most likely). Of the 63 patients that responded 60 rated the experience as a 9 or 10.

Patient were also asked about their experience of the service two weeks following a surgical procedure, responses included:

- 99% (75 out of 76) patients said they found it easy or very easy to make contact and arrange a consultation with the service.
- 95% (72 out of 76) patients said they received a warm or very warm welcome at the clinic.
- 100% (77 out of 77) patients said they rated the treatment received at the clinic as good or excellent.

Patients were also able to leave individual comments which were very positive.

The last survey was undertaken six weeks following any procedure. A rating was made based on whether the feedback received was positive or negative. The rating for the last 12 months was five out of five stars.

**Involvement in decisions about care and treatment**

Staff helped patients be involved in decisions about their care.

- Feedback received from the patients through the completed CQC patient comment cards told us that clinical staff took the time to involve them in their care. Patients said that they did not feel rushed during their consultations and felt listened to. They were encouraged to ask questions and have further consultations if needed before making any decisions.
- We saw evidence from patient records that patients' needs, wishes and preferences were discussed as part of the consultation process.
- The provider made use of various formats to communicate with patients so that they could find out more about the procedures they interested in. This included written information that was available for patients to take away, information videos on the provider website and a social media forum which was monitored by the provider to ensure the correct information was being given. Patients were able to ask questions via the provider website or call the service.
- The provider would not go ahead with a procedure if they felt a patient was unsure and able to give examples of this.

The provider carried out ongoing patient surveys, results for the last 12 months showed:

- All of the 75 of patients (100%) who responded said they were given enough time and information during their first clinic appointment.
- 75 out of 76 patients (99%) who responded felt they were given enough support following their consultation.
- 73 out of the 77 patients (95%) who responded said they felt they received the right amount of support following discharge home.

**Privacy and Dignity**

# Are services caring?

Staff respected and promoted patients' privacy and dignity.

- Reception staff knew that if patients wanted to discuss sensitive issues or appeared distressed they could offer them a private room to discuss their needs.
- Privacy screens were provided in the treatment room to maintain patients' privacy and dignity during examinations, investigations and treatments.
- Patient information was held securely in locked facilities. Risk assessments had been completed when transporting information between sites.

# Are services responsive to people's needs?

(for example, to feedback?)

## Our findings

**Responding to and meeting people's needs**

The service organised and delivered services to meet patients' needs. It took account of patient needs and preferences.

- The provider understood the needs of their population and tailored services in response to those needs. Patients were given flexibility as to where they had their consultation and treatment. This was at either the clinic or a private hospital.
- Patients were able to contact the service for more information with no obligation to go ahead with treatment until they were confident it was what they wanted.
- The provider offered once a month free 15 minute consultations so people could find out more about the service.
- The provider had late evening opening each Wednesday for patients who may find it difficult attending during usual working hours. Patients could also obtain an evening appointment at a private hospital.
- Patients were able to access support from a psychologist to support them when considering cosmetic surgery.
- The provider told us that they did not discharge any patients from their care following a surgical procedure. Patients who had undergone treatment were able to return at any time in the future. The provider also maintained contact with patients (with their agreement) through social media and regular newsletters.
- The provider made reasonable adjustments when patients found it hard to access services. For example, the premises were accessible to patients with mobility difficulties. There was a buzzer at the entrance to alert staff if assistance was required and the service had a portable ramp for ease of entrance into the premises and disabled toilet facilities. There was a consulting room located on the ground floor. The minor operations room was located on the first floor so if patients were unable to use the stairs they would be offered an appointment at a private hospital for this.
- Patients requiring translation services would be seen at one of the private hospitals where the hospital would assist in arranging an interpreter.

**Timely access to the service**

Patients were able to access care and treatment from the service within an acceptable timescale for their needs. The service provided only elective surgery (non-urgent).

- The service was open for appointments between 9.15am and 4.30pm on Mondays, Tuesdays, Wednesdays and Fridays. On a Wednesday the service opened between 9.15am and 8pm. The clinic also opened on a Saturday on an ad hoc basis.
- The next appointments available for a new consultation were within two and three weeks depending on which consultant they saw.

The provider asked patients as part of their in-house survey how long they waited for their consultation. Of the 76 patients who responded over the last 12 months 64 (84%) said they waited between 0 and 15 minutes before seeing their consultant. No patients said they waited longer than 30 minutes.

**Listening and learning from concerns and complaints**

The provider took complaints and concerns seriously and had systems in place for responding to them.

- The provider had a complaints procedure in place. This detailed who to contact should the patient have a complaint and expected timescales for a response. The provider advised us that the complaints procedure was displayed in the waiting area however, it was not prominently displayed as we were unable to find it in the waiting room or on the website.
- Staff told us that they recorded and investigated verbal and written complaints and had received three complaints in the 12 months.
- We discussed these complaints and reviewed relevant documentation. We found that complaints were handled appropriately and within expected timescales.

# Are services well-led?

(for example, are they well-managed and do senior leaders listen, learn and take appropriate action?)

## Our findings

**Leadership capacity and capability;**

Leaders had the capacity and skills to deliver high quality, sustainable care.

- The service was led by the principal consultant supported by a small team which included a clinic manager and secretary.
- The leadership team was visible and approachable. They worked closely to provide compassionate and high quality care which was reflected in the positive feedback in relation to the service and outcomes from patients.
- Patient care and experience was given high priority.

**Vision and strategy**

The service had a vision for the future to deliver high quality care and promote good outcomes for patients.

- The provider discussed with us their vision for the service. How they wanted to develop a brand that provided high quality plastic surgery, to improve the customer journey and experience for patients undergoing these procedures.
- The vision and values for the service was displayed in the premises. They focused on the patient and providing them with the best experience. Staff were aware and understood these values and expected standards.
- The provider discussed the visions and values at their team meetings and identified areas for improvement.

**Culture**

The service had a culture of high-quality sustainable care however, we identified some areas for improvement.

- Staff we spoke with felt respected, supported and valued. They told us that it was a small team that worked well together and regularly communicated.
- The service focussed on the needs and wishes of patients when delivering the service.
- Our conversations with staff indicated that behaviour and performance of staff was consistent with their vision and values.
- Staff demonstrated an openness and honesty during our inspection. When handling complaints patients were offered the option of a second opinion as appropriate. The provider was aware of and had systems to ensure compliance with the requirements of duty of candour.
- There was an emphasis on the safety of staff. The provider had various policies in place to support staff including non-harassment, lone working and whistle blowing policies. Action was taken to improve staff safety following reported incidents.
- However, formal opportunities for appraisal and to discuss learning and development needs were not well embedded. Information made available to us relating to staff training did not enable us to verify what core training staff were expected to complete and whether they were up to date.

**Governance arrangements**

There were clear responsibilities, roles and systems of accountability to support the governance and management of the service.

- Staff we spoke with told us that they felt clear about their roles and responsibilities. They knew their areas but were able to overlap to support other members of staff and ensure the continuity of the service if needed. Staff had personal job specifications.
- The service held staff meetings to discuss matters arising. Staff told us that they had weekly informal meetings to discuss the outcomes of patients who had recently undergone a procedure, these meetings were not documented. Staff also told us they held quarterly staff meetings, however minutes provided did not indicate these occurred frequently. The latest minutes shared with us were for March 2017 and focussed on the business side of the organisation.
- The provider had established policies and procedures to support the safety of the service. These were regularly reviewed to ensure they remained up to date and were accessible to all staff.

**Managing risks, issues and performance**

Processes for managing risks, issues and performance were not consistently well implemented.

- We found areas where risks relating to patient safety had been well managed however we also found some areas where improvement was needed. For example,

# Are services well-led?

## (for example, are they well-managed and do senior leaders listen, learn and take appropriate action?)

child safeguarding, recruitment and ongoing staff checks, legionella, equipment, unforeseen medical emergencies, management of safety alerts and for monitoring infection prevention and control.
- Performance was monitored in relation to individual patient outcomes following procedures combined with the views of patients.
- The principal consultant had oversight of incidents and complaints.
- There was some evidence of improvement activity to support improvements in the quality of care but this was limited to patient feedback and audit of patient notes.
- The provider had in place systems for business continuity in the event of unforeseen disruptions to services.
- We found the provider receptive to feedback following the inspection and were starting to make changes for example, in relation to the process for reviewing patient identification and child safeguarding.

**Appropriate and accurate information**

The provider acted on appropriate and accurate information.

- Records seen contained appropriate information to support care and treatment. The provider undertook notes audit to check important information was recorded.
- Patient outcomes following procedures were routinely collected and monitored by the principal consultant.
- Patient information was held securely.
- We found documents maintained by the service were tidy and organised.

**Engagement with patients, the public, staff and external partners**

The provider involved patients, staff and external partners to support high quality sustainable services.

- The provider sought ongoing feedback from patients about the service provided. This was used to monitor patient satisfaction and identify areas for improvement. Feedback about the service was very positive. Examples were given by staff about changes made as a result of patient feedback. This included changes to the way in which the clinic was announced on the telephone so that it was not obvious to others that it was a plastic surgery clinic.
- The service worked closely with external stakeholders where appropriate to ensure patients received care they needed and a positive experience. This included a local psychologist and private hospitals.
- Staff told us that as a small team they spoke regularly and were able to provide feedback if needed although could not recall any specific examples where this may have led to changes.

**Continuous improvement and innovation**

We asked the provider about systems and processes for learning, continuous improvement and innovation.

- Staff told us that they focused on ensuring patients felt well cared for throughout their experience. They used various systems for communicating with patients to ensure patients received accurate information, including social media sites and newsletters. Patients were able to opt out of this if they wanted. The provider introduced a buddy systems for patients thinking of having surgery, with agreement from both parties contact details were shared. This enabled patients to speak to someone who had received the procedure they were considering. Patients were able to attend as many consultations needed before making a decision. They were never discharged from care and could always come back at any time following a procedure for a free consultation.

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<br>Surgical procedures | Regulation 17 HSCA (RA) Regulations 2014 Good governance<br>**How the regulation was not being met:**<br>The registered person had systems or processes in place that operating ineffectively in that they failed to enable the registered person to assess, monitor and mitigate the risks relating to the health, safety and welfare of service users and others who may be at risk. In particular:<br>• There were insufficient processes in place to for checking the age and identity of patients.<br>• Risks relating to legionella had not been appropriately assessed.<br>• Clinical equipment had not undergone routine calibration checks.<br>• Effective systems for receiving, reviewing and acting on safety alerts (such as those from the Medicines and Healthcare Products Regulatory Agency and Central Alerting System) were not in place.<br>• Infection control audits were not sufficiently effective to fully identify potential risks.<br>• No risk assessment had been undertaken in the absence of routinely sending tissue samples for histology or systems for monitoring results had been returned for all samples taken.<br>• There was limited evidence of any clinical improvement activity such as clinical audit.<br>• The complaints process was not clearly displayed.<br>This was in breach of regulation 17(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. |

| Regulated activity | Regulation |
|---|---|
| Diagnostic and screening procedures<br>Surgical procedures | Regulation 19 HSCA (RA) Regulations 2014 Fit and proper persons employed |

This section is primarily information for the provider

# Requirement notices

**How the regulation was not being met:**

The registered person had not ensured that all the information specified in Schedule 3 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 was available for each person employed.

In particular: gaps and inconsistencies in approach for checking staff.

- There was an inconsistent approach for undertaking recruitment staff checks.
- No information was available for one consultant.
- Gaps in the provision of information such as proof of identity and conduct in previous employment for example, references.
- Disclosure and Barring Service (DBS) check was from previous employment and not current at the time of recruitment to this service.

This was in breach of regulation 19(3) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

| Regulated activity | Regulation |
| --- | --- |
| Diagnostic and screening procedures<br>Surgical procedures | Regulation 18 HSCA (RA) Regulations 2014 Staffing<br>**How the regulation was not being met:**<br>The service provider had failed to ensure that persons employed in the provision of a regulated activity received such appropriate support, training, professional development, supervision and appraisal as was necessary to enable them to carry out the duties they were employed to perform.<br>In particular:<br>• The provider had not clearly identified core training required for staff.<br>• Training records did not demonstrate staff were up to date training such as basic life support and child safeguarding. |

This section is primarily information for the provider

# Requirement notices

- Appraisals seen did not demonstrate an effective process for identifying and actioning staff learning and development needs.

The service provider had failed to ensure that persons employed who are registered with a health care or social care regulator, were enabled to provide evidence to the regulator in question demonstrating, where it is possible to do so, that they continued to meet the professional standards which are a condition of their ability to practise or a requirement of their role.

In particular:

- The service did not have systems in place for monitoring and demonstrating that, where relevant, staff registration with relevant professional bodies was up to date.

This was in breach of regulation 18(2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

| Regulated activity | Regulation |
| --- | --- |
| Diagnostic and screening procedures<br>Surgical procedures | Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment<br>**How the regulation was not being met:** |

Assessments of the risks to the health and safety of service users of receiving care or treatment were not being carried out. In particular:

- Risk in relation to unforeseen medical emergencies had not been assessed in the absence of equipment and emergency medicines and mitigated against.

This was in breach of regulation 12(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.