On the face of it

A review of the organisational structures surrounding the practice of cosmetic surgery

NCEPOD

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A report by the National Confidential Enquiry into Patient Outcome and Death (2010)

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Contents

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Foreword

There is nothing wrong with cosmetic surgery. People are and should be as free to pay for surgical treatment for what they see as physical imperfections or the less attractive consequences of ageing as they should be free to seek treatment of pain or significant disease. Much of it may have little to do with the treatment of illness, but it is a service that meets a need that people experience. Awareness of this point has developed in the 20 years since some citizens of Oregon provoked a public outcry by choosing cosmetic breast surgery before treatment of open thigh fracture when they were consulted in an attempt to create a transparent set of healthcare priorities.[1]

However, we should recognise that those who meet this need are responding to a distinctive demand that poses its own problems because the tolerance of physical imperfections is subjective. Furthermore, because a large proportion of cosmetic surgery is not available on the NHS, commercial interests hold a decisive sway. Most other private practice is a supplement to NHS practice, carried out in their spare time by surgeons doing operations that they have been trained to do in the NHS. This means that the regulation of this pattern of care raises different problems from many other aspects of medicine.

NCEPOD usually studies a cohort of cases looking for events that show room for improvement in the views of our specialist advisors. We always include criticisms of organisational factors where these are relevant; however this study is unusual in being concerned entirely with organisational matters. We have not studied individual cases nor criticised what has happened to a single patient. We have not considered the extent of complications, plainly unacceptable results or patients who are dissatisfied by results that their surgeons deem to be acceptable. This report describes the facilities and methods that the clinics bring to their work. The yardsticks against which the authors have measured their findings are in most instances objective published data and since this published data must also be available to most of those who work in the sites studied, the extent of the room for improvement that has been identified is remarkable.

The description of the data returns in Chapter 1 warns the reader of the choppy waters that lie ahead. Ignore the 212 sites that usually participate in our work and concentrate on the 619 that do not: 11.5%, that is 71 of them are clinics that had ceased to exist between being identified and being approached. Of the remaining 548, 68% (371) either did not answer or refused to take part. This suggests that they are unaware of their obligation to take part in the work of the confidential enquiries or take an nonchalant attitude to such obligations.

In other reports low participation rates may be understood in the context of the difficulty of finding and copying bulky sets of clinical notes. Neither applies here. Of particular concern to NCEPOD is whether the 32% who responded are likely to be more conscientiously organised than their less co-operative peers. As with previous studies, one wonders whether this report may give a misleadingly reassuring impression of what is really happening in this market place. If so, it only adds force to the findings and recommendations of the authors.

When we come to the meat of the Study, I think the fundamental weakness of the pattern of care that is described seems to be that it is often far too dispersed and disorganised. Throughout medicine it is now becoming a commonly accepted dogma that performing procedures occasionally is unacceptable practice. Cardiac surgeons were the first to learn painfully in the wake of the Bristol scandal of the '90's that small centres are not beautiful. Since then most other specialties have introduced criteria that acknowledge the same point. For example, in *Scoping our Practice* (2004), NCEPOD

reported that performing 20 procedures a year was insufficient to maintain an individual's endoscopy skills. In those areas of medicine where the results of inadequate skill are less starkly evident we have learned the same lessons, albeit more slowly.

Yet, in cosmetic surgery we find numerous teams who are apparently prepared to "*have a go*" at procedures that they rarely perform. Unsurprisingly but worryingly, it is the more difficult procedures that are undertaken most rarely. Thus, we find from Table19 on page 28 that there are 31 places doing the relatively common and straightforward breast augmentations who do them less than 10 times a year. This is occasional surgery by any standards. Yet more troublingly, when we look at breast reduction, which is relatively complex surgery, 79% of centres undertaking it do so on less than 20 occasions a year. There are 84 centres doing between 1 and 10 breast reductions in a year. No doubt some of the Consultants are working in the private sector in their spare time, so that one member of the team may be doing these procedures more regularly in the NHS; however it is not clear where there are any controls. Who in the private clinic knows what the surgeons are doing elsewhere? One wonders how the team as a whole can maintain their skills to undertake these procedures and what they are doing the rest of the time.

The second casualty seems to be safety. As a consequence of this disparate provision our authors found an alarming lack of equipment available in theatre,[2] in proper recovery facilities,[3] in HDU facilities[4] and in out of hours surgical cover.[5] In small centres the unit cost of providing this sort of back-up becomes prohibitively expensive.

Another casualty seems to be surgical training. It is available in only 16% of these sites (page 31). In one sense this may be just as well: what sort of training can be offered in a centre that performs most of its procedures less than once a month? However, there is also no doubt that if this work were concentrated in fewer centres where there was a proper throughput of work, we could expect to see an improvement in training as well as regulation and surgical competence. As the definition of an NHS hospital becomes looser, the obligation on the private sector to pull its weight in training is likely to become more intense. This shoe is pinching here first because it is only in the private sector that procedure-specific training can be provided where procedures are not carried out in NHS hospitals.

A third issue is patient selection. The patrons of these premises include a proportion of patients who may have unrealistic aspirations and more deep-seated problems. So it is dispiriting to see that the majority of places do not include a psychological assessment as part of the routine initial consultation,[6] and where a psychological assessment is carried out, at only 4% of sites is it normal for a patient to see a Clinical Psychologist.[7]

What is to be done?

It is trite to say that the first line of protection must be the patients themselves. In seeking out this sort of treatment they are asserting the personal right with which I began. In doing so patients should interrogate their surgeons and their teams and we hope this report may help them to identify the questions they need to ask. I suggest that if the glossy brochures do not condescend to the detailed description of issues identified by our authors, patients should be encouraged by this report to ask and I draw attention to the list of questions our authors have prepared which are available on our website. If the team are shy about saying how often the procedure being contemplated is done by the surgeon at the centre, or there is not readily available detailed information about the recovery arrangements, resuscitation facilities and out of hours cover, then a patient may be in the wrong place. This report may also encourage patients to consult their general practitioners before approaching such a specialist.

Yet we must acknowledge that the essence of modern regulation is to protect those who are too trusting and fail to ask questions. A consumer of medical services should not have to be an auditor. Just as we do not demand to

check the hygiene in the kitchen and fridges before we sit down to eat in a strange restaurant, patients are entitled to suppose that clinics offering surgery in the High Street are properly regulated by those who are paid to do so. Thus the patients' common sense must here be fortified by an enhanced role for the regulators.

This is not a report that demands the expenditure of money or primary legislation by central government, in the first instance at least. The remedy for these problems lies principally in the hands of the clinics and the profession and those who regulate them both.

First and foremost this report reveals a challenge for the Care Quality Commission (CQC). This part of the CQC's inheritance has here been identified as a problematic cottage industry pattern of laissez-faire provision. The CQC should insist that those it regulates are properly equipped and adhere to appropriate standards.

The GMC should give clearer guidance to doctors as to their responsibilities when caring for a cohort of patients, some of whom may be acting unwisely. Doctors performing these procedures should have procedure-specific training and the professional regulator should insist that they adhere to a code of conduct that is responsive to the particular needs of their patients and the environment in which they work. The GMC book *"Consent: Patients and Doctors Making Decisions Together"* contains guidance about patients who lack legal capacity, but not about those who may be acting unwisely in seeking treatment that may not be in their best interest. Such guidance in defining the characteristics of the acceptable would be invaluable to doctors as well as patients. Good doctors benefit from guidance on which they can rely to demarcate the limits of what is appropriate, when it is not always obvious.

In the meantime I hope this report will empower patients by putting in their hands the information that will enable them to make more informed choices about where and to whom they should entrust themselves.

On behalf of NCEPOD I am grateful to those who have made this study possible. The expert group who advised NCEPOD on what to assess and the questions to ask included a number of senior insiders. We had two distinguished Consultant Plastic Surgeons, Chris Khoo and Mark Henley; also there were four senior managers: Sally Taber, the Director of the Independent Healthcare Advisory Services; Jacqueline Cuming, from the Harley Medical Group; Jackie Row from Aspen Healthcare and James Partridge, the Chief Executive of Changing Faces. Douglas Justins who is an NCEPOD Trustee as well as being a senior anaesthetist also helped to devise the study. Martin Utley from the Clinical Operational Research Unit at UCL, who is also a member of our Steering Group kept them all on the mathematically straight and narrow.

The nine researchers who did most of the work in collecting material were led by Hannah Shotton and Kathryn Kelly who were also authors with two of our Clinical Co-ordinators, Alex Goodwin and Ian Martin. The contents of the report were carefully considered and discussed by the whole Steering Group of our stakeholders at our meeting in February and since then drafts of the report have been circulated and reviewed by all involved on at least two further occasions. We believe it is this methodology of guidance by knowledgeable insiders and comment from a broad group of questioning professionals that make our studies robust.

Bertie Leigh
Chair of NCEPOD

1. Klein Rudolf: On the Oregon Trail 1991; BMJ 302;1-2,
2. see table 33 page 39, 3. see table 36 page 41
4. see table 39 page 42, 5. see table 24 page 32
6. see table 14 page 22, 7. see figure 3 page 23

Key Findings

- Many cosmetic surgery sites are offering a menu of procedures some of which were only performed infrequently
- All the sites returning a questionnaire were either registered with the Care Quality Commission (or equivalent regulatory body in the devolved administrations) or were not required to be under current regulations
- 348/361 (96%) sites indicated that patient outcomes were monitored
- Routine psychological evaluation prior to cosmetic surgery was carried out in 119/335 (35%) of sites, and in only 4/100 (4%) of those sites were assessments routinely performed by a clinical psychologist
- A two-stage (deferred) consent process was not performed in 91/282 (32%) of sites
- 46/138 (33%) of independent hospitals with inpatient beds providing cosmetic surgery did not have a cosmetic surgery consultant rota for anaesthesia
- 67/220 (30%) of sites performing cosmetic surgery did not have a Level 2 care unit
- Only 101/228 (44%) of operating theatres were fully equipped to undertake cosmetic surgery
- 39/216 (18%) of sites performing cosmetic surgery had no emergency re-admission policy

Recommendations

- Regulatory bodies, such as the Care Quality Commission, should more closely monitor the adherence to national requirements for audit and scrutiny of sites under licence. The scope of regulation should include all sites including those only undertaking consultation.
- National professional cosmetic surgery bodies should issue guidelines as to the training, level of knowledge and experience required for a cosmetic surgeon to achieve and maintain competence in the procedures which he or she undertakes.
- Those considering having cosmetic surgery should be advised to check Care Quality Commission registration of any site they attend.
- Guidelines for the equipping of theatres and the peri-operative monitoring of patients must be followed.
- Good practice demands a two-stage consent process for those undergoing cosmetic surgery.
- A national cosmetic surgery outcome database should be considered.
- More formal training programmes must become established, and like any other surgical training, these should be subject to rigorous assessment of competence, which should lead to a certificate attesting to the surgeon's level of competence in specified procedures. The present reliance on inclusion on the specialist register does not give any assurance that a surgeon has received adequate training in cosmetic surgery.
- Cosmetic surgical practice should be subject to the same level of regulation as any other branch of surgery.
- Independent health care providers should only allow practising privileges to those cosmetic surgeons who can demonstrate that they have achieved and are able to maintain competence in the procedures which they offer.
- Defence organisations might consider whether it is appropriate to indemnify practitioners who are unable to demonstrate the attainment and maintenance of appropriate levels of competence for the procedures which they perform.
- Psychological assessment is an important part of any patient's cosmetic surgery episode and should be routine. This part of a patient's care must be delivered by those adequately trained and reliable psychological assessment tools need to be developed.
- Regulation should be introduced to prevent the use of financial inducements to influence the process of informed consent.

Introduction

The remit of NCEPOD covers not only practice within the NHS but also within the independent sector. Cosmetic surgery is perhaps the most controversial area of independent practice and certainly one which is a major growth "industry". Cosmetic surgery has become more available, socially acceptable and financially achievable for a wider cross section of society. In 2008 the British Association of Aesthetic Plastic Surgeons (BAAPS) reported a 275% increase in breast augmentation operations since 2002.[1] Cosmetic surgery differs in one major respect from other types of surgery in that it is undertaken as a life style choice as opposed to surgery to cure or ameliorate a disease. Furthermore, patients are effectively entering into a contract by paying a surgeon to produce an agreed result, be that the shape of the nose or the size of the breasts they desire, or to combat the perceived undesirable effects of ageing.

There is a lack of a definition of cosmetic surgery which adds to the misinformation and confusion surrounding the practice. The term is often used interchangeably with 'plastic surgery' or 'aesthetic surgery'.

The lack of definition in part stems from the fact that it is not an official surgical specialty in its own right, but involves practitioners of plastic surgery, oral and maxillofacial surgery, ENT, ophthalmology and dermatology among others. The lack of defined specialisation in this country has implications for ensuring that surgical procedures are carried out by appropriately qualified surgeons. According to The Care Standards Act, 2000[2] practitioners performing cosmetic surgical procedures in the independent sector must have undergone basic medical training and (those registered after 2002) must be on the specialist register of the GMC. However, the lack of a cosmetic surgery specialty makes regulation difficult.

According to The Care Standards Act, all independent clinics and hospitals that provide cosmetic surgery in England must be registered and inspected by the CQC. In Wales they must register with the Healthcare Inspectorate of Wales (HIW) and in Northern Ireland, with the Registration and Quality Improvement Authority (RQIA).[2]

In 2004, the Healthcare Commission (now the CQC) carried out an extensive review of the provision, safety and quality of cosmetic surgery practice in England and presented the findings to the Chief Medical Officer in the 2005 report "*Provision of cosmetic surgery in England: Report for the Chief Medical Officer Sir Liam Donaldson*".[3] In the same year, the Department of Health took the Healthcare Commission report into consideration and published "*Expert Group Report on the Regulation of Cosmetic Surgery to the Chief Medical Officer*".[4] These two studies reviewed regulated cosmetic procedures as well as reviewing staff training and development, consumer information, patient records and clinical audit.

Both reports indicated a need for better information and regulation of the practice of cosmetic surgery and several recommendations were made to the government. Since their publication there has been a review of the national minimum standards[5] as well as the publication of guidelines for good medical practice in cosmetic surgery, by the Independent Healthcare Advisory Services, in 2006.[6] The NHS Modernisation Agency also looked at plastic, reconstructive and aesthetic surgery within the NHS and provided recommendations for good practice, which involved a more coordinated approach

to delivery of optimum service within a local stakeholder commissioning group framework.[7]

In this study NCEPOD aimed to investigate key areas of variation in the practice of cosmetic surgery in the NHS and the independent sector. The study has reviewed basic information regarding structure, function and locations of cosmetic practice. This report does not include those aesthetic or cosmetic procedures undertaken to manage disease processes. NCEPOD considers this study to be a first step in identifying the variations in organisation and practice of cosmetic surgery.

1 – Method and Data returns

Study aim

The aim of this study was to investigate variations in organisational structures surrounding the practice of cosmetic surgery in England, Scotland, Wales, Northern Ireland and the Offshore Islands.

Four areas were studied, in order to obtain baseline information which should help inform and direct subsequent more detailed investigation of practice. These areas were:

1 Advertising, consent and patient information
2 The structure and case mix of teams providing cosmetic surgery
3 Postoperative follow up, policies, facilities and protocols
4 Patient records and clinical audit

Definition of cosmetic surgery
Cosmetic surgery was defined for the purpose of this study as:
"Operations that revise or change the appearance, colour, texture, structure or position of the bodily features to achieve what patients perceive to be more desirable"[8]

Expert group

A multidisciplinary expert group, representing professional cosmetic surgery providers and the Industry, contributed to the design of the questionnaire and reviewed the results of the analysis of the data returned. This composition of the Expert group is outlined on page 3.

Pilot study

A pilot study was performed to test the questionnaire for clarity and validity. Twenty four sites were contacted (seven independent hospitals, Fourteen clinics and three NHS hospitals). Six questionnaires were returned and following this the questionnaire was finalised.

Main study

Site identification
All sites identified in England, Wales, Northern Ireland, the Isle of Man and the Channel Islands that perform cosmetic surgical procedures or carry out consultations for cosmetic surgery were included in the study. Additionally, for this study, independent hospitals and clinics in Scotland were included with the agreement of the Scottish Audit for Surgical Mortality (SASM).

Data acquisition

A questionnaire was sent to the following sites in which cosmetic surgery was performed or organised:

1 Independent sector hospitals in England, Wales and Northern Ireland
2 NHS hospitals in England, Wales and Northern Ireland
3 Independent sector hospitals in Scotland
4 Members of BAAPS who see patients at sites other than hospitals already covered
5 IHAS members: National multi-site providers of cosmetic surgery
6 Independent hospitals, clinics and non-surgical cosmetic treatment centres registered with the CQC, The Health Inspectorate of Wales (HIW) or The Regulation and Quality Improvement Authority of Northern Ireland (RQIA)
7 Clinics and treatment centres listed on Yell.com and other web listings listed as providers of cosmetic surgery (see Appendix 2 for the complete list)

Sites were excluded if they were found to be non-cosmetic sites, non-surgical sites or sites providing only reconstructive surgery as part of the management of disease processes. As this study was at the organisational level, data were collected from each individual site (a site being administratively and/or geographically separate from all others). Therefore, each individual clinic belonging to a large multi-site provider was treated separately. Likewise, to avoid repetition of organisational data, data from cosmetic surgeons were only included if they carried out consultations at a site separate to the hospital where the surgery was performed and they were only questioned on the consultation aspects of their practice.

On the basis of anecdotal evidence that cosmetic surgery was being carried out in some general practice (GP) surgeries, data collection was attemped from this group. However, having approached individual primary care trusts and the Royal College of General Practitioners (RCGP) it became clear that obtaining email addresses of UK GPs, in order to carry out an initial mailing would not be possible. Therefore GP sites were only included if they were listed on the CQC register for independent health care providers or if they advertised cosmetic surgical procedures in the included web listings.

During the full study 1093 questionnaires were sent out to cosmetic surgery sites between July and September 2009. Reminder letters were sent after six weeks then again a further four weeks later and a final reminder in December on behalf of NCEPOD and the study expert group members. Study researchers also carried out telephone and email chasing of questionnaires with the final deadline for return being the 15th January 2010.

Data analysis

The data from the questionnaire were electronically scanned into a preset database. Prior to analysis, the data were cleaned to ensure that there were no duplicate records and that erroneous data had not been entered during scanning. Fields containing spurious data that could not be validated were removed.

Following cleaning, the data were analysed using descriptive statistics using Microsoft Excel. The results were reviewed by the study Expert Group and the NCEPOD Steering Group prior to publication.

Data returns

Of the 1093 questionnaires sent out, 291 were sent to sites which already participate in the work of NCEPOD (NHS and independent hospitals). Seventy nine of these sites were excluded as they undertook reconstructive surgery only, leaving 212 sites. Of these 185 (87%) returned questionnaires and 26 failed to return their questionnaires. One questionnaire was sent but did not arrive.

A further 802 sites were identified which did not participate in the core work of NCEPOD. Sites were excluded if they were non-surgical cosmetic (69), non-cosmetic (82), other e.g. duplication (31) or reconstructive (1). Therefore 619 sites were assumed to be eligible to participate. Of these, further verification confirmed that 71 sites no longer existed, leaving 548 currently practicing. Of these sites 176 (32%) returned their questionnaires, 13 refused to complete the questionnaire and 358 failed to answer and return the questionnaire despite repeated reminders. Overall, 361/760 sites returned questionnaires (see figure 1). With 11.5% of companies listed but no longer trading, there appeared to be a substantial turn-over of companies providing cosmetic surgery.

The Care Standards Act and IHAS: Good Medical Practice in Cosmetic Surgery/Procedures, requires all independent practitioners, clinics and hospitals to be registered with the CQC.[2,6] Part of this registration requires that the sites participate in national audit which includes the work of the National Confidential Enquiries.[9] While the requirement to complete the questionnaire was made clear, there was substantial difficulty in obtaining data from sites unfamiliar with NCEPOD. This may simply reflect a lack of familiarity or could be interpreted as a general unwillingness to participate in self review. Audit, be it personal, local or national is an integral part of maintaining high standards of patient care. This raises concern for those sites that were unwilling to participate. All patients should enquire as to the CQC registration and last inspection of the site they are considering attending. The CQC needs to ensure that all licensed sites demonstrate participation in national audit.

The HIW and RQIA appeared to have similar arrangements for registration of independent providers of cosmetic surgery as the CQC in England,[10,11] however in Scotland, it appeared that currently only independent hospitals are obliged to register with the Scottish Commission for the Regulation of care.[12] Small clinics are not required to be registered even if they carry out cosmetic surgery on site.

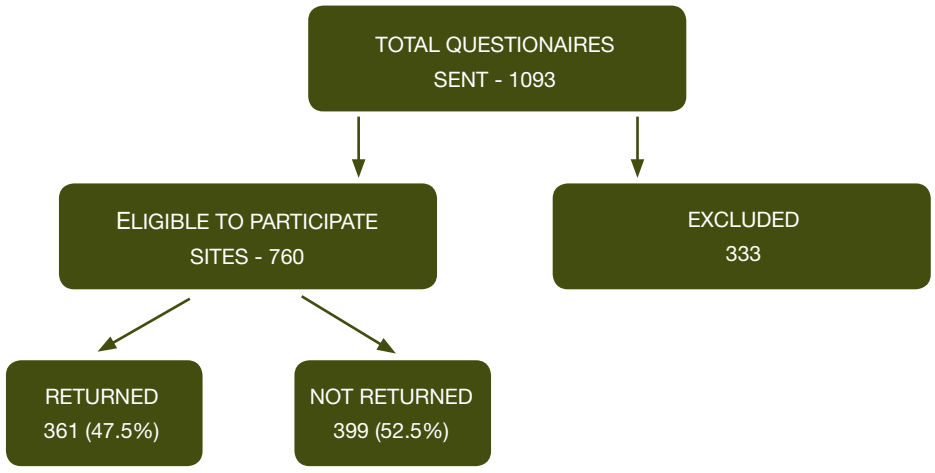

Figure 1. Data returns

The denominator changes throughout this report. This is because there are sites which have a differing level of involvement in the care of cosmetic surgery patients and which completed different sections of the questionnaire. There are sites that act as an initial point of contact for prospective patients, brokering services that have no further involvement in the patient pathway. There are sites where only initial consultations are performed but no surgery is carried out on site. There are sites that only carry out surgery and sites that are involved with every step of the patient pathway. The total number of sites that returned questionnaires was 361 of which 350 sites acted as the initial point of contact for patients. Of these 344 sites carried out initial consultations and 228 sites carried out cosmetic surgery on site.

Description of sites participating

The type of site from which a questionnaire was returned is shown in Table 1.

Table 1. Type of site that returned a questionnaire

Description of site	Total	%
Independent Hospital - in patient	**159**	44.0
Non-surgical Treatment Centre	**100**	27.7
NHS Hospital	**37**	10.2
Cosmetic Surgeon	**21**	5.8
Other	**14**	3.9
Independent Hospital - out patient	**12**	3.3
Small clinic (<3 clinicians)	**8**	2.2
Referral Service (abroad)	**4**	1.1
Referral Service (UK)	**3**	<1
Clinic (>3 clinicians)	**2**	<1
GP	**1**	<1
Total	**361**	

Of those included 324/361 sites providing cosmetic surgery lie outside the National Health Service. The structure of the cosmetic surgery industry is complicated. There are several different types of provider of cosmetic surgery who are responsible for different parts of the patient pathway, which may add to the difficulty in regulation and determining who has ultimate responsibility for the patient's welfare. The majority of sites returning questionnaires were independent hospitals in patient (IP) and out patient/day-case (OP), most of which who oversee the patient throughout the whole process from the initial consultation to the postoperative follow-up appointment, allowing a degree of continuity. Questionnaires were received from 100 non-surgical treatment centres that only perform non-surgical cosmetic treatments on site, but where consultations for cosmetic surgery take place. A further 37 questionnaires were received from NHS hospitals that carry out a small number of cosmetic surgical procedures for reasons other than to correct a pathology or for reconstructive purposes. Questionnaires were received from 21 independent surgeons who see patients at sites other than hospitals already covered. Large (>3 clinicians employed) and small (<3 clinicians employed) independent clinics made up a smaller proportion of the sample (large clinics = 2/361, small clinics = 8/361) as did the brokers for UK (3/361) and abroad (4/361). One questionnaire was returned from a GP surgery. The description of 14 'other' sites did not come under any of the categories listed on the questionnaire. These identified themselves as: Private patient facility within NHS hospital (six), a group of surgeons practicing in more than one hospital (two), non-cosmetic surgeon (one) ambulatory surgical/ diagnostic unit (two) independent sector treatment centre (ISTC) carrying out consultations and day case surgery for some procedures on site but other procedures elsewhere (three).

Registration with a Regulatory Body

All sites carrying out cosmetic surgery should be registered with CQC.[9] (Table 2)

Table 2. Type of site registered with the CQC

	Registered with the CQC							
Description of site	**Yes**	%	**No**	%	**Subtotal**	NA	Unanswered	**Total**
Independent Hospital - in patient	**152**	98.7	**2**	1.3	**154**	3	2	**159**
Non-surgical Treatment Centre	**87**	87.9	**12**	12.1	**99**	1	0	**100**
NHS Hospital	**25**	89.3	**3**	10.7	**28**	4	5	**37**
Individual Cosmetic Surgeon	**10**	66.7	**5**	33.3	**15**	6	0	**21**
Other	**8**	80.0	**2**	20.0	**10**	3	1	**14**
Independent Hospital - out patient	**12**	100.0	**0**	0.0	**12**	0	0	**12**
Small Clinic (<3 clinicians)	**8**	100.0	**0**	0.0	**8**	0	0	**8**
Referral Service (abroad)	**0**	0.0	**1**	100.0	**1**	2	1	**4**
Referral Service (UK)	**0**	0.0	**0**	0.0	**0**	3	0	**3**
Clinic (>3 clinicians)	**2**	100.0	**0**	0.0	**2**	0	0	**2**
GP	**1**	100.0	**0**	0.0	**1**	0	0	**1**
Total	**305**	86.1	**25**	7.7	**330**	22	9	**361**

Table 2 shows that responses from twenty five sites stated that they were not registered with the CQC. When these were looked at in more detail, it was found that eighteen sites only carried out consultations on site and therefore were not under the present regulations required to be registered. A further seven sites were based in Wales, Northern Ireland or Scotland and were registered with the equivalent regulatory bodies in the devolved administrations (i.e. HIW, the RQIA and the SCRC, respectively).

For sites that answered 'Not Applicable', similar results were found: thirteen sites did not perform any surgery on site and six were regulated by regulatory bodies within the devolved administrations, with the exception of one clinic in Scotland that is currently not required to be registered. All the sites that failed to answer the question were either registered with a regulatory body or were not required to be registered.

2 – Advertising, consent and patient information

Advertising

The advertising of medical services is constrained by codes of conduct laid down by the Committee of Advertising Practice (CAP)[13] who are overseen by the Advertising Standards Authority (ASA)[14]. The BAAPS and the IHAS have also produced consensual agreement on the standards employed in the advertising of cosmetic surgery procedures.[15,16,17]

Marketing materials must be drafted and designed to safeguard patients from unrealistic expectations. Advertisements should depict real life. Unjustifiable claims should not be made and discounts or financial incentives must not be offered. Good medical practice states that any information that appears in print about the services a doctor provides must be verifiable, truthful and that they must not make claims that they are any better than any other practitioner[18]. Claims should not be made about the quality or outcomes of services in any information provided to patients. Advertising must not offer guarantees of cures, nor exploit patients' vulnerability or lack of medical knowledge. Equally a patient's vulnerability or lack of medical knowledge must not be exploited when making charges for treatment or services.[6]

When asked about advertising, 303/342 (88.6%) sites stated that they advertised their services (Table 3).

Table 3. Type of site and advertising of services

	Advertise						
Description of site	**Yes**	%	**No**	%	**Subtotal**	Unanswered / Not applicable	**Total**
Independent Hospital - in patient	**147**	95.5	**7**	4.5	**154**	0	**154**
Independent Hospital - out patient	**12**	100.0	**0**	0.0	**12**	0	**12**
NHS Hospital	**0**	0.0	**27**	100.0	**27**	6	**33**
Small Clinic (< 3 clinicians)	**8**	100.0	**0**	0.0	**8**	0	**8**
Non-surgical Treatment Centre	**98**	100.0	**0**	0.0	**98**	2	**100**
Individual cosmetic surgeon	**18**	85.7	**3**	14.3	**21**	0	**21**
GP	**1**	100.0	**0**	0.0	**1**	0	**1**
Referral service (UK)	**3**	100.0	**0**	0.0	**3**	0	**3**
Referral Service (abroad)	**4**	100.0	**0**	0.0	**4**	0	**4**
Other	**12**	85.7	**2**	14.3	**14**	0	**14**
Total	**303**	88.6	**39**	11.4	**342**	8	**350**

The two sites that did not advertise and described themselves under the category 'other' were one private site within an NHS hospital and one group of surgeons practicing at more than one hospital.

Methods used for advertising are shown in Figure 2. Multiple answers may have been provided by each site (from a maximum of 342 sites).

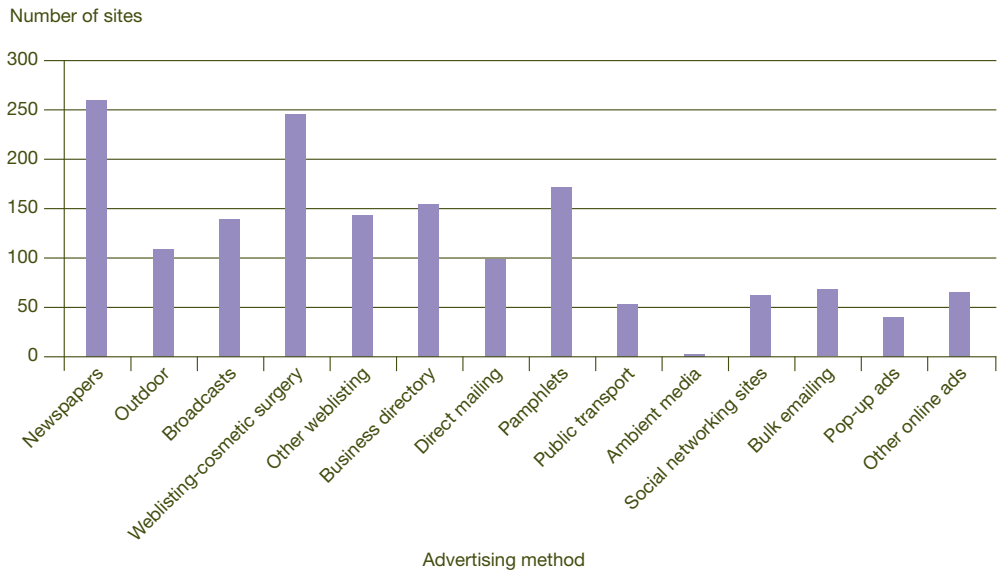

Figure 2. Methods of advertising utilised by sites providing or organising cosmetic surgery

The group using broadcast media (radio and television) were divided into the groups shown in Table 4. This group fell entirely outside the NHS.

Table 4. Type of site using broadcast media

Description of site	Total	%
Independent Hospital - in patient	**58**	41.7
Independent Hospital - out patient	**2**	1.4
Small Clinic (<3 clinicians)	**2**	1.4
Non-surgical Treatment Centre	**68**	48.9
Individual Cosmetic Surgeon	**2**	1.4
Referral Service (abroad)	**1**	<1
Other	**6**	4.3
Total	**139**	

The sites using social networking sites and pop-up advertisements and bulk emailing, which fall outside of any formal regulatory process were in the groups shown in Tables 5 to 7.

Table 5. Type of social networking websites used

Description of site	Total
Independent Hospital - in patient	18
Independent Hospital - out patient	1
Small Clinic (<3 clinicians)	2
Non-surgical Treatment Centre	38
Referral Service (abroad)	2
Other	1
Total	62

Table 6. Type of site using pop-up advertisements

Description of site	Total
Independent Hospital - in patient	12
Independent Hospital - out patient	1
Small Clinic (<3 clinicians)	2
Non-surgical Treatment Centre	23
Total	38

Table 7. Type of site using bulk emailing

Description of site	Total
Independent Hospital - in patient	10
NHS Hospital	2
Small Clinic (<3 clinicians)	2
Non-surgical Treatment Centre	52
Individual Cosmetic Surgeon	1
Other	2
Total	69

The use of electronic media to promote and advertise cosmetic surgery by its nature much harder to regulate. Bulk emailing, pop-ups, social networking sites and web based advertisements may be more likely to influence groups of patients more vulnerable to suggestion. Such is the concern over the effects of advertising on patients that a number of countries have recently tightened up the legislation surrounding cosmetic surgery advertising[19-21] and in France, since 2005, it has been banned completely in every format including web based publicity.[22]

In the UK the guidelines issued by the BAAPS and the IHAS form the foundations of a code of conduct, which is not necessarily enforceable by law. Therefore, only if the more general CAP codes of practice are contravened can advertisers be penalised by the ASA. However, misleading advertisements may also come under the jurisdiction of trading standards officers.

Sites that admitted to promoting special offers are shown in Table 8. Of the sites that answered the question 77/295 (26%) admitted to promoting special offers. Financial offers are permitted according to the IHAS guidelines as long as they are not advertised in the public domain.[17] Such offers, when time is limited, may put undue pressure on patients to have an operation in haste for which they may be inadequately prepared.

In addition to the questions on advertising in the questionnaire, a sample of advertisements from newspapers and magazines were assessed as to whether they conform to the guidelines produced by the IHAS and the BAAPS.

Every advertisement for cosmetic surgery in the printed published media was collected over the course of one year (summer 2009-summer 2010). From newspapers and magazines over 150 advertisements were collected. However, having removed duplicates, the final sample consisted of only 39 advertisements. Nevertheless

Table 8. Site type and promotion of special offers

	Special offers promoted							
Description of site	**Yes**	%	**No**	%	**Subtotal**	NA	Unanswered	**Total**
Independent Hospital - in patient	**32**	22.2	**112**	77.8	**144**	7	3	**154**
Independent Hospital - out patient	**1**	8.3	**11**	91.7	**12**	0	0	**12**
NHS Hospital	0	0.0	16	100.0	16	17	0	33
Small Clinic (<3 clinicians)	**1**	14.3	**6**	85.7	**7**	1	0	**8**
Non-surgical Treatment Centre	**37**	49.3	**38**	50.7	**75**	1	24	**100**
Individual Cosmetic Surgeon	**2**	9.5	**19**	90.5	**21**	0	0	**21**
GP	**0**	0.0	**0**	0.0	**0**	0	1	**1**
Referral Service (UK)	**0**	0.0	**3**	100.0	**3**	0	0	**3**
Referral Service (abroad)	**2**	50.0	**2**	50.0	**4**	0	0	**4**
Other	**2**	15.4	**11**	84.6	**13**	1	0	**14**
Total	**77**	26.1	**218**	73.9	**295**	27	28	**350**

these 39 advertisements were objectively assessed as to whether they advertised prices and special offers (discouraged by IHAS and BAAPS guidelines) and whether they displayed the CQC logo and their CQC registration number.

The majority of sites did not advertise discounts in line with the published guidelines. However, there were two advertisements that clearly did so (Table 9).

Similarly, most advertisements assessed did not display prices in accordance with the guidelines, however, there were 8/39 advertisements that clearly displayed the price of cosmetic surgical procedures, in violation of the guidelines (Table 10).

It was found that only a minority of sites 5/39 displayed the CQC logo (Table11) and only 2/39 displayed their CQC registration number (data not shown). The CQC now specifically prohibits the use of their logo by institutions registered with them.[23] Patients need to easily recognise those sites with appropriate registration. The removal of the CQC logo from material produced by those providers practicing at an appropriate level of regulation is a backward step. It is unclear as to whether the display of a CQC registration number is also prohibited. The importance of raising awareness amongst potential cosmetic surgery patients of the necessity of checking provider's credentials with respect to CQC registration has been highlighted elsewhere in the report.

Table 9. Number of advertisements that displayed discounts

Discounts advertised	**Total**
Yes	**2**
No	**36**
NA	**1**
Total	**39**

Table 10. Number of advertisements that displayed prices

Prices displayed	**Total**
Yes	**8**
No	**30**
NA	**1**
Total	**39**

Table 11. Number of advertisements that displayed logo

CQC logo displayed	Total
Yes	5
No	30
NA	4
Total	**39**

Patient information

In order that a patient might give informed consent he or she needs to be fully informed about the risks and benefits of the procedure. In cosmetic surgery, the consenting process is also important to ensure that patients have realistic expectations of the effect that the procedure will have. Information may be delivered in several different forms. Table 12 shows how potential patients were provided with information.

Information is central to a patient's ability to make a decision about their health care. Patients need access to impartial, high quality information so they can make informed decisions. In the National '*Building on the Best Choice*' consultation in 2003 nearly 90% of respondents said that in order to make choices about their health and health care they needed the right information at the right time with the support they need to use it.[24] With poor information patients cannot make effective choices.[24]

Table 12. Methods of informing patients

Description of site	Patient info leaflet	Patient info CD/DVD	Verbal discussion: doctor	Verbal discussion: nurse	Non clinical advisor info	Refer to DH info on cosmetic surgery	Other	Unanswered	Total
Independent Hospital - in patient	150	8	154	115	16	37	13	0	**154**
Non-surgical Treatment Centre	90	28	90	59	51	8	3	7	**100**
NHS Hospital	26	2	34	20	1	5	5	0	**33**
Independent Hospital - out patient	11	1	12	5	0	2	3	0	**12**
Small Clinic (<3 clinicians)	8	1	8	4	2	3	2	0	**8**
Referral Service (UK)	3	0	3	1	3	0	0	0	**3**
Referral Service (abroad)	3	1	2	0	7	1	1	0	**4**
Individual Cosmetic Surgeon	16	0	21	7	1	7	4	0	**21**
Other	11	0	14	7	1	1	1	0	**14**
GP	1	0	1	0	0	0	0	0	**1**
Total	**319**	**41**	**339**	**218**	**82**	**64**	**32**	**7**	**350**

(Multiple answers may have been given, total = 350 sites)

Specifically a patient needs information on their own condition, care options and possible outcomes. When they have good access to these, patients are better equipped to give valid informed consent.

Patients should have access to accurate, high quality, comprehensive information delivered in the way they want and can understand. They should have their personal needs considered and discussed at every contact with a surgeon, receiving as much support as they want to access and understand information. They should be allowed to ask questions and be involved as far as they wish in making decisions about the benefits and risks of cosmetic surgery. Only 64/350 sites referred patients to the Department of Health independent information on cosmetic surgery (Table 12). It has been previously recommended that patients should have access to independent information about cosmetic surgery.[3] It is also recommended that patients should have access to written information in support of appropriate verbal information. There should be no reason why this is not provided for cosmetic surgery, but in a number of sites, both within the NHS and independent sector, written information was not available.

The IHAS recommend that the initial consultation be carried out by a surgeon or registered practitioner, so that unsuitable patients can be excluded at an early stage.[25] In 191/337 (56.7%) of sites, the initial consultation was always and only conducted by a consultant surgeon (Table 13). Whilst the vast majority of sites that answered this question complied with this standard, there was one site where patients undergo initial consultations with a non-medical member of staff.

Table 13. Staff member conducting the initial consultation

Who conducted the consultation	Total	%
Always/only consultant surgeon	**191**	56.7
Consultant surgeon or other doctor or nurse	**96**	28.5
Consultant surgeon or other personnel including non-medical staff	**33**	9.8
Consultant surgeon or psychologist	**1**	<1
Non-consultant specialist (no consultant)	**3**	<1
Specialist doctor/nurse (no consultant)	**1**	<1
GP	**1**	<1
Specialist nurse practioner (no consultant)	**1**	<1
Other registered nurse (no consultant)	**9**	2.7
Only see non-medical staff	**1**	<1
Subtotal	**337**	
Not applicable	6	
Unanswered	7	
Total	**350**	

Pre-operative psychological evaluation

The decision to undertake cosmetic surgery lies with the patient and surgeon. The role of psychological assessment is to inform that decision-making process. Sarwar and Crerand (2004) drew two tentative conclusions from their investigation of patients undergoing cosmetic surgery. Firstly that this population exhibits a variety of psychological symptoms and secondly that it is premature to assume that surgery leads to a positive outcome.[26] There are no prospective studies that define predictors of poor outcome. However putative factors associated with poor outcome are known to be youth, male, depression and anxiety and personality disorders.[27] Body dysmorphic disorder is not uncommon in patients seeking cosmetic surgery. It is estimated that up to 5-15% cosmetic surgery patients may be suffering from the disorder.[28] Cosmetic surgery may not be appropriate in this group of patients.

Psychological assessment of patients will be of use not only in identifying those patients who might prove problematic in the operative period, but more importantly, it will identify patients in whom surgery will be of benefit. Pre-operative psychological evaluation by a properly trained and or supervised professional should be standard practice in cosmetic surgery (Table 14).

Table 14. Description of site and routine employment of a psychological evaluation during the initial consultation for cosmetic surgery.

	Psychological evaluation undertaken						
Description of site	**Yes**	%	**No**	%	**Subtotal**	Unanswered	**Total**
Independent Hospital - in patient	**54**	35.8	**97**	64.2	**151**	2	**153**
Non-surgical Treatment Centre	**45**	45.9	**53**	54.1	**98**	2	**100**
NHS Hospital	**4**	13.3	**26**	86.7	**30**	3	**33**
Individual Cosmetic Surgeon	**3**	15.0	**17**	85.0	**20**	0	**20**
Other	**3**	21.4	**11**	78.6	**14**	0	**14**
Independent Hospital - out patient	**7**	63.6	**4**	36.4	**11**	1	**12**
Small Clinic (<3 clinicians)	**2**	28.6	**5**	71.4	**7**	1	**8**
Referral service (abroad)	**0**	0.0	**2**	100.0	**2**	0	**2**
GP	**1**	100.0	**0**	0.0	**1**	0	**1**
Referral service (within UK)	**0**	0.0	**1**	100.0	**1**	0	**1**
Total	**119**	**35.5**	**216**	**64.5**	**335**	9	**344**

These results suggest that the majority of sites fall short in evaluating patients for psychological disorders prior to surgery. A wide range of health care professionals was reported as carrying out the screening. No evidence was provided as to the quality of this assessment or the method of training of these individuals. For all sites, where an assessment was carried out, it was rare 4/100 (4% of sites reported as standard) for a patient to see a Clinical Psychologist (Figure 3).

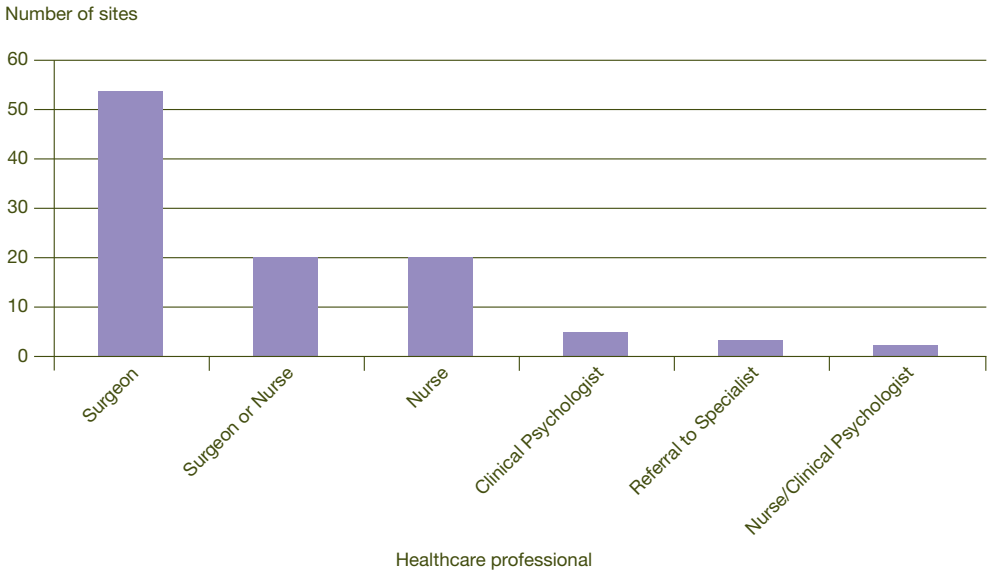

Figure 3. Designation of the healthcare professional carrying out psychological assessment at sites that carried it out as standard (n = 100, 19 unanswered)

Consent

The process of obtaining informed consent from a patient is well documented. It is a basic tenet of good medical practice.[29]

Table 15 shows that the surgeon obtained consent for the procedure in all cases in the majority of sites (295/342); this is in line with the GMC's outline of good medical practice.[29] Of more concern is the apparent lack of adherence to a two-stage consent process (Table 16).

The GMC states that the patient should be given the opportunity for reflection[29] and the IHAS states that patients should have a two week cooling off period to consider and think over their decision to have an operation.[25]

As an example, sites that offered a major surgical proceedure such as rhinoplasty were looked at in more detail. Of these sites that offered rhinoplasty 77/237 did not undertake a two-stage consent process (Table 17). Thirty-three of these were Independent Hospitals with in patient beds.

Table 15. Who obtained consent

Who obtained consent	Total	%
Always/Only Consultant Surgeon	**295**	86.3
Consultant or Trainee Surgeon	**15**	4.4
Consultant, Trainee or Non-consultant Specialist	**4**	1.2
Surgeon or Specialist Nurse Practitioner	**2**	<1
Consultant Surgeon or Non-consultant Specialist	**3**	<1
Consultant Surgeon or Trainee - trained in obtaining consent	**6**	1.8
Consultant Surgeon/ Specialist Nurse Practitioner	**2**	<1
Consultant Surgeon or Nurse	**10**	2.9
Non-consultant Specialist	**4**	1.2
GP	**1**	<1
Subtotal	**342**	
Unanswered	2	
Total	**344**	

Table 16. Two-stage (deferred) consent process utilised

	Two-stage consent process used						
Description of site	**Yes**	%	**No**	%	**Subtotal**	Unanswered	**Total**
Independent Hospital - in patient	**101**	74.8	**34**	25.2	**135**	18	**153**
Non-surgical Treatment Centre	**39**	54.2	**33**	45.8	**72**	28	**100**
NHS Hospital	**20**	66.7	**10**	33.3	**30**	3	**33**
Individual Cosmetic Surgeon	**10**	66.7	**5**	33.3	**15**	5	**20**
Other	**10**	76.9	**3**	23.1	**13**	1	**14**
Independent Hospital - out patient	**7**	87.5	**1**	12.5	**8**	4	**12**
Small clinic	**1**	20.0	**4**	80.0	**5**	3	**8**
Referral Service (abroad)	**1**	50.0	**1**	50.0	**2**	0	**2**
Referral Service (UK)	**1**	100.0	**0**	0.0	**1**	0	**1**
GP	**1**	100.0	**0**	0.0	**1**	0	**1**
Total	**191**	67.7	**91**	32.3	**282**	62	**344**

Table 17. Type of site offering rhinoplasty and whether a two-stage consent process is utilised

	Two-stage consent process used						
Description of site	**Yes**	%	**No**	%	**Subtotal**	Unanswered	**Total**
Independent Hospital - inpatient	**100**	75.2	**33**	24.8	**133**	16	**149**
Non-surgical Treatment Centre	**33**	51.6	**31**	48.4	**64**	25	**89**
NHS Hospital	**8**	53.3	**7**	46.7	**15**	2	**17**
Independent Cosmetic Surgeon	**8**	88.9	**1**	11.1	**9**	2	**11**
Other	**6**	75.0	**2**	25.0	**8**	1	**9**
Small clinic (<3 clinicians)	**1**	50.0	**1**	50.0	**2**	2	**4**
Independent Hospital	**2**	66.7	**1**	33.3	**3**	0	**3**
Referral service (abroad)	**1**	50.0	**1**	50.0	**2**	0	**2**
Referral service (within UK)	**1**	100.0	**0**	0.0	**1**	0	**1**
Total	**160**	67.5	**77**	32.5	**237**	48	**285**

The GMC clearly states that consent must be sought before commencing examination, treatment or the provision of care.[29] The seeking and giving of consent should be a process, rather than a one-off event. For major interventions, it is good practice where possible to seek the individual's consent to the proposed procedure well in advance, when there is time to respond to the individual's questions and provide adequate information. Clinicians should then check, on the day of surgery, that the individual still consents. If an individual is not asked to signify their consent until just before the procedure is due to start, at a time when they may be feeling particularly vulnerable, there may be real doubt as to the validity of consent.

Pre-anaesthetic assessment

The Royal College of Anaesthetists has highlighted the importance of pre-operative assessment. In addition to assessing the patient's fitness for surgery, the pre-operative assessment provides a further opportunity to clarify the information that they have been provided with as part of an ongoing participative consent process, and minimise the chances of patients making ill-informed or inappropriate treatment choices.[30] Table 18 shows whether sites routinely carried out a pre-anaesthetic assessment on cosmetic surgery patients.

Table 18. Type of site and whether a pre-operative anaesthetic assessment was performed

	Pre-anaesthetic assessment performed						
Description of site	**Yes**	%	**No**	%	**Subtotal**	Unanswered	**Total**
Independent Hospital - in patients	**146**	96.7	**5**	3.3	**151**	2	**153**
Non-surgical treatment centre	**96**	98.0	**2**	2.0	**98**	2	**100**
NHS Hospital	**33**	100.0	**0**	0.0	**33**	0	**33**
Individual cosmetic surgeon	**19**	100.0	0	0.0	**19**	1	**20**
Other	**14**	100.0	**0**	0.0	**14**	0	**14**
Independent Hospital - out patients	7	63.6	**4**	36.4	**11**	1	**12**
Small clinic (<3 clinicians)	**7**	87.5	**1**	12.5	**8**	0	**8**
Referral service (abroad)	**2**	100.0	**0**	0.0	**2**	0	**2**
GP	**0**	0.0	**1**	100.0	**1**	0	**1**
Referral service (UK)	**1**	100.0	**0**	0.0	**1**	0	**1**
Total	**325**	96.2	**13**	3.8	**338**	6	**344**

The majority of sites (325/338) performed a pre-anaesthetic assessment. However, there were five independent hospitals, one small clinic and a GP all performing surgery but not undertaking pre-anaesthetic assessment.

3 – The structure and case mix of teams providing cosmetic surgery

Types and numbers of procedures

The number of sites offering each different type of cosmetic surgical procedure is shown in Figure 4. These data come both from sites that carry out the procedures on site and sites that carry out the procedure elsewhere. The four commonest procedures were related to breast, eye and nose procedures and liposuction. In 2005 The Healthcare Commission reported similar findings – breast (42.9%), nose (9.6%), liposuctions (8.8%) and eyelid (6.3%).[2]

When the procedures offered were considered against the number actually performed (Tables 19 and 20) there was disparity from site to site, with some offering procedures that were rarely performed. It is recommended that surgical teams carry out a threshold number of cases per annum to ensure their skills are maintained. This is in line with other areas of clinical practice where recommendations are made on case load in order that specialists maintain their skills and morbidity/mortality is minimised. It is established that higher volume hospitals are associated with a lower mortality.[32,33]

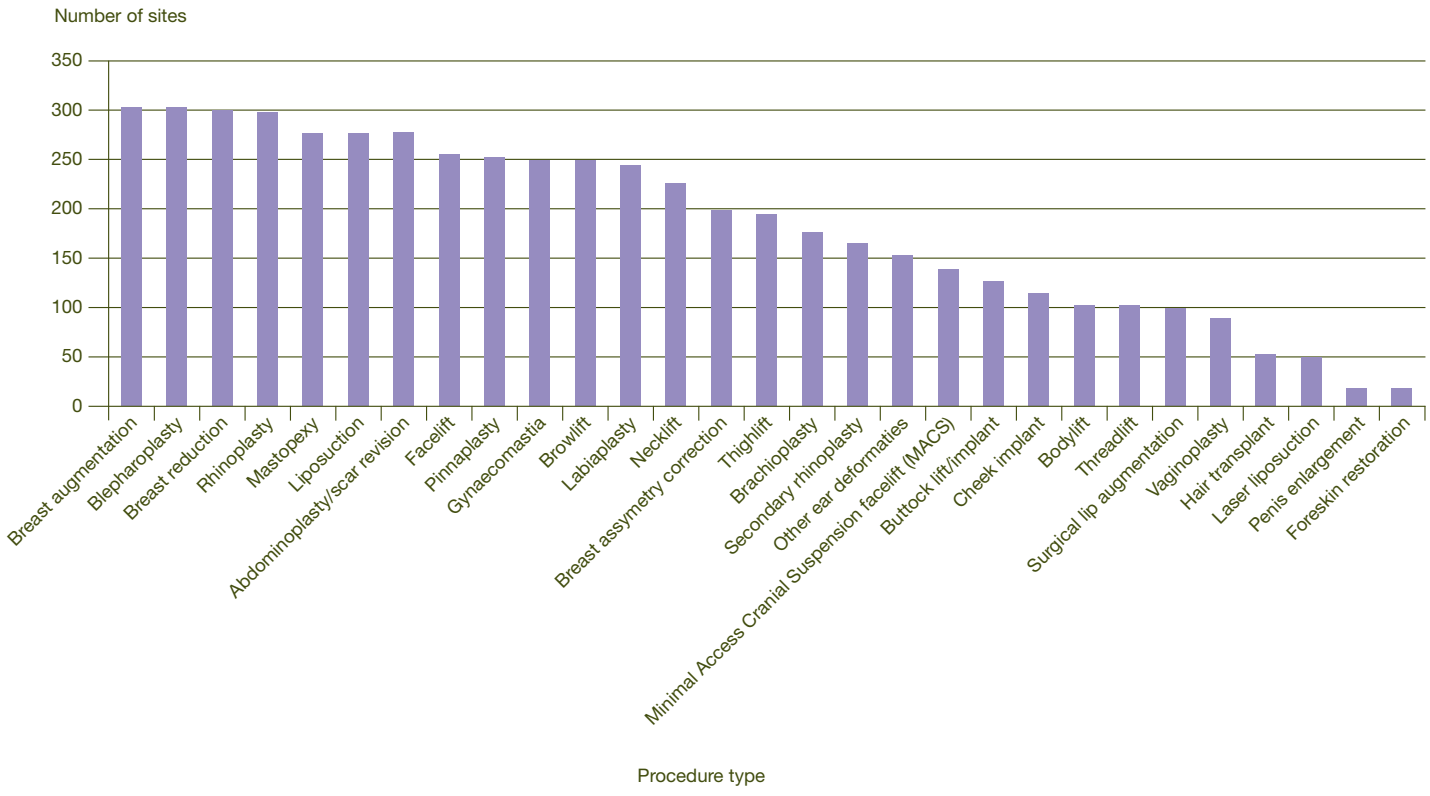

Figure 4. Number of sites at which each procedure is offered

Table 19 displays the ten most frequently offered procedures, showing the number of sites performing each frequency range of procedures during one financial year. The maximum number of sites (that carry out cosmetic surgery on site) was 228 but for each procedure, the denominator is the number of sites within the sample offering the procedure (minus the sites which did not provide this data).

Table 19. Ten most frequently offered procedures-number of sites performing each frequency range of procedures during one year. Ranges of number of procedures performed

10 most commonly offered procedures	0	%	1-10	%	11-20	%	21-50	%	51-100	%
Breast Augmentation	**4**	2.3	**31**	17.5	**33**	18.6	**40**	22.6	**37**	20.9
Breast Reduction	**13**	7.4	**84**	47.7	**42**	23.9	**27**	15.3	**6**	3.4
Rhinoplasty	**9**	5.8	**66**	42.6	**27**	17.4	**37**	23.9	**8**	5.2
Mastopexy	**19**	13.0	**87**	57.6	**21**	13.9	**16**	10.6	**3**	2.0
Abdominoplasty	**9**	5.7	**67**	42.4	**30**	19.0	**37**	23.4	**8**	5.1
Liposuction	**12**	8.1	**64**	43.2	**30**	20.3	**29**	19.6	**6**	4.1
Facelift	**10**	7.8	**66**	51.2	**23**	17.8	**24**	18.6	**4**	3.1
Pinnaplasty	**28**	19.0	**99**	67.3	**6**	4.08	**11**	7.5	**1**	<1
Gynaecomastia	**28**	21.0	**94**	70.7	**7**	5.26	**2**	1.5	**1**	<1
Upper Blepharoplasty	**7**	4.2	**79**	47.0	**39**	23.2	**33**	19.6	**5**	3.0
Lower Blepharoplasty	**11**	7.3	**96**	63.6	**27**	17.9	**14**	9.3	**0**	0.0

10 most commonly offered procedures *continued*	101-200	%	201-1000	%	>1000	%	Subtotal	Procedure offered but no data	Procedure not offered	Total
Breast Augmentation	**15**	8.5	**12**	6.8	**5**	2.8	**177**	27	24	**228**
Breast Reduction	**4**	2.3	**0**	0.0	**0**	0.0	**176**	25	27	**228**
Rhinoplasty	**3**	1.9	**4**	2.6	**1**	<1	**155**	32	41	**228**
Mastopexy	**2**	1.3	**3**	2.0	**0**	0.0	**151**	34	43	**228**
Abdominoplasty	**5**	3.2	**2**	1.3	**0**	0.0	**158**	26	44	**228**
Liposuction	**1**	<1	**6**	4.1	**0**	0.0	**148**	32	48	**228**
Facelift	**1**	<1	**1**	0.8	**0**	0.0	**129**	28	71	**228**
Pinnaplasty	**2**	1.4	**0**	0.0	**0**	0.0	**147**	27	54	**228**
Gynaecomastia	**0**	0.0	**1**	0.8	**0**	0.0	**133**	39	56	**228**
Upper Blepharoplasty	**2**	1.2	**3**	1.8	**0**	0.0	**168**	28	32	**228**
Lower Blepharoplasty	**2**	1.3	**1**	0.7	**0**	0.0	**151**	39	38	**228**

It is of note that for each procedure approximately 10% of sites could not provide data on the numbers of procedures performed. Breast augmentations were performed most frequently with 5/177 sites performing more than 1000 procedures during one financial year. Other procedures were performed less frequently. Table 20 shows the percentage of sites that perform each procedure less than (or equal to) 50 and less than (or equal to) 20 times during the financial year.

One would expect patients to choose a surgical team that performs a particular procedure say 100 times per year as opposed to 10 times per year. Experience and competence run hand in hand. As shown in Table 20, with the exception of breast augmentation, the majority of centres performed fewer than 20 of the offered procedures per year. Patients should enquire how often the procedure they wish to have is carried out at the sites they are considering attending. National regulatory bodies should set minimum requirements for surgeons and indeed surgical teams to be considered competent. This has occurred in Singapore with respect to the minimum number of cosmetic surgical operations performed by individual surgeons.[31]

Table 20. Percentage of sites performing procedures ≤50 and ≤20 times per annum

10 most commonly offered procedures	**Total ≤50 per annum**	% ≤50 per annum	**Total ≤20 per annum**	% ≤20 per annum	**Subtotal**
Breast Augmentation	**108**	61.0	**68**	38.4	**177**
Breast Reduction	**166**	94.3	**139**	79.0	**176**
Rhinoplasty	**102**	89.7	**139**	65.8	**155**
Mastopexy	**143**	94.7	**127**	84.1	**151**
Abdominoplasty	**143**	90.5	**106**	67.1	**158**
Liposuction	**135**	91.2	**106**	71.6	**148**
Facelift	**123**	95.3	**99**	76.7	**129**
Pinnaplasty	**144**	98.0	**133**	90.5	**147**
Gynaecomastia	**131**	98.5	**129**	97.0	**133**
Upper Blepharoplasty	**158**	94.0	**125**	74.4	**168**
Lower Blepharoplasty	**148**	98.0	**134**	88.7	**151**

Table 21. Designation of the person performing the surgery

Who performs cosmetic surgery	Total	%
Consultant surgeon	**194**	85.5
Consultant/Trainee surgeon	**15**	6.6
Consultant/Trainee surgeon/Non-consultant Specialist	**5**	2.2
Consultant Surgeon/ Non-consultant Specialist	**3**	1.3
Cons Surgeon/ Specialist Nurse Practitioner	**2**	<1
Consultant Surgeon/ Specialist Nurse Practitioner/Other Nurse	**1**	<1
Consultant Surgeon/Other	**1**	<1
Non-consultant Specialist	**4**	1.8
Non-consultant Specialist/Other	**1**	<1
GP	**1**	<1
Subtotal	**227**	
Unanswered	1	
Total	**228**	

Delivery of surgery

Table 21 shows the number of sites where cosmetic surgery was performed by each grade of clinician. In most cases (194/227) cosmetic surgery was said to be always and only carried out by a consultant surgeon. However, no evidence was provided as to the presence of an individual consultant on the GMC's specialist register and the term 'consultant' may be used for differing standards of practitioner outside the NHS.

Surgeons responsible for the cosmetic surgery are from a variety of specialties (Figure 5 and Table 22) and should ideally be listed on an appropriate specialist register. However, cosmetic surgery is yet to be recognised as a specialty for registration purposes, and the training and experience in cosmetic surgery of surgeons on the existing specialist lists cannot be assured by the existing certification process.

Table 22. Specialties carrying out cosmetic surgery

Specialties carrying out cosmetic surgery	Total	%
Answer includes non-surgical specialty	**38**	17
Answer includes surgical specialties	**185**	83
Subtotal	**223**	
Unanswered	5	
Total	**228**	

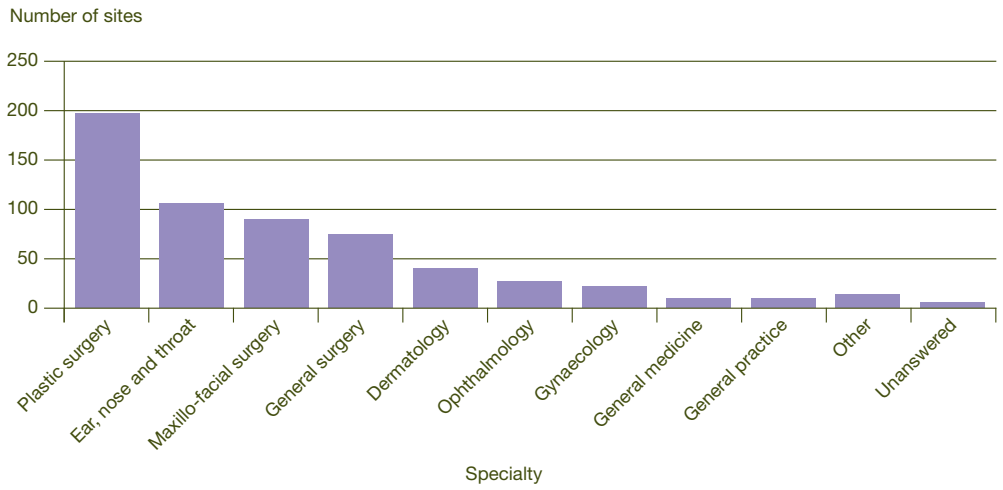

Figure 5. Specialties carrying out cosmetic surgery.
Those that selected 'Other' specified cosmetic surgery, cosmetic medicine, genitourinary and hand surgery as specialities carrying out cosmetic surgery at their site.

Table 23. Cosmetic surgery training provided

	Cosmetic surgery training given						
Description of site	**Yes**	**%**	**No**	**%**	**Subtotal**	Unanswered	**Total**
Independent Hospitals	**9**	5.5	**156**	94.5	**165**	6	**171**
NHS Hospitals	**23**	65.7	**12**	34.3	**35**	2	**37**
All other sites	**3**	15.0	**17**	85.0	**20**	0	**20**
Total	**35**	15.9	**185**	84.1	**220**	**8**	**228**

Provision of training

Training in cosmetic surgery was available only in 35/220 (15.9%) sites. The remaining 185 sites did not provide any training, and this represents a substantial loss of training opportunities in cosmetic surgery. Future patients would be better served if formal training programmes were established across the health care environment.

Traditionally, surgical training has been provided exclusively in the NHS. Cosmetic surgery might present an opportunity to increase training within the independent health care sector. Table 23 shows the number of sites offering training in cosmetic surgery techniques (answers are grouped by whether the site is an NHS or independent hospital).

Consultant rota for anaesthetic sessions

Only 92/138 (67%) independent hospitals with overnight beds had a dedicated consultant rota for anaesthetic sessions. Of all sites carrying out cosmetic surgery that returned a questionnaire 136/192 (70.8%) had a dedicated cosmetic surgery anaesthetic rota (Table 24).

Table 25 shows who covered the postoperative care out of hours. It is important that both staff and patients have access to a surgical opinion throughout any cosmetic surgery episode.

The GMC requires that doctors provide adequate postoperative support to patients under their care.[6] From the respondents 25/228 sites did not answer this question.

Table 24. Description of site, and existence of a dedicated consultant rota covering anaesthetic sessions

	Consultant rota for cosmetic surgery							
Description of site	**Yes**	**%**	**No**	**%**	**Subtotal**	NA	Unanswered	**Total**
Independent Hospital - in patient	**92**	66.7	**46**	33.3	**138**	17	4	**159**
NHS Hospital	**36**	100.0	**0**	0.0	**36**	0	1	**37**
Independent Hospital - out patient	**0**	0.0	**6**	100.0	**6**	5	1	**12**
Other	**5**	62.5	**3**	37.5	**8**	1	1	**10**
Small Clinic (<3 clinicians)	**1**	50.0	**1**	50.0	**2**	3	2	**7**
Clinic (>3 Clinicians)	**2**	100.0	**0**	0.0	**2**	0	0	**2**
GP	**0**	0.0	**0**	0.0	**0**	1	0	**1**
Total	**136**	70.8	**56**	29.2	**192**	**27**	**9**	**228**

Table 25. Out of hours cover for postoperative surgical care

Postoperative care	**Total**	**%**
Nursing staff plus: surgeon/resident medical officer/ anaesthetist	**82**	40.4
Resident medical officer plus: surgeon/nurse/anaesthetist	**51**	25.1
On-call team	**27**	13.3
Surgeon plus: Nurse/resident medical officer/anaesthetist	**16**	7.9
Other doctor plus: surgeon/nurse/anaesthetist	**14**	6.9
Recovery staff/anaesthetist	**4**	2.0
Other hospital staff	**4**	2.0
Clinicians carrying out the procedure	**2**	1.0
NA	**3**	1.5
Subtotal	**203**	
Unanswered	25	
Total	**228**	

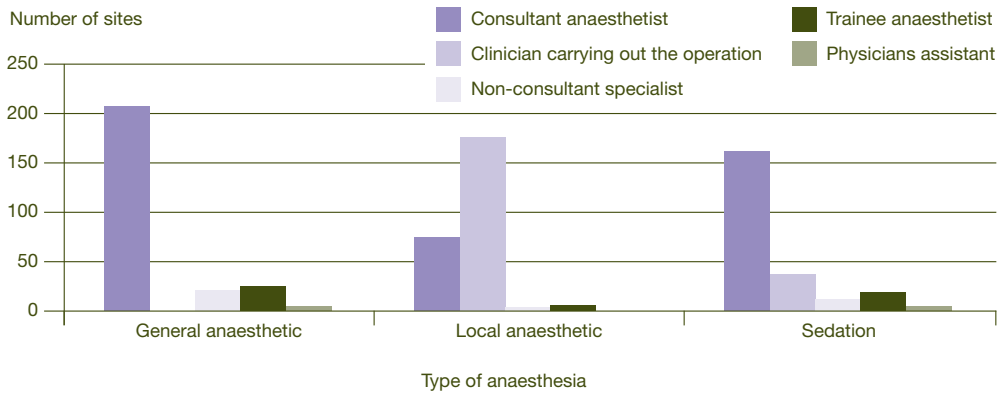

Figure 6. Designation of the person who delivered different types of anaesthesia

Delivery of anaesthesia

The majority of general anaesthetics were administered by consultant anaesthetists (207/228). Non-consultant specialists gave anaesthetics rarely (13/228) and two sites reported that Physicians Assistants (anaesthesia) delivered general anaesthesia (Figure 6). This should be under the supervision of a consultant anaesthetist as required by the Royal College of Anaesthetists.[34]

Clinicians carrying out the operation often gave local anaesthetic (LA) or sedation 36/178 (20%) (Table 26). The Academy of Medical Royal Colleges and associated specialist societies recognise that sedation, as an adjunct to good pain relief and sympathetic patient management, can improve both patient tolerance and acceptance.[35] Furthermore it can increase the technical success of the procedure, but at all times patient safety must be preserved. The Academy has found that many users of sedation have received no formal training and that they do not follow existing guidelines - often because they are not even aware of them.[35] As a result patients are being exposed to unnecessary risk. Patients must ensure and indeed demand that those delivering sedation have received formal training in sedation techniques.

Table 26. Types of anaesthesia given by the 'clinician carrying out the operation'

Description of site	LA	LA, Sedation	Sedation	Subtotal	Unanswered	Total
Independent Hospital - in patient	**98**	**27**	**1**	**126**	33	**159**
NHS Hospital	**25**	**4**	**0**	**29**	8	**37**
Independent Hospital - out patient	**7**	**0**	**0**	**7**	5	**12**
Other	**6**	**3**	**0**	**9**	1	**10**
Small Clinic (<3 clinicians)	**5**	**1**	**0**	**6**	1	**7**
Clinic (>3 clinicians)	**0**	**0**	**0**	**0**	2	**2**
GP	**1**	**0**	**0**	**1**	0	**1**
Total	**142**	**35**	**1**	**178**	50	**228**

4 – Postoperative follow up, policies, facilities and protocols

The care pathway for patients undergoing cosmetic surgery is no different to that of other specialties. From referral for surgery to their discharge following a surgical episode, outcome and patient satisfaction may be affected at each step of the care pathway. In other surgical specialties it is routine for patients to be reviewed and supported in the postoperative period. Protocols and pathways should be in place for every eventuality following surgery. Sites should be equipped to deal with any eventuality. Complacency in equipping clinical areas will affect patient outcomes if there is any potential for a reduction in recognised levels of safety.[36]

Postoperative appointment

Table 27 shows that all sites that answered the question organise a postoperative appointment in line with good practice.[36]

Table 27. Description of site and organisation of postoperative appointment

	Postoperative appointment organised			
Description of site	**Yes**	**No**	Unanswered	**Total**
Independent Hospital - in patient	**153**	**0**	0	**153**
Non-surgical Treatment centre	**95**	**0**	5	**100**
NHS Hospital	**33**	**0**	0	**33**
Individual Cosmetic Surgeon	**20**	**0**	0	**20**
Other	**14**	**0**	0	**14**
Independent Hospital - out patient	**12**	**0**	0	**12**
Small Clinic (<3 clinicians)	**8**	**0**	0	**8**
Referral Service (abroad)	**2**	**0**	0	**2**
GP	**1**	**0**	0	**1**
Referral Service (UK)	**1**	**0**	0	**1**
Total	**339**	**0**	**5**	**344**

Table 28. Description of site and provision of patient information card

	Information card provided						
Description of site	**Yes**	**%**	**No**	**%**	**Subtotal**	Unanswered	**Total**
Independent Hospital - in patient	**144**	96.0	**6**	4.0	**150**	3	**153**
Non-surgical Treatment Centre	**91**	98.9	**1**	1.1	**92**	8	**100**
NHS Hospital	**26**	81.3	**6**	18.8	**32**	1	**33**
Individual Cosmetic Surgeon	**18**	90.0	**2**	10.0	**20**	0	**20**
Other	**13**	92.9	**1**	7.1	**14**	0	**14**
Independent Hospital - out patient	**8**	66.7	**4**	33.3	**12**	0	**12**
Small Clinic (<3 clinicians)	**8**	100.0	**0**	0.0	**8**	0	**8**
Referral Service (abroad)	**2**	100.0	**0**	0.0	**2**	0	**2**
GP	**1**	100.0	**0**	0.0	**1**	0	**1**
Referral Service (UK)	**1**	100.0	**0**	0.0	**1**	0	**1**
Total	**312**	**94.0**	**20**	**6.0**	**332**	**12**	**344**

However, 20 out of 332 sites stated that they did not provide patients with an information card of contact details and information on what to do in case of complications, for use in the immediate postoperative period (Table 28).

Emergency telephone hotline

It was of note that 45 of 334 (13.5%) sites did not specify that they had a telephone help line for patients to call (Table 29). A further 10 sites did not answer the question.

Table 29. Description of site and provision of telephone helpline

	Telephone helpline						
Description Of site	**Yes**	**%**	**No**	**%**	**Subtotal**	Unanswered	**Total**
Independent Hospital - in patient	**126**	83.4	**25**	16.6	**151**	2	**153**
Non-surgical Treatment Centre	**93**	100.0	**0**	0.0	**93**	7	**100**
NHS Hospital	**18**	56.3	**14**	43.8	**32**	1	**33**
Individual Cosmetic Surgeon	**20**	100.0	**0**	0.0	**20**	0	**20**
Other	**10**	71.4	**4**	28.6	**14**	0	**14**
Independent Hospital - out patient	**11**	91.7	**1**	8.3	**12**	0	**12**
Small Clinic (<3 clinicians)	**7**	87.5	**1**	12.5	**8**	0	**8**
Referral Service (abroad)	**2**	100.0	**0**	0.0	**2**	0	**2**
GP	**1**	100.0	**0**	0.0	**1**	0	**1**
Referral Service (UK)	**1**	100.0	**0**	0.0	**1**	0	**1**
Total	**289**	**86.5**	**45**	**13.5**	**334**	**10**	**344**

Of those sites that claimed to have had a telephone help line for patients (289), 15/284 (5%) stated that it was not available 24 hours /day (five sites did not answer - data not shown).

Re-admission

All independent providers of health care should have policies for the re-admission of patients following surgery. There were 39/216 (18%) sites that did not have a policy for the emergency re-admission of patients (Table 30). The default position would be that the NHS would care for these patients should they require re-admission and hence shoulder the cost.

If complications resulting from the procedure necessitate re-admission (assuming the patient has followed all advice on after care), 35/332 sites suggested that the NHS would be responsible for the cost of readmission. Thirty of these sites were NHS hospitals.

Three sites said that the patient or the NHS would be responsible and 22/332 (6.6%) stated that the patient would be responsible for costs incurred (Table 31).

Table 30. Description of site that carry out cosmetic surgery on site and that have a policy for the re-admission of cosmetic surgery patients.

	Site had a policy for patient re-admission						
Description of site	**Yes**	**%**	**No**	**%**	**Subtotal**	Unanswered	**Total**
Independent Hospital - in patient	**138**	90.2	**15**	9.8	**153**	6	**159**
NHS Hospital	**24**	72.7	**9**	27.3	**33**	4	**37**
Independent Hospital - out patient	**5**	41.7	**7**	58.3	**12**	0	**12**
Other	**7**	70	**3**	30	**10**	0	**10**
Small Clinic (<3 clinicians)	**1**	20	**4**	80	**5**	2	**7**
Clinic (>3 clinicians)	**2**	100	**0**	0	**2**	0	**2**
GP	**0**	0	**1**	100	**1**	0	**1**
Total	**177**	**81.9**	**39**	**18.1**	**216**	**12**	**228**

Table 31. Covering the cost of a re-admission

Description of site	The patient	Site providing the cosmetic surgery	Site providing cosmetic surgery/site that referred the patient	Site that referred the patient	The patient or the NHS	The NHS	Other	Unknown	Subtotal	Unanswered	Total
Independent Hospital – in patient	12	125	3	2	0	1	2	3	148	11	159
NHS Hospital	0	1	0	0	1	30	0	0	32	5	37
Non-surgical Treatment Centre	2	58	0	26	0	1	0	4	91	9	100
Independent Hospital – out patient	3	6	0	0	0	0	0	2	11	1	12
Small Clinic (<3 clinicians)	0	5	0	1	0	1	1	0	8	0	8
Referral Service (abroad)	1	1	0	1	1	0	0	0	4	0	4
Individual Cosmetic Surgeon	3	14	0	0	0	0	3	1	21	0	21
Referral Service (UK)	0	1	0	2	0	0	0	0	3	0	3
GP	0	0	0	0	0	0	0	1	1	0	1
Other	1	6	0	2	1	2	0	1	13	1	14
Clinic	0	0	0	0	0	0	0	0	0	2	2
Total	22	217	3	34	3	35	6	12	332	29	361

The referral of patients abroad

Doctors are required to "act in their patient's best interests when making referrals and providing or arranging treatment or care".[18] Those referring patients abroad need to ensure that follow-up and emergency backup in the postoperative period are available.

Only 17/341 sites claimed to refer patients abroad (Table 32); of these, four sites described themselves exclusively as a "Cosmetic Surgery Referral Service for surgery outside the UK". Only these four sites returned questionnaires out of a possible 31 of this site type that were sent one. The 31 sites that were included were out of 130 sites that were identified, but which did not have an address in the UK and so could not be included. Of the 17 sites that responded, 14/17 made some provision for the translation of patient information into English, 15/17 provided patient support before and after the procedure, 16/17 claimed that they ensure standards are equivalent to the UK and 16/17 claimed that there are extensive provisions in place to deal with any complications that might arise after the patient returns to the UK. These data suggest good practice; however, it is a very small sample of sites that responded. The size of the sample and the lack of response make it difficult to draw any meaningful conclusions as to the quality of the care of cosmetic surgery patients abroad. The lack of participation and difficulties in obtaining information from sites that have no administrative base in the UK may reflect the wider problems in regulating this sector of the cosmetic surgery industry.

Table 32. Description of site and whether patients were referred abroad

	Patients referred abroad						
Description of site	**Yes**	**%**	**No**	**%**	**Subtotal**	Unanswered	**Total**
Independent Hospital - in patient	**1**	<1	**152**	99.3	**153**	1	**154**
NHS Hospital	**0**	0.0	**33**	100.0	**33**	0	**33**
Non-surgical Treatment Centre	**12**	12.9	**81**	87.1	**93**	7	**100**
Independent Hospital - out patient	**0**	0.0	**12**	100.0	**12**	0	**12**
Small Clinic (<3 clinicians)	**0**	0.0	**8**	100.0	**8**	0	**8**
Referral Service (Abroad)	**4**	100.0	**0**	0.0	**4**	0	**4**
Individual Cosmetic Surgeon	**0**	0.0	**20**	100.0	**20**	1	**21**
Referral Service (UK)	**0**	0.0	**3**	100.0	**3**	0	**3**
GP	**0**	0.0	**1**	100.0	**1**	0	**1**
Other	**0**	0.0	**14**	100.0	**14**	0	**14**
Total	**17**	**5.0**	**324**	**95.0**	**341**	**9**	**350**

Facilities available

The same level of patient monitoring is required whether the patient is treated in an isolated operating environment, a large NHS or independent sector hospitals.

The questionnaires were analysed to identify if the equipment listed was immediately available in theatre: ECG, temperature measurement, capnography, Doppler ultrasound, nerve stimulator, oxygen supply and pulse oximetry. Only 101/226 (44.6%) of sites had a fully equipped operating department (Tables 33 and 34).

Table 33. Number of sites in which equipment from a required list was available/missing

Equipment available/missing	Total
Full set of equipment	**101**
1 item missing	**62**
2 items missing	**28**
3 items missing	**20**
4 items missing	**6**
5 items missing	**5**
Temperature measurement only	**2**
Oxygen supply only	**1**
ECG only	**1**
Subtotal	**226**
Unanswered	2
Total	**228**

Table 34. The number of sites that stated each item of equipment on the list was available

Site type	ECG	Temperature measurement	Capnography	Doppler ultrasound	Nerve stimulator	Oxygen supply/suction	Pulse oximeter	Subtotal	Unanswered	Total
Independent Hospital - in patient	**159**	**159**	**113**	**112**	**120**	**158**	**159**	**159**	0	**159**
Independent Hospital - out patient	**5**	**8**	**2**	**1**	**1**	**10**	**9**	**12**	0	**12**
NHS Hospital	**36**	**36**	**35**	**23**	**30**	**35**	**34**	**36**	1	**37**
Clinic (>3 Clinicians)	**2**	**2**	**0**	**0**	**0**	**2**	**2**	**2**	0	**2**
Small clinic (<3 clinicians)	**2**	**3**	**0**	**0**	**0**	**5**	**4**	**6**	1	**7**
GP	**1**	**1**	**0**	**0**	**0**	**1**	**1**	**1**	0	**1**
Other	**10**	**10**	**8**	**8**	**6**	**9**	**9**	**10**	0	**10**
Total	**215**	**219**	**158**	**144**	**157**	**220**	**218**	**226**	2	**228**

There was not a great difference between NHS and inpatient independent hospitals, approximately 50% of each being fully equipped.

Good Medical Practice (GMC) states that a practitioner must ensure that the premises are suitable and the equipment available is appropriate and adequate for the procedures or treatment provided and all are able to treat patients safely.[18] The Association of Anaesthetists of Great Britain and Ireland (AAGBI) has issued standards required for patient monitoring.[37] The same standards of monitoring apply when the anaesthetist is responsible for a local /regional anaesthetic or sedative technique for an operative procedure.

These recommendations state the monitoring devices which are essential and those which must be immediately available during anaesthesia. If it is necessary to continue anaesthesia without a device categorised as 'essential', the anaesthetist must clearly note the reasons for this in the anaesthetic record.

Procedures performed outside of an operating theatre

Only 13 sites claimed to undertake minor surgery away from a formal operating theatre (Table 35). Yet in five sites this was stated to include procedures such as blepharoplasty and labiaplasty.

Table 35. Procedures carried out away from a formal operating theatre

Details of procedures carried out in non-theatre environment	Total
Hair transplant in treatment room	3
Under local anaesthetic	1
Minor surgery	1
Minor surgery: Blepharoplasty (in treatment room)	1
Minor surgery: Pinnaplasty,Blepharoplasty, Scar revision, Labiaplasty, Earlobe surgery	1
Thread/Suture face lift	1
Thread/Suture facelift, Blepharoplasty (In treatment room in outpatient department)	1
Upper Blepharoplasty, Pinnaplasty, Otoplasty- carried out in treatment rooms	1
Minor Ops Room: Minor operations: upper/lower Blepharoplasty - under local anaesthetic	1
Out-patient procedures	2
Total	**13**

If surgery of the nature listed above is not carried out in a theatre environment, the question of sterility must be raised and hence patients may be at risk of postoperative infection. The true scale of this practice cannot be estimated as a number of sites did not respond to the questionnaire.

Recovery

After general or regional anaesthesia, all patients should recover in a specially designated area, which should conform to the guidelines of the Department of Health (DH) and the AAGBI for design and equipment.[38]

Three sites stated that they did not have pulse oximetry in their recovery areas (Table 36). These were two day case independent hospitals and one small clinic that carried out a number of procedures that may be performed under local anaesthesia but also including more major procedures such as abdominoplasty and breast augmentation that would normally require a general anaesthetic.

Twenty four independent hospitals reported having Level 3 postoperative care (Table 37). In those sites without Level 3 care, all apart from two sites had an operational protocol for patient transfer in the event of an untoward peri-operative event (Table 38).

Table 36. Description of site and availability of Pulse oximetry equipment in the recovery area

	Pulse oximetry in the recovery area						
Description of site	**Yes**	**%**	**No**	**%**	**Subtotal**	Unanswered	**Total**
Independent Hospital - in patient	**158**	100.0	**0**	0.0	**158**	1	**159**
Independent Hospital - out patient	**10**	83.3	**2**	16.7	**12**	0	**12**
NHS Hospital	**36**	100.0	**0**	0.0	**36**	1	**37**
Small Clinic (<3 clinicians)	**4**	80.0	**1**	20.0	**5**	2	**7**
Clinic (>3 clinicians)	**2**	100.0	**0**	0.0	**2**	0	**2**
GP	**1**	100.0	**0**	0.0	**1**	0	**1**
Other	**10**	100.0	**0**	0.0	**10**	0	**10**
Total	**221**	**98.7**	**3**	**1.3**	**224**	**4**	**228**

Table 37. Description of site and presence of a Level 3 care unit on site

	Level 3 care on site						
Description of site	**Yes**	**%**	**No**	**%**	**Subtotal**	Unanswered	**Total**
Independent Hospital - in patient	**24**	15.2	**134**	84.8	158	1	**159**
Independent Hospital - out patient	**0**	0.0	**12**	100	12	0	**12**
NHS Hospital	**34**	94.4	**2**	5.6	36	1	**37**
Small Clinic (<3 clinicians)	**0**	0.0	**5**	100	5	2	**7**
Clinic (>3 clinicians)	**0**	0.0	**2**	100	2	0	**2**
GP	**0**	0.0	**1**	100	1	0	**1**
Other	**5**	50.0	**5**	50	10	0	**10**
Total	**63**	**28.1**	**161**	**71.9**	**224**	**4**	**228**

Table 38. Description of site and the existence and type of standard procedure for transfer from theatre in event of peri-operative complication

Description of site	On site Emergency Department	On site Emergency Department/ Nearby acute hospital	Nearby acute hospital	No standard procedure	Other	Subtotal	Unanswered	Total
Independent Hospital - in patient	**11**	**19**	**120**	**0**	**6**	**156**	3	**159**
NHS Hospital	**16**	**1**	**4**	**3**	**10**	**34**	3	**37**
Independent Hospital - out patient	**1**	**0**	**11**	**0**	**0**	**12**	0	**12**
Other	**2**	**1**	**4**	**0**	**0**	**7**	3	**10**
Small Clinic (<3 clinicians)	**0**	**0**	**2**	**0**	**3**	**5**	2	**7**
Clinic (>3 clinicians)	**0**	**0**	**2**	**0**	**0**	**2**	0	**2**
GP	**0**	**0**	**1**	**0**	**0**	**1**	0	**1**
Total	**30**	**21**	**144**	**3**	**19**	**217**	11	**228**

Table 39. Level 2 care unit on site

	Level 2 care unit on site						
Description of site	**Yes**	**%**	**No**	**%**	**Subtotal**	Unanswered	**Total**
Independent Hospital - in patient	**113**	72.9	**42**	27.1	**155**	4	**159**
Independent Hospital - out patient	**1**	8.3	**11**	91.7	**12**	0	**12**
NHS Hospital	**34**	97.1	**1**	2.9	**35**	2	**37**
Small Clinic (<3 clinicians)	**0**	0.0	**5**	100.0	**5**	2	**7**
Clinic (>3 clinicians)	**0**	0.0	**2**	100.0	**2**	0	**2**
GP	**0**	0.0	**1**	100.0	**1**	0	**1**
Other	**5**	50.0	**5**	50.0	**10**	0	**10**
Total	**153**	**69.5**	**67**	**30.5**	**220**	8	**228**

All sites carrying out acute elective surgery should have the ability to deliver Level 2 postoperative care at least until a patient might be transferred to another site.[39]

Of the sites in this study, 67/220 (30.5%) did not have a Level 2 care unit on site (see Table 39).

Provision for resuscitation

One site answered that resuscitation equipment was unavailable in areas where the surgery/anaesthesia took place. Four sites did not answer the question (Table 40).

Resuscitation training

The dataset showed that 220 of 222 sites gave regular resuscitation training to their recovery staff in line with CQC requirements (Table 41). However, only 166/224 (74.1%) sites could state that there would always be a member of staff on duty that holds full provider certificate (e.g. ALS).

Table 40. Description of site and provision of resuscitation

	Resuscitation equipment on site				
Description of site	**Yes**	**No**	**Subtotal**	Unanswered	**Total**
Independent Hospital - in patient	**158**	**0**	**158**	1	**159**
NHS Hospital	**36**	**0**	**36**	1	**37**
Other	**10**	**0**	**10**	0	**10**
Independent Hospital - out patient	**12**	**0**	**12**	0	**12**
Small Clinic (<3 clinicians)	**4**	**1**	**5**	2	**7**
Clinic (>3 clinicians)	**2**	**0**	**2**	0	**2**
GP	**1**	**0**	**1**	0	**1**
Total	**223**	**1**	**224**	**4**	**228**

Table 41. Description of site and provision of resuscitation training

	Resuscitation training provided				
Description of site	**Yes**	**NA**	**Subtotal**	Unanswered	**Total**
Independent Hospital - in patient	**158**	**0**	**158**	1	**159**
NHS Hospital	**36**	**0**	**36**	1	**37**
Independent Hospital - out patient	**8**	**1**	**9**	3	**12**
Other	**10**	**0**	**10**	0	**10**
Small Clinic (<3 clinicians)	**5**	**1**	**6**	1	**7**
Clinic (>3 clinicians)	**2**	**0**	**2**	0	**2**
GP	**1**	**0**	**1**	0	**1**
Total	**220**	**2**	**222**	**6**	**228**

Member of staff with full provider certificate (e.g. ALS)

It is a recommendation of the Royal College of Anaesthetists[30] that at least one member of the recovery staff on duty has a full Advanced Life Support Certificate.

Table 42. shows that 48 of 214 (22%) respondents did not adhere to this standard.

Table 42. Description of site type and whether there is always a member staff on duty with a full provider certificate (e.g. ALS)?

	Staff on duty with full provider certification							
Description of site	**Yes**	**%**	**No**	**%**	**Subtotal**	NA	Unanswered	**Total**
Independent Hospital - in patient	**118**	76.6	**36**	23.4	**154**	1	4	**159**
NHS Hospital	**27**	77.1	**8**	22.9	**35**	0	2	**37**
Independent Hospital - out patient	**6**	85.7	**1**	14.3	**7**	2	3	**12**
Other	**9**	90.0	**1**	10.0	**10**	0	0	**10**
Small Clinic (<3 clinicians)	**3**	60.0	**2**	40.0	**5**	0	2	**7**
Clinic (>3 clinicians)	**2**	100.0	**0**	0.0	**2**	0	0	**2**
GP	**1**	100.0	**0**	0.0	**1**	0	0	**1**
Total	**166**	**77.6**	**48**	**22.4**	**214**	**3**	**11**	**228**

5 – Patient records and clinical audit

Both individual clinicians and organisations delivering health care are required by governing bodies to participate in audit.[18,40] It is a priority of all those delivering care to patients to ensure meticulous records are kept in an appropriate confidential manner.

Medical records - held by the site

As shown in Table 43 the vast majority of sites (340/342) held a copy of the patients' medical records in line with good medical practice.[18]

Table 43. Description of site and whether the patients' medical records are held by the site

	Medical records held on site						
Description of site	**Yes**	**%**	**No**	**%**	**Subtotal**	Unanswered	**Total**
Independent Hospital - in patient	**155**	99.4	**1**	0.6	**156**	3	**159**
Non-surgical Treatment Centre	**97**	100.0	**0**	0.0	**97**	3	**100**
NHS Hospital	**37**	100.0	**0**	0.0	**37**	0	**37**
Individual Cosmetic Surgeon	**10**	90.9	**1**	9.1	**11**	10	**21**
Other	**14**	100.0	**0**	0.0	**14**	0	**14**
Independent Hospital - out patient	**12**	100.0	**0**	0.0	**12**	0	**12**
Small Clinic (<3 clinicians)	**8**	100.0	**0**	0.0	**8**	0	**8**
Referral Service (UK)	**1**	100.0	**0**	0.0	**1**	3	**4**
Referral Service (abroad)	**3**	100.0	**0**	0.0	**3**	0	**3**
Clinic (>3 clinicians)	**2**	100.0	**0**	0.0	**2**	0	**2**
GP	**1**	100.0	**0**	0.0	**1**	0	1
Total	**340**	**99.4**	**2**	**0.6**	**342**	19	**361**

Data protection policy

The vast majority of sites: 344/352 (98%) had policies for the storage of medical records in accordance with the Data Protection Act (1998) and good medical practice[5] (Table 44).

Informing patients' GPs about their surgery

The majority (323/361 (89.5%) of sites recorded the referral route of patients. Of these 291/323 (90%) of sites accept patients from sources including those other than a GP referral (Data not shown). Table 45 displays these 291 sites, showing whether they routinely inform the patients' GP about their cosmetic surgery (with the patients' consent) in line with IHAS guidelines.[6] 12/279 (4.3%) of these sites did not have a policy of informing the patients' GP contrary to IHAS guidelines.

Table 44. Description of site and existence of a policy for handling medical records in accordance with the DPA (1998)

	Handled data according to the DPA 1998						
Description of site	**Yes**	**%**	**No**	**%**	**Subtotal**	Unanswered	**Total**
Independent Hospital - in patient	**155**	98.7	**2**	1.3	**157**	2	**159**
Non-surgical Treatment Centre	**97**	100.0	**0**	0.0	**97**	3	**100**
NHS Hospital	**37**	100.0	**0**	0.0	**37**	0	**37**
Individual Cosmetic Surgeon	**16**	84.2	**3**	15.8	**19**	2	**21**
Other	**14**	100.0	**0**	0.0	**14**	0	**14**
Independent Hospital - out patient	**12**	100.0	**0**	0.0	**12**	0	**12**
Small Clinic (<3 clinicians)	**7**	100.0	**0**	0.0	**7**	1	**8**
Referral Service (UK)	**2**	66.7	**1**	33.3	**3**	1	**4**
Referral Service (abroad)	**1**	33.3	**2**	66.7	**3**	0	**3**
Clinic (>3 clinicians)	**2**	100.0	**0**	0.0	**2**	0	**2**
GP	**1**	100.0	**0**	0.0	**1**	0	**1**
Total	**344**	**97.7**	**8**	2.3	**352**	**9**	**361**

Table 45. Description of site and policy to inform the patients' GP of their surgery

	GP informed						
Description of site	**Yes**	**%**	**No**	**%**	**Subtotal**	Unanswered	**Total**
Independent Hospital - in patient	**116**	94.3	**7**	5.7	**123**	5	**128**
Non-surgical Treatment Centre	**90**	96.8	**3**	3.2	**93**	2	**95**
Individual Cosmetic Surgeon	**18**	100.0	**0**	0.0	**18**	1	**19**
Other	**11**	91.7	**1**	8.3	**12**	1	**13**
Independent Hospital - out patient	**8**	88.9	**1**	11.1	**9**	3	**12**
NHS Hospital	**9**	100.0	**0**	0.0	**9**	0	**9**
Small Clinic (<3 clinicians)	**8**	100.0	**0**	0.0	**8**	0	**8**
Referral Service (abroad)	**3**	100.0	**0**	0.0	**3**	0	**3**
Clinic (>3 clinicians)	**2**	100.0	**0**	0.0	2	0	**2**
Referral Service (UK)	**2**	100.0	**0**	0.0	**2**	0	**2**
Total	**267**	**95.7**	**12**	4.3	**279**	12	**291**

Clinical governance

Outcome measurement is an important aspect of quality assurance in all surgeons. Sites reported monitoring outcomes as shown in Table 46, (answers may be multiple from 361 sites).

Table 46. Patient outcomes measured

Patient outcomes monitored	**Total**
Infection rates	**333**
Unplanned hospital re-admission rates	**324**
Patient satisfaction questionnaires	**315**
Psychosocial assessment	**46**
Complaints	**20**
Revision rates	**19**
Return to theatre	**12**
Adverse outcomes/complications/DVT	**10**
Length of stay	**3**
Other performance indicators	**1**
Other form of audit	**1**
Unanswered	**13**

The majority of sites 348/361 (96%) specified that they carried out some form of outcome measurement, with over 80% measuring infection rates, re-admission rates and/or some form of assessment of patient satisfaction. However the question was not answered from 13 sites.

The type of site from which a questionnaire was received where the question was not answered are shown in Table 47.

Table 47. The types of site that did not respond when asked which patient outcomes were measured

Description of site	**Total**
Individual Cosmetic Surgeon	**3**
Referral Service (UK)	**2**
NHS Hospital	**2**
Non-surgical Treatment Centre	**2**
Referral Service (abroad)	**2**
Other	**1**
Independent Hospital - in patient	**1**
Total	**13**

The CQC requires sites that are registered with them to report to them on an annual basis. This allows an external verification of the quality of the clinical practice taking place.[41] Table 48 shows whether sites make audit results available to external regulatory bodies.

Table 48. Number of sites that make the results of their audit available to external regulatory body

Audit results available	Total	%
Yes, CQC	**206**	69.6
Yes (not specified)	**42**	14.2
Yes (other regulatory body)	**34**	11.5
No	**12**	4.1
Unknown	**2**	<1
Subtotal	**296**	
Unanswered	**65**	
Total	**361**	

Of the sites that answered the question 282/296 (95%) claimed that the results of their audit are made available to external governing bodies. In 206/296 (69.6%) this was the CQC. 12/296 (4.1%) of sites claimed that they did not make the results of their audit available to any external governing body. They come from the site types listed in Table 49.

Table 49. Type of site that did not report audit findings to an external governing body

Description of site	Total
Individual Cosmetic Surgeon	**4**
Other	**2**
NHS Hospital	**2**
Non-surgical Treatment Centre	**2**
Small Clinic (<3 clinicians)	**1**
Referral Service (abroad)	**1**
Total	**12**

Table 50 shows the type of site of the 65/361 sites (18%) from which an answer was not received.

Table 50. Type of site that did not answer whether they reported their audit findings to an external body

Description of site	Total
Independent Hospital - in patient	**22**
NHS Hospital	**16**
Non-surgical Treatment Centre	**10**
Individual Cosmetic Surgeon	**7**
Other	**4**
Referral Service (abroad)	**3**
Referral Service (UK)	**2**
Independent Hospital - out patient	**1**
Total	**65**

It is of note that 22 independent hospitals with in patients and 16 NHS hospitals failed to answer this question. The guiding principle of any medical intervention is that it is effective (successful) and that the patient's safety is the primary goal. Those performing cosmetic surgery should engage in some form of quality review.

283/361 (78%) sites stated that they monitor implementation of action/change in response to their own audit report by carrying out some form of re-audit, clinical governance, medical advisory committee meetings, action plan or clinical effectiveness meetings (data not shown). Those sites that did not answer the question or responded negatively come from the site types listed in Table 51.

Table 51. Description of sites that do not monitor implementation or action of their audit findings or did not answer this question

Description of site	Total
Independent Hospital – in patient	23
NHS Hospital	17
Non-surgical Treatment Centre	13
Individual Cosmetic Surgeon	11
Other	5
Referral Service (UK)	3
Referral Service (abroad)	3
Independent Hospital - out patient	2
Small Clinic (<3 clinicians)	1
Total	**78**

In line with other surgical specialties (cardiac surgery and vascular surgery) the need for morbidity and outcome data is pressing. The Healthcare Commission had previously called for the development of assessment methodology to allow the comparison of outcome measurements. A national database for cosmetic surgery should be implemented to allow patients to be better informed.

Conclusion

This study highlights the very great difficulties that there are in accurately identifying who is doing what in cosmetic surgery and provides a new perspective on the reasons for concern in this sector. Undoubtedly some perform well but others could do better. Commercial priorities must not influence patient welfare.

Numerous cosmetic surgery procedures are performed each year in the United Kingdom. Previous reports (Healthcare Commission) have highlighted issues in this area of medical practice. Focus groups have highlighted areas of concern – brokering of services, regulation of advertising and assessment of clinical performance indicators.

The regulation of cosmetic surgery remains poor. Those representing providers have said that they would welcome specific regulation. This has not occurred.

This study has reinforced these concerns and highlighted other areas which need attention. As with any other type of surgery, the safety of cosmetic surgery patients is paramount. The failure of a large number of providers to participate in this study effectively means they are not complying with the expectations of the CQC or professional regulators, and hence are not being adequately regulated. There needs to be a change in statute to ensure robust regulation of cosmetic surgery for the safety of patients. At present, there is a part of the sector that gives the impression of being a cottage industry – unregulated and too small and disparate to ensure best possible patient care. Too many sites appear to be offering procedures that they perform infrequently. Concentrating expertise and experience in fewer centres is recognised to improve outcome.

The establishment of the British Academy of Cosmetic Practice goes some way toward introducing common standards, but it is likely that membership will be on a voluntary basis, questioning its effectiveness. This academy must be inclusive, demonstrating that a patient's outcome is related to the quality of the team involved in their care. The introduction of a number of inter-specialty cosmetic surgical training fellowships is to be welcomed, but these relatively rare posts are insufficient to train the number of surgeons required to deliver the demand for cosmetic surgery. Until there is a recognition that the independent sector needs to fully contribute to the resourcing of surgical training for those procedures performed in the main outside the NHS, the issue of accreditation and standardisation of training will not be resolved.

The report has highlighted areas of concern around the peri-operative safety of patients. Failure to adequately monitor patients is a recipe for disaster, highlighted by many published case reports. Staff caring for patients must be adequately trained to deal with all eventualities. National bodies need to be more rigorous in their enforcement of these standards.

The report questions the care given to vulnerable patients. There should be more availability of trained psychologists to assess patients who seek surgery on the basis of a personal and subjective intolerance of their own appearance.

Voluntary codes of conduct with regard to advertising are insufficient to regulate unscrupulous advertising that could take advantage of the vulnerable patient. The solution to this rests with the government.

There are some good signs on the horizon. There is a cadre of providers which are able to demonstrate that they are delivering high quality cosmetic care, however the regulators do not appear to have grasped the nettle despite the Healthcare Commission and DH reports to the Chief CMO. The effect of this failure of regulation is that it is difficult for patients to be assured that they are receiving an appropriate level of care, when they decide to seek treatment from a particular provider. The CQC should recognise that the findings of this report create a challenge for national regulation. There should be specific guidance to cosmetic surgeons in a public format that is able to empower patients and protect good clinicians.

On the face of it cosmetic surgery providers could do better.

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Appendices

Appendix 1 - Glossary of terms and abbreviations

Abdominoplasty, scar revision - This is an operation also known as a 'tummy tuck', it involves removing excess fat and skin in order to make the abdomen more firm.
ALS - Advanced life support certificate. The holder has passed an ALS course, reaching the standard defined by the resuscitation council (UK). The certificate is recognised Europe wide and lasts for 4 years.
Ambient media - Advertisements that have the aim of either drawing mass-attention in centralised locations or that directly interact with consumers during normal everyday activities. E.g. projecting images on sides of buildings or displaying advertisements on car-park receipts, supermarket trolleys etc.
ASGBI - Association of Surgeons of Great Britain and Ireland. This is a defined speciality association for general surgery.
AAGBI - The Association of Anaesthetists of Great Britain& Ireland. The association represents the aspiration of over 10,000 anaesthetists.
ASA - The Advertising Standards Authority (ASA) is the UK's independent regulator of advertising across all media, including TV, internet, sales promotions and direct marketing.
BAAPS -The British Association of Aesthetic Plastic Surgeons
BACP - British Academy of Cosmetic Practice. An independent overarching academic body that holds a list of practitioners who comply with a number of specific descriptors in relation to qualifications, training, experience and professional registration.
BAPRAS - British Association of Plastic, Reconstructive and Aesthetic Surgeons.
Blepharoplasty - This is a cosmetic procedure used to remove excess skin from the either the upper or lower eyelid.
Breast Augmentation/Reduction - Breast augmentation involves surgically inserting an artificial implant to increase the size of the breast. Breast reduction involves removing excess tissue to reduce the size of the breasts.
Brachioplasty - A brachioplasty, or arm lift, is a surgical procedure to remove loose skin and excess fat deposits in the upper arm.
Browlift - Also known as a forehead lift or browplasty, is a cosmetic surgery procedure used to elevate a drooping eyebrow that may obstruct vision and/or to remove the deep "worry" lines that run across the forehead.
Buttock lift/ implant - A surgical procedure that removes excess skin and fat from the buttocks, and/or the insertion of an implant may enhance the appearance, size and definition of gluteal muscles in the buttock area.
Body Dysmorphic Disorder - Defined as a preoccupation with one or more defects in one's appearance for which most people can hardly notice or do not believe to be important. To fulfil the criteria for diagnosis of body dysmorphic disorder, it must also cause significant distress or difficulty to the person.
Body lift - A body lift is surgery performed to correct excess loose and sagging skin. Surgical body lifting improves the shape and tone of the underlying tissue that supports fat and skin.
CAP - Committee of Advertising Practice
Cheek implant - Also known as Malar augmentation, uses implants, usually made of synthetic material, to make cheek bones more prominent

Clinic - This refers to an establishment (employing >3 cosmetic surgeons on a sessional basis) that carries out cosmetic surgery on site (although they may additionally refer patients to other large hospitals for certain surgical procedures).Cosmetic surgery is the only service offered by clinics, which may have overnight beds or cater only for out-patients.

CMO - Chief Medical Officer

Cosmetic surgery - For the purpose of this study the definition of cosmetic surgery "Operations that revise or change the appearance, colour, texture, structure or position of the bodily features to achieve what patients perceive to be desirable" was employed. Reconstructive plastic surgery (e.g. breast reconstruction after cancer) or bariatric surgery was not included. Non-surgical procedures such as botox R(copyright), fillers, chemical peels. dermabrasion, were also excluded.

CQC -The Care Quality Commission is the regulatory body for health care in England.

Data Protection Act - The Data Protection Act 1998 places obligations on organisations or individuals who record and use personal data, and must follow sound and proper practices (defined in the data protection principles). The Act defines eight principles of good practice in relation to the storing, processing or managing of personal data, and requires all organisations to comply with these principles.

DH - Department of Health

Direct mailing - Targeted advertisement messages are sent directly to consumers usually in the form of a letter in the mail.

ED - Emergency Department

Facelift - Also called rhytidectomy, facelift is a plastic surgery procedure used to remove facial wrinkles, sagging skin, fat deposits, or other visible signs of aging for cosmetic purposes.

Foreskin restoration - is the process of expanding the residual skin on the penis, via surgical or non-surgical methods, to create the appearance of a natural foreskin.

GA - General anaesthetic

GMC - General Medical Council

GP - General Practitioner

Gynaecomastia - gynaecomastia is a common condition in teenage boys where firm tender breast tissue grows under the nipples. It is usually caused by an in balance if hormones during puberty and usually disappears in a couple of years.

Hair transplant - A surgical technique that involves moving skin containing hair follicles from one part of the body (the donor site) to bald or balding parts (the recipient site).

HIW – Health Inspectorate of Wales- the independent inspectorate and regulator of all health care in Wales.

IHAS - Independent Healthcare Advisory Services - a representative organisation for the independent healthcare sector. A member of the Trade Association Forum, IHAS exists to share innovation, knowledge and expertise for the common good.

Independent hospital - This refers to a large facility (employing more than 3 cosmetic surgeons on a sessional basis) that is privately (or charitably) funded. These sites offer a range of clinical services of which cosmetic surgery is but one. These sites may have overnight beds for in-patients or only day-beds, but cosmetic surgery would be carried out on site. These organisations would normally oversee the patient throughout the patient pathway from initial consultation to post surgical aftercare. However they may also receive referrals from other organisations and only be responsible for the surgery itself.

Individual cosmetic surgeon - This refers to a surgeon who acts independently from any other organisation and conducts consultations for surgery at a location geographically or administratively separate. He/She is paid by the patient for their surgery and is responsible for the patient's care throughout the patient pathway.

Initial consultation - For the purposes of this study, the 'initial consultation' refers to the appointment with a member of staff within the organisation during which the patient first agrees to undergo a surgical procedure and/or pays for, or commits to paying for this to take place.

IP/OP - In patient / Out patient

ISTC - Independent Sector Treatment Centre

LA - Local Anaesthetic
Labiaplasty - A surgical procedure to reshape the inner lips of the vagina.
Laser liposuction - A method of liposuction that utilizes a laser during surgery to assist in unwanted fat removal.
Level 2 care - Level 2 care or a high dependency unit (HDU) is an area for patients who require more intensive observation, treatment and nursing care than can be provided on a general ward. It would not normally accept patients requiring mechanical ventilation, but could manage those receiving invasive monitoring.
Level 3 care - Level 3 care or an intensive care unit (ICU) is an area to which patients are admitted for treatment of actual or impending organ failure, especially when mechanical ventilation is necessary.
MACS facelift - Minimal Access Cranial Suspension facelift or minilift. A successor to the traditional facelift.
MAC meetings- meetings of the Medical Advisory Committee
Mastopexy - Plastic surgery in which the breasts are lifted or reshaped.
MDT – Multi-disciplinary team
Necklift - Plastic surgery to remove facial wrinkles, sagging skin, fat deposits, or other visible signs of aging for cosmetic purposes.
NHS hospital - A hospital that is funded by the National Health Service (even if certain aspects of care are independent).
Non-Surgical Treatment Centre - This is a facility that mainly carried out non-surgical cosmetic procedures, but may provide consultations for cosmetic surgical procedures.
Penis enlargement - There are two penis enlargement procedures: enlargement phalloplasty (increasing penis length) and girth enlargement (increasing penis width).
Pinnaplasty - Also known as otoplasty, a surgical procedure done to correct misshaped or protruding ears.
RCGP - Royal College of General Practitioners - the professional membership body for family doctors in the UK and abroad. We are committed to improving patient care, clinical standards and GP training.
Referral Service (UK & Abroad) - This is an organisation that organises cosmetic surgical operations. They act as a broker, not carrying out any surgery but refer patients for surgery that is carried out elsewhere. The consultation may or may not take place on site, but a commission is usually charged. A referral service may organise cosmetic surgery in the UK or abroad.
Rhinoplasty - Aesthetic surgery of the nose where cartilage and bone are reshaped and reconstructed; excess bone or cartilage may be removed.
RMO - Resident Medical Officer
RQIA - Regulation and Quality Improvement Authority (Northern Ireland)- the independent body responsible for monitoring and inspecting the availability and quality of health and social care services in Northern Ireland, and encouraging improvements in the quality of those services
SASM - Scottish Audit of Surgical Mortality – SASM identifies all deaths that occur in Scottish hospitals under the care of a surgeon, whether an operation has taken place or not. SASM forms are completed by the relevant Surgeon and where appropriate Anaesthetist. The forms then undergo a peer review process carried out by virtually every practising clinician within the audited specialties on behalf of their colleagues.
SCRC - were set up in April 2002 under the Regulation of Care (Scotland) Act 2001 to regulate all adult, child and independent healthcare services in Scotland. We make sure that care service providers meet the Scottish Government's National Care Standards and work to improve the quality of care.
Small clinic - This refers to a small establishment (employing 1-3 cosmetic surgeons on a sessional basis)that carries out cosmetic surgery on site (although they may additionally refer patients to other large hospitals for certain surgical procedures). Cosmetic surgery is the only service offered by small clinics, which may have overnight beds or cater only for out patients.
Specialist nurse practitioner - A registered nurse (RN) who has completed an advanced training program in a medical specialty. A specialist nurse practitioner may function as a primary direct provider of health care and prescribe medications.

Thigh lift - A thigh lift can be performed to tighten sagging muscles and remove excess skin in the thigh area.
Thread/suture facelift - Minimally-invasive facelift procedure involving the insertion of fine threads (sutures) through small incisions into deeper tissues. The threads are attached to soft tissues and are pulled upwards to tighten the deep tissues
Vaginoplasty - is a plastic surgery procedure used to construct or reconstruct a vaginal canal and mucous membrane.

Appendix 2 - Web-listings used to identify sites providing cosmetic surgery

- Yell.com
- EEZE Business
- Consulting Rooms
- BAAPS
- Hotfrog.co.uk
- Private Healthcare.com
- Skinlaser directory
- Harley Street guide.co.uk
- Laserlipo.co.uk
- Cosmetic Surgery and Beauty Guide
- Zettai.net
- Revahealth.com
- Google
- Cosmeticsurgeon.co.uk
- Cosmetic Surgery London
- Cosmetic Health.net

Appendix 3 - Corporate structure and role of NCEPOD

The National Confidential Enquiry into Patient Outcome and Death (NCEPOD) is an independent body to which a corporate commitment has been made by the Medical and Surgical Colleges, Associations and Faculties related to its area of activity. Each of these bodies nominates members on to NCEPOD's Steering Group.

The role of NCEPOD

The role of NCEPOD is to describe the gap between the care that should be delivered and what actually happens on the ground. In some ways it is a glorious anachronism: an exercise by the professions themselves to criticise the care that they deliver in the cause of improving the quality of the Service.

The process is simple but effective. We begin with an idea. Subjects can be suggested by anyone, but most come from the professional associations. It is measure of how deeply the medical profession are committed to the improvement of their service that they should be voluble and enthusiastic about having the care that they deliver assessed and criticised by their peers.

We have far more proposals than we can carry out and each year studies are chosen by competitive secret ballot of the NCEPOD Steering Group, after what is often a lively and partisan debate. In November 2007, when Parenteral Nutrition (PN) was chosen with Surgery in the Elderly which we will publish later this year, there were a further 12 disappointed studies.

Having gained Steering Group approval, the staff and co-ordinators together with an expert group work up the study design so as to get the raw material that they think they will need to explore the quality of care. They design the study and the questionnaires.

Trustees

Mr Bertie Leigh - Chairman
Professor G T Layer - Honorary Treasurer
Professor M Britton
Professor J H Shepherd
Dr D Justins
Professor L Regan
Professor R Endacott

Company Secretary - Dr M Mason

Clinical Co-ordinators

The Steering Group appoint a Lead Clinical Co-ordinator for a defined tenure. In addition there are seven Clinical Co-ordinators who work on each study. All Co-ordinators are engaged in active academic/clinical practice (in the NHS) during their term of office.

Lead Clinical Co-ordinator	Dr G Findlay (Intensive Care)
Clinical Co-ordinators	
Dr J A D Stewart	(Medicine)
Dr D G Mason	(Anaesthesia)
Dr K Wilkinson	(Anaesthesia)
Dr A P L Goodwin	(Anaesthesia)
Professor S B Lucas	(Pathology)
Mr I C Martin	(Surgery)
Professor M J Gough	(Surgery)

Steering Group as at 16th September 2010

Dr R Birks	Association of Anaesthetists of Great Britain and Ireland
Mr T Bates	Association of Surgeons of Great Britain & Ireland
Mr J Wardrope	College of Emergency Medicine
Dr S Bridgman	Faculty of Public Health Medicine
Professor R Mahajan	Royal College of Anaesthetists
Dr A Batchelor	Royal College of Anaesthetists
Dr B Ellis	Royal College of General Practitioners
Ms M McElligott	Royal College of Nursing
Dr T Falconer	Royal College of Obstetricians and Gynaecologists
Mrs M Wishart	Royal College of Ophthalmologists
Dr I Doughty	Royal College of Paediatrics and Child Health
Dr R Dowdle	Royal College of Physicians
Professor T Hendra	Royal College of Physicians
Dr M Clements	Royal College of Physicians
Dr S McPherson	Royal College of Radiologists
Mr B Rees	Royal College of Surgeons of England
Mr M Parker	Royal College of Surgeons of England
Mr D Mitchell	Faculty of Dental Surgery, Royal College of Surgeons of England
Dr M Osborn	Royal College of Pathologists
Ms S Panizzo	Patient Representative
Mrs M Wang	Patient Representative

Observers

Ms R Brown	National Patient Safety Agency
Mrs C Miles	Institute of Healthcare Management
Dr R Hunter	Coroners' Society of England and Wales
Dr N Pace	Scottish Audit of Surgical Mortality
Professor P Littlejohns	National Institute for Health and Clinical Excellence

NCEPOD is a company, limited by guarantee (Company number: 3019382) and a registered charity (Charity number: 1075588), managed by Trustees.

Appendix 4 - Supporting organisations

The organisations that provided funding to cover the cost of this study:
National Patient Safety Agency on behalf of the Department of Health in England and the Welsh Assembly Government
Department of Health, Social Services and Public Safety (Northern Ireland)
Aspen Healthcare Ltd
BMI Healthcare
BUPA Cromwell
Covenant Healthcare Ltd
East Kent Medical Services Ltd
Fairfield Independent Hospital
HCA International
Hospital of St John and St Elizabeth
Isle of Man Health and Social Security Department
King Edward VII's Hospital Sister Agnes
Netcare Healthcare UK Ltd
New Victoria Hospital
Nuffield Health
Ramsay Health Care UK
Spire Health Care
St Anthony's Hospital
St Joseph's Hospital
States of Guernsey Board of Health
States of Jersey, Health and Social Services
The Benenden Hospital Trust
The Horder Centre
The Hospital Management Trust
The London Clinic
The London Oncology Clinic
Ulster Independent Clinic

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The NCEPOD report On the face of it, looked into the provision of service of cosmetic surgery, not at the quality of care of individual patients; however, as a matter of general interest, NCEPOD and our advisors have looked at what the report means for those that may be considering cosmetic surgery.

The Department of Health[1], the BAAPS[2] and the BAPRAS[3] all have published checklists of questions that those considering cosmetic surgery should ask of their potential provider. On the basis of the NCEPOD report, On the face of it, NCEPOD suggests that patients considering cosmetic surgery should also ask the following questions of themselves and of their cosmetic surgery provider:-

Group 1: Questions you should ask yourself

Cosmetic surgery is a personal choice. The only indication for it is your own personal desire to change your appearance. We think you should ask yourself the following questions.

1. Am I proposing to have this operation to remedy something that I think really needs improving rather than because someone else has told me I need it?

   Note: As the BAAPS website points out, the real expert on your appearance and any concerns you may have is you. You do not need advice from a nurse or surgeon about what is wrong with your appearance.

2. Am I in the right frame of mind to be undergoing a cosmetic surgery operation?

   Note the BAAPS website says you should avoiding surgery if you have just undergone a major life event, such as moving house, changing job, bereavement, break up of a relationship or the arrival of children.

3. Am I confident that those who are proposing to undertake this operation fully understand the emotional needs that have brought me to this decision?

   Note what the NCEPOD report says about the value of psychological evaluation on pages 22-23.

4. Have I received enough information about this procedure, including any possible risks, well before making the decision to undergo surgery?

   Note: The process of gaining information about what is available for you and the decision that you should opt to undergo this operation should be separated, so that you have a chance to consider the advantages and disadvantages.

5. Have I given written consent for the surgical procedure in two stages? the first at the time of the consultation, and the second stage just before the surgery – at least 2 weeks later?

   Note: The risks and other disadvantages of this sort of surgery should be spelled out well before you take your decision, you need to make preparations to be off work and generally become emotionally committed to the decision you have taken. As the BAPRAS website puts it, "cool off before you commit."

6. Am I confident that I have been given enough time for reflection or have I been hurried into a decision or offered any financial incentive to have the procedure done soon?

   Note: The BAAPS website advises you to beware of what appear to be "free" consultations and any financial arrangements that may appear to influence your judgement or lock you into a decision.

Group 2: Questions you could ask the Clinic

These questions may seem pointed and direct, but they are all requests for information that we think should be made available to people who are proposing to undergo surgery at the hands of the clinic/hospital. If the Clinic/ hospital does not welcome the opportunity to answer them you may be in the wrong place.

7. Is there a financial penalty if I change my mind about having surgery? If yes, up to which date can I change my mind without a financial penalty?

8. Has the surgeon performed the same operation I am to undergo with the same team in the clinic or hospital where I am to have my operation regularly in the last 12 months?

   Note what the NCEPOD report says about infrequent surgery on page 29.

9. How many of those patients have complained to you about the quality of their result or any other aspect of their experience?

10. Does the surgeon hold an NHS consultant appointment? If yes, in which hospital is this? And in which specialty is the surgeon on the GMC specialist register?

    Note: Consider the sort of operation you are proposing to undergo and the relevance of the training that your surgeon has received. The range of surgeons doing this work is described on pages 30-31.The views of BAAPS and BAPRAS are set out on their websites.

11. Is the surgeon a member of an appropriate specialist association e.g. ASGBI,BAAPS, BAOMS, BAORLHNS, or BAPRAS?

12. Who will deliver the anaesthesia for my operation, and are they on the specialist register as an anaesthetist?

13. Is the hospital/ clinic registered with the CQC? If so:
    7.1 Is the Regulated Activity the Performance of Surgical Procedures?
    7.2 When was the last inspection? And
    7.3 What was the outcome?

    Note: the CQC is the official government regulator of these clinics, but it regulates a number of other sorts of healthcare establishments as well.

14. Will I be provided with guidelines on what to do if I become ill after going home, and is there an emergency 24 hour telephone help-line to call?

15. Which hospital will I go to if I become ill after going home?

16. If there is a problem during or after my operation and I need a greater level / dependency of care than can be provided at this hospital, where will I go?

    Note what the NCEPOD report states on this subject of post operative support if things do not go well on pages 32-5

References

1. The Department of Health: http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_4138410.pdf
2. BAAPS: http://www.baaps.org.uk/safety-in-surgery/consumer-safety-guidelines
3. BAPRAS http://www.bapras.org.uk/guide.asp?id=135