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Royal College of Surgeons

Requirements for a future national audit of cosmetic surgical practice

Royal College of Surgeons
ADVANCING SURGICAL CARE

Aim of paper

To outline the requirements for any future national audit of cosmetic surgery and to invite key stakeholders to consider the proposals and how they might be implemented and linked with other areas of work, such as certification and the national breast implant registry and any future additions to registry.

Cosmetic surgery is defined as the choice to undergo an operation, or invasive medical procedure, to alter one's physical appearance for aesthetic rather than medical reasons. It is rarely available through the NHS, primarily taking place in the private sector. For the purposes of this document, invasive cosmetic procedures are defined as set out in the *Professional Standards for Cosmetic Practice* (RCS, 2013)

The case for change

There is a lack of quantifiable data about cosmetic practice within the independent healthcare sector in the UK and considerable concerns that, in certain cases, patients are being pressurised into having unnecessary treatment and practitioners who lack essential credentials are carrying out surgery.

In April 2013, the Department of Health published Sir Bruce Keogh's review into the regulation of cosmetic interventions, highlighting an urgent need for robust regulation of cosmetic practice.[1] It noted that 'the existing regulatory framework has not kept up to pace with changes and it does not provide enough protection against many of the potential risks from cosmetic procedures'.

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The review made numerous recommendations to improve regulation of the industry. Specifically, The Royal College of Surgeons of England (RCS) was asked to set up the Cosmetic Surgery Interspecialty Committee (CSIC) to take forward the recommendations relating to cosmetic surgery.

As part of the Keogh recommendations, the CSIC was asked to 'establish and oversee a clinical audit database for cosmetic surgery working with the Healthcare Quality improvement Partnership (HQIP)'. Membership of the CSIC has included the relevant surgical and professional associations, patient and provider representatives, and regulators.

Recommendations and next steps

The CSIC has discussed the requirements for a future national audit of cosmetic surgical practise and recommends that it reviews adherence to agreed service standards and collects essential demographic data about the current practice within cosmetic surgery.

We ask stakeholders to consider these proposals and to identify the following for the recommendations listed below:

a) Organisational ownership
b) Funding

Proposed objectives, capabilities delivered and desired outcomes

The two different aspects of this proposed work have been split into two 'phases'. They could be completely separate pieces of work or be one project with both parts implemented in parallel, depending on ownership and funding.

Phase 1

In order to develop service standards for cosmetic surgery, a multistakeholder group would be required to review current evidence, agree a set of standards and carry out a formal consultation process prior to publication.

Key aspects of care that should be incorporated into any new standards are:

- Representation of the whole patient pathway
- Outpatient care, first assessment and discussion of surgical options
- Surgical and operative care, including preoperative requirements, consent, theatres and postoperative care
- Inpatient care environment, equipment and staffing
- Staff qualifications, training and CPD requirements
- Issues such as pain management, recovery, postoperative care and discharge
- Governance of the service including policies, protocols and management of risk
- Standards for advertising and financial packages for patients
- Patient requirements from a service including the information required at each stage, rights to advocacy, dignity and respect

Such work is anticipated to take 9–12 months. Any agreed standards would require widespread endorsement from all stakeholder organisations to ensure that they are implemented in practice. A more detailed plan for this aspect of work is listed in Appendix 1.

Phase 2

Upon development of agreed standards, the following should be considered for inclusion within a national audit:

- Demographic data such as numbers of procedures, numbers of staff, types of patients, service environment, etc
- Staffing and environmental arrangement of the service
- Compliance against key aspects of service standards

It is anticipated such work would take approximately 18 months and would incorporate the translation of agreed standards into audit questions, development of a web-based audit tool, piloting, data collection, data analysis and report writing. A more detailed plan for this aspect of work is listed in Appendix 2.

There are plans to extend the Breast Implant Registry to incorporate other types of implant used in cosmetic surgery. This resource could be a useful means of delivering an audit in future.

Scope of work

Within scope (subject to agreement of responsible body and funding)

- Development of service standards
- Development of a business case to commission a national audit
- Development of a pilot and roll-out of a national organisational audit on cosmetic surgery services

Outside of scope

The planning or implementation of:

- A clinical audit
- A patient survey
- Additional quality improvement work

Benefits

The following benefits would be realised from successful completion of both phases of the plan:

PHASE 1			
Consideration	**Benefit**	**To be experienced by**	**Type of benefit**
Standardisation of care	• Nationally agreed levels identified for services to work towards	• Staff, national audits, patients	• Patient choice • Quality improvement
Support patient information	• Provide clear information for patients about expected standards of care they should expect	• Patients	• Patient choice
Support CQC inspections and monitoring	• Support inspection of services against nationally agreed standards	• Care Quality Commission, cosmetic surgery services	• Quality improvement

PHASE 2			
Consideration	**Benefit**	**To be experienced by**	**Type of benefit**
Supporting improved accessibility/transparency of data at a service level	• Provides accurate demographic data about the types of cosmetic surgery and where these are taking place • Allows a baseline measurement of current quality of care, which could then support quality improvement • Allows patients to see more detailed data about the quality of services	Service staff and users, CQC, patients	• Patient choice • Quality improvement
Standardisation of care	• Accurate quantification of baseline service activity and quality of care and identification of areas for service improvement	Staff, national audits, patients	• Patient choice • Quality improvement
Quality improvement and safety	• Patient safety in surgery is of high public and political concern • Improving monitoring of quality of care	Independent cosmetic surgery staff and users, patients	• Quality improvement
Support CQC inspections and monitoring	• Support accurate benchmarking against agreed standards	Care Quality Commission, cosmetic surgery services	• Quality improvement
Support assessment of risk by insurance providers	• Allow improved assessment of quality of care and overall provision of care by independent cosmetic surgery providers	Cosmetic surgery services, insurance companies	• Quality improvement • Cash releasing

Risks

Project risks are listed below and are split into the risks associated with the overall work or individual phases 1 and 2

Phases of work	Risk description	Likelihood score	Impact score	RAG score	Mitigating actions	Likelihood score following mitigation	Impact score following mitigation	RAG score following mitigation
1 & 2	Changing organisational priorities within stakeholder organisations and DoH	3	4	12	Clear plan for implementation, consideration of alternative methodologies and possible splitting of project	2	2	4
2	Unclear roles and responsibilities where the project team does not perform as expected	2	4	8	Clinical leadership with sufficient seniority and with adequate sponsorship to support project management team achieve goals	1	2	2
1	Poor engagement with key stakeholders may undermine use of standards in practice	2	3	6	Ensure appropriate stakeholder engagement at Board level and clear communication strategy throughout	1	2	2
2	Lack of engagement by independent sector in implementing standards and auditing care	2	4	8	Ensure stakeholders have adequate chance to comment on developing standards and that final product sets standards that are achievable	2	2	4
2	Funding requirements may increase depending on the methodology chosen	3	4	12	Clear agreement early in project by responsible organisation on the chosen methodology for audit development and review of funding requirements	2	2	4

Constraints and dependencies

Choice of methodology for delivering work

The plan and costings included within this document are dependent on the choice of methodology for both phase 1 and phase 2. If an alternative methodology for audit development is chosen – e.g. a different audit tool – then costs and timeframes may vary.

Organisational ownership and funding

Commissioning of an organisational owner and funding the work is essential. This project could be split into two clearly defined projects with different funders and organisational owners or could be carried out as a single project.

Development of service standards

Developing a national audit of cosmetic surgery practice is dependent on completing an agreed set of service standards.

Overall management of both projects

There would be a requirement for a clinical lead with dedicated time for development of this work, alongside a project manager to coordinate activities.

Phase 1

Appendix 1 shows an outline of the process and timescale for the development of nationally agreed service standards.

Phase 2

An audit proposal and plan outlining key aims and objectives, methodology, funding required and reporting arrangements would need to be developed.

The audit proposal would need to include:

- Methodology for audit
- Timeline for development of audit questions, development of audit tool, pilot, data collection, analysis and reporting
- Proposed governance and risk management
- Funding required
- Reporting arrangements

There are several sources of data that could support future audit that would reduce repetition of data entry and the burden on services:

a) Utilising data that will be collected and submitted by services to PHIN

b) Utilising data that will be collected for submission to the Breast Implant Registry

Ensuring that alignment with other work being carried out within cosmetic surgery will be important in building the case for and implementing an audit. Once funding and a responsible body have been agreed, the audit would take 18 to 21 months, depending on implementation methodology.

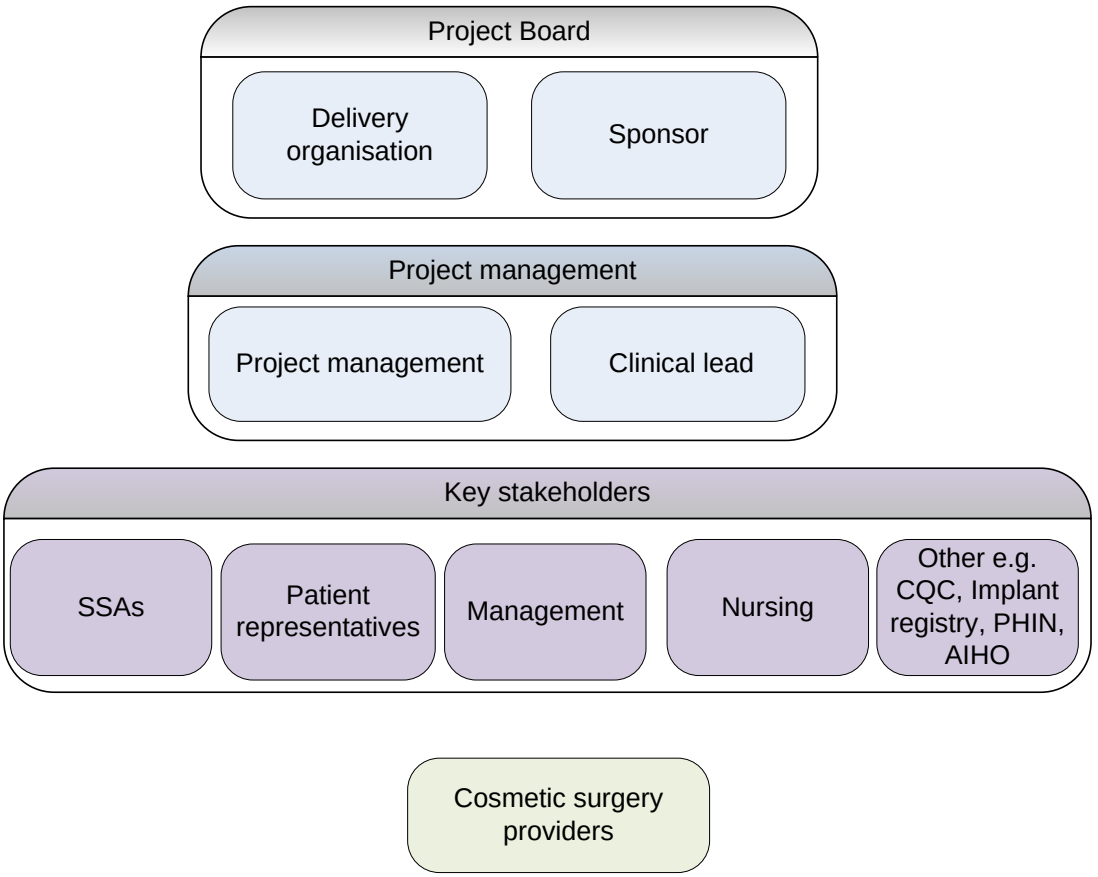
Funding requirements

The costs listed below are based on development of standards and an audit with the methodologies and timeframes listed in Appendices 1 and 2.

Estimated costs for phase 1 and 2 of development of a national audit of cosmetic surgery services				
Area of work		Detail	Year 1	Year 2
Management	Clinical lead	1 PA/week	13,000	13,000
	Project management	0.5 WTE (Band D)	16,640	17,074
	Subtotal		**29,640**	**30,074**
Meetings	Rooms, AV, catering for 20 and travel)	Cost per meeting = 1,500, 2 for phase 1 and quarterly for phase 2	3,500	6,000
	Teleconferences	Cost per meeting = 100 (one per quarter)	400	400
	Subtotal		**3,900**	**6,400**
Additional costs	Phase 1	Literature search*	**2,000**	n/a
		Consumables	**500**	
	Phase 2	Audit tool development (if externally developed)*		**70,000**
		Statistician		**10,000**
		Reporting, publication, other consumables		**2,500**
Total			**36,040**	**118,974**

*This price excludes VAT

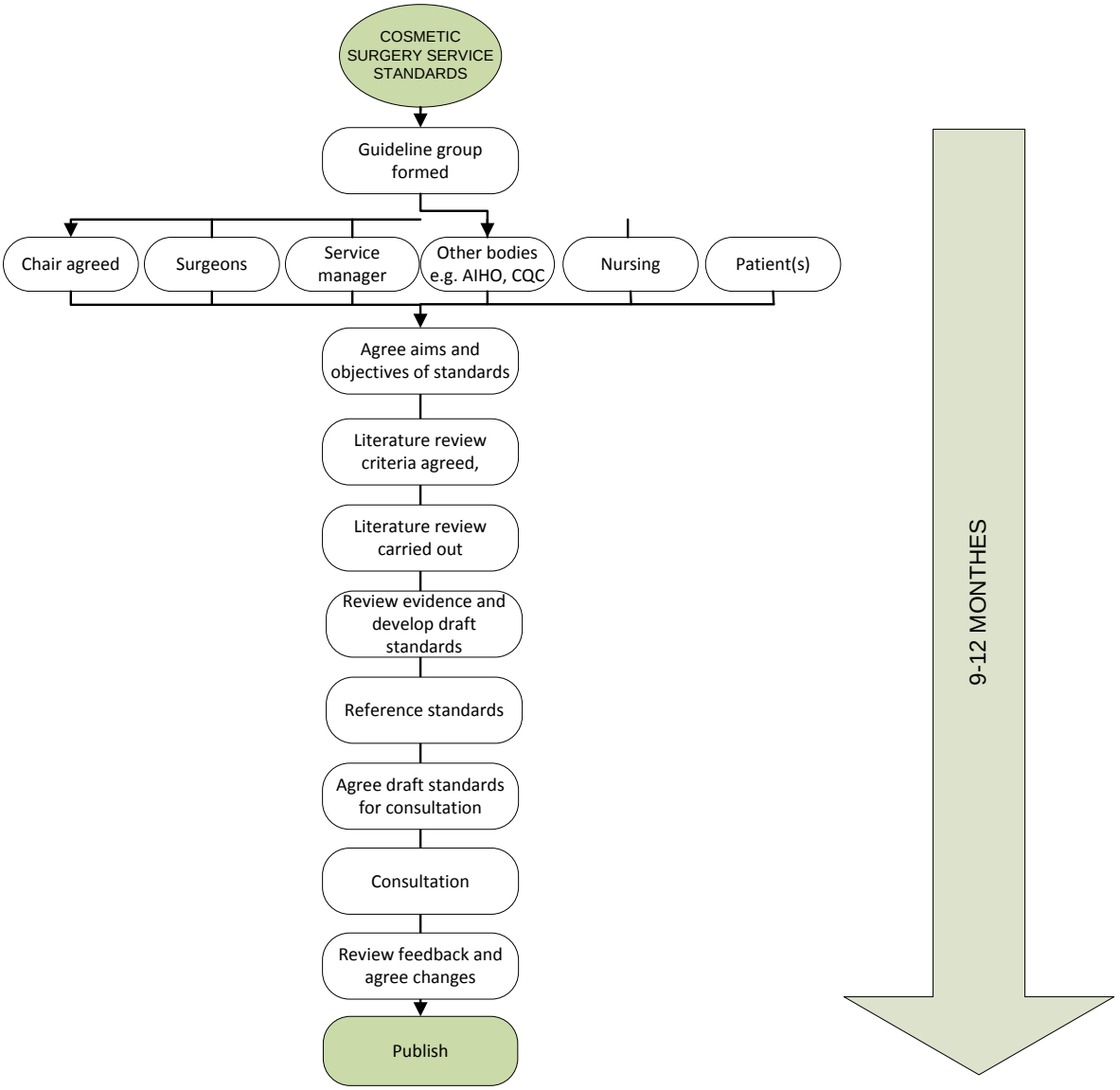
Organisation, governance and assurance



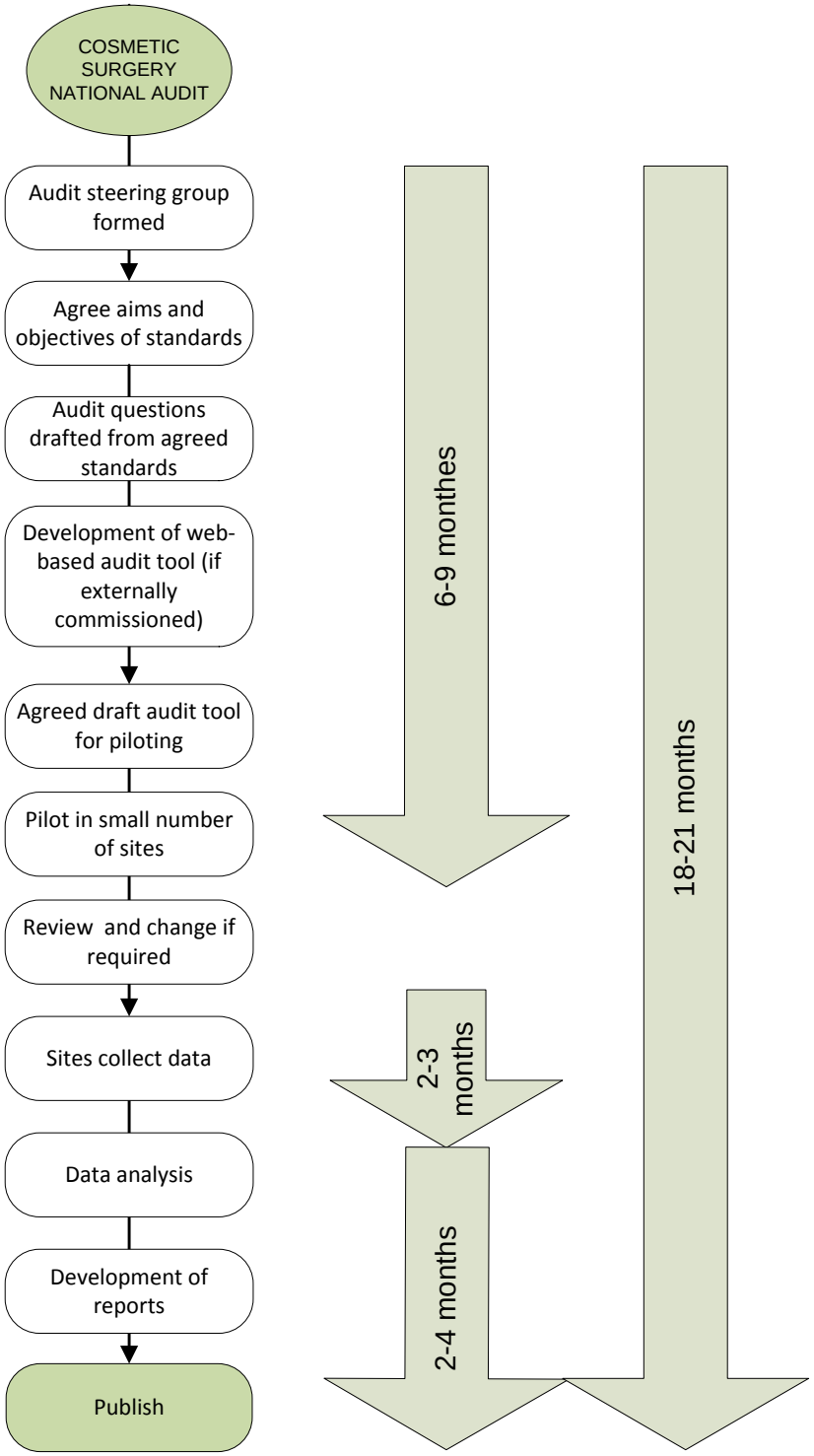
The funding body or sponsor would commission the delivery organisation to complete an agreed work programme within set timescales. The delivery organisation would be responsible for appointing a project manager to coordinate work, alongside a clinical lead who would provide clinical input. This project team would then appoint a reference group of key stakeholders and would also be responsible for liaising and implementing the audit within cosmetic surgery providers.

Task and finish groups with specific stakeholders to deliver specific outputs would have a set remit, purpose and end date.

Appendix 1: Timeline and stages for development of service standards



Appendix 2: Timeline and stages for development of national audit



The College would like to thank the members of the Cosmetic Surgery Interspecialty Committee (CSIC) for their contribution to this document. Members include:

The Academy of British Cosmetic Practice

The Association of Breast Surgery (ABS)

The Association of Independent Healthcare Organisations (AIHO)

The British Association of Aesthetic Plastic Surgeons (BAAPS)

The British Association of Oral and Maxillofacial Surgeons (BAOMS)

The British Association of Otorhinolaryngology – Head and Neck Surgery (ENT UK)

The British Association of Plastic, Reconstructive and Aesthetic Surgery (BAPRAS)

The Royal College of Ophthalmologists (RCOphth)

The Royal College of Surgeons Patient Liaison Group (PLG)