Harley Street Healthcare Ltd

Harley Street Healthcare - Gray's Inn Road

Inspection report

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

Ratings

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

Summary of findings

Overall summary

Harley Street Healthcare Limited is operated by Harley Street Healthcare Limited. The service was registered by CQC on 26 March 2021. The service provides day case surgical hair transplant procedures to private patients over the age of 18. The service provided hair transplants using the follicular unit extraction (FUE) method. All procedures were undertaken using local anaesthesia. We inspected this service using our comprehensive inspection methodology.

We carried out an announced inspection on 12 May 2022, at the Gray's Inn Road, London location. During the inspection we visited reception areas, waiting areas, treatment rooms, consultation rooms and a decontamination room. We spoke with four senior staff members, including the registered manager. We also spoke with a surgeon, two technical assistants and a patient. Following the inspection, we spoke with a further four patients.

The service is registered to provide the following regulated activities:

• Surgical Procedures

• Diagnostic and screening procedures

• Treatment of disease, disorder and injury

There has been a registered manager in post since the service registered with CQC.

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Surgery	Good 	Our rating of this service improved. We rated it as good because: • Practices around consent and records were actively monitored and reviewed to improve how people were involved in making decisions about their care and treatment. • The service was tailored to meet the needs of individual people and was delivered in a way to ensure flexibility, choice and continuity of care. • The leadership, governance and culture were used to drive and improve the delivery of high-quality person-centred care. All staff engaged in activities to monitor and improve quality and outcomes. Outcomes for people who used the service were positive and consistent. • Governance arrangements had been developed and demonstrated commitment to best practice performance and risk management. The organisation ensured staff had the skills and knowledge to use those systems and processes effectively. Problems were identified and addressed quickly and openly. • There was an embedded and systematic approach to improvement. Improvement methods and skills were available and used across the organisation, and staff were empowered to lead and deliver change. • The service had enough staff to care for patients and keep them safe. Staff had training in key skills, understood how to protect patients from abuse, and managed safety well. The service controlled infection risk well. Staff assessed risks to patients, acted on them and kept good care records. They managed medicines well. • Staff provided good care and treatment, gave patients enough to eat and drink, and gave them pain relief when they needed it. Staff worked well together for the benefit of patients, advised them on how to lead healthier lives, supported them to make decisions about their care, and had access to good information.

Summary of findings

- Staff treated patients with compassion and kindness, respected their privacy and dignity, took account of their individual needs, and helped them understand their conditions.
- Staff understood the service's vision and values, they felt respected, supported and valued. Staff were clear about their roles and accountabilities. The service engaged well with patients and the community to plan and manage services and all staff were committed to improving services continually.

Summary of findings

Contents

Summary of this inspection

Background to Harley Street Healthcare - Gray's Inn Road

We previously inspected this service using our comprehensive inspection methodology on 14 and 15 September 2021.

During that inspection, we identified numerous concerns as a result of which, on 21 September 2021, we served an urgent notice under section 31 of the Health and Social Care Act 2008, resulting in suspension of the provider's registration in respect of the regulated activities carried out. We suspended the provider's registration for a period of four weeks.

We re-inspected the service on 19 October 2021 to review the improvements made by the provider in specific areas of concern identified in the notice.

As it was a follow up focused inspection, reviewing actions taken in response to previously identified specific areas of concerns, on that occasion we did not re-rate the service. Due to the suspension, at the time of the inspection, the service was not operational. That meant we were unable to assess the impact of the improvements made by the provider on patients and the practical service delivery.

On this occasion we returned to conduct a comprehensive inspection of all aspects of the service and base our ratings upon our findings.

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

The key questions we asked during this inspection were, was it safe, effective, responsive and well-led.

Outstanding practice

We found the following outstanding practice:

- General Medical Council (GMC) registered as a Designated Body with a Responsible Officer so they could employ clinicians directly. This had built a strong team ethos and showed professional investment in the service.
- The service provided in house training workshops and tested staff on their understanding of the teaching, ensuring they were competent to deliver their roles.
- The service employed and trained staff to provide a year-round 9am – 9pm patient hotline.

Our findings

Overview of ratings

Our ratings for this location are:

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

Good

Surgery

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

Are Surgery safe?

Good

Mandatory training

The service provided mandatory training in key skills to all staff and made sure everyone completed it.

Staff received and kept up to date with their mandatory training. The training was comprehensive and met the needs of patients and staff.

A training matrix had been produced which showed the status of the individual staff members regarding their mandatory training as red, amber or green (RAG). With green - completed, amber - needs to be completed and red – expired. Managers monitored the matrix and alerted staff when they needed to update their training. At the time of inspection all staff had completed their training.

In addition, staff also completed training in the World Health Organisation (WHO) surgical checklist, recognising and what to do if a patient shows signs of sepsis, and National Early Warning Score (NEWS2). Sepsis is the body's extreme reaction to an infection and NEWS2 is a scoring system which improves the detection and response to clinical deterioration in adult patients and is a key element of patient safety and improving patient outcomes.

We were told and saw evidence during our inspection of training followed by a short examination to make sure staff understood what they had been told. If required, one to one training was provided.

The two hair transplant technicians (HTT) we spoke with described the mandatory training they had undertaken and the support they had received from the managers in completing this.

Managers made sure staff received any specialist training for their role. Technicians were being developed and trained to deal with different hair types, for example, African and Caribbean hair.

Training needs were discussed during annual staff appraisals and at the six-monthly managers supervision meetings with staff.

Good

Surgery

Safeguarding

Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it.

Staff received training specific for their role on how to recognise and report abuse. Safeguarding training was included in the training matrix.

Staff knew how to make a safeguarding referral, who the safeguarding lead was and who to inform if they had concerns.

The senior team were trained to level 3 in safeguarding for adults and children and the operations manager was the safeguarding lead. In this service they do not treat children, but the registered manager told us to ensure the staff had a well-rounded understanding of safeguarding all staff were dual trained.

There were posters on safeguarding in every treatment room with the indicated safeguarding lead, appropriate contacts and process to follow for a safeguarding incident.

Staff had participated in a workshop for female genital mutilation (FGM) and were able to describe the learning gained. There had also been a workshop on safeguarding where the escalation processes were discussed.

We reviewed the safeguarding policies which were in date and comprehensive.

Cleanliness, infection control and hygiene

The service controlled infection risk well. The service used systems to identify and prevent surgical site infections. Staff used equipment and control measures to protect patients, themselves and others from infection. They kept equipment and the premises visibly clean.

Treatment rooms were visibly clean and had suitable furnishings which were also visibly clean and well-maintained. Daily cleaning records were up to date and infection control checks had been completed daily. There was an infection control log in each treatment room. To demonstrate equipment had been cleaned, staff placed green stickers to visibly show equipment was safe to use. Red ‘clean me’ stickers were used to identify furniture and equipment which required cleaning.

There was a service level agreement (SLA) in place with an external cleaning company to provide cleaning to the NHS national standards of healthcare cleanliness 2021. Each room had two cleaning logs on the wall. One was completed by the cleaning contractors and the other was a visual check of standards by HSH staff. We saw that both had been completed and were up to date.

The service had two autoclaves which were used to sterilise some equipment used during the FUE procedures. Most of the items used were single use but the service used metal surgical tweezers which required decontamination and sterilisation. There was a separate decontamination room in which one of the autoclaves was kept. Once decontaminated, equipment was pouched and sterilised. Sealed pouches enabled the service to provide an effective and safe solution against recontamination after sterilisation.

Staff checked and recorded fridge temperatures daily and tested the autoclaves each morning and recorded the results in a log.

Good

Surgery

The service had a service level agreement (SLA) for the safe removal of sharps bins and clinical waste. We checked the sharps bins and found them to be correctly labelled and the clinical waste safely stored when awaiting collection.

Staff used records to identify how well the service prevented infections. We saw evidence to show the service had recorded no procedure related infections during 2021 or so far in 2022.

Although at the time of inspection Government COVID-19 guidelines had been significantly reduced, patients were screened over the telephone for COVID19 and other infectious diseases, as well as their fitness for the procedure they were visiting the service for. Reception staff checked visitors and patients' temperatures before advising them to sit on the socially distanced chairs to await a member of HSH staff. Visors were available for patients who were exempt from wearing masks. We saw staff wore face masks within the service, except one who was medically exempt.

Staff we observed followed infection control principles, which included wearing the correct personal protective equipment (PPE). Staff donned gloves, aprons and protective visors during treatment and always wore masks. Although FUE is considered a clean, not a sterile procedure, we saw staff put on full sterile PPE for the procedure. This was a decision by the management team to lessen the chance of patient infections. There were posters to show staff and patients what PPE was expected to be worn during the FUE procedures. There was also COVID-19 signage for social distancing and mask wearing on each floor.

Staff were required to take and submit the results of COVID-19 lateral flow tests twice a week.

The service completed IPC audits including hand hygiene, infection rate, autoclave, fridge temperature, and cleaning every three months and the results are reported and discussed at the monthly governance meetings.

We saw daily IPC room checks in each room which had been completed each day.

Environment and equipment

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

The design of the environment followed national guidance and the service had enough suitable equipment to help them to safely care for patients.

The treatment rooms were spacious and fully equipped with the necessary items for the procedure. Equipment such as pulse oximeters had been routinely checked and serviced. We saw evidence of all equipment servicing certificates.

We saw evidence the autoclaves had been serviced by an external specialist company. Staff conducted daily checks and the service had use of a backup autoclave in the event of breakdown. Stock was stored in a secure room and regular stock checks were conducted by staff. Stock that was near to its expiry date was placed in a quarantine box, so staff knew to use this stock first. This system had been in place for the last four months and we examined the quarantine box and found no out of date or near out of date stock in other areas.

Safety equipment was readily available to use. We saw evidence of equipment such as a defibrillator, oxygen, body fluid spill kit, anaphylaxis kit and an emergency grab bag had been routinely risk assessed and was safe to use.

Fire assessments had been regularly completed by an external specialist company and there were comprehensive fire drills held at regular intervals.

We saw evidence that legionella risk assessments had been completed and the operations manager had recently completed a legionella risk assessor course.

There was an equipment and servicing log which also contained review dates and portable appliance testing (PAT) dates. We were shown a locked cleaning cupboard complete with control of substances hazardous to health (COSHH) signage.

We saw evidence the Control of Substances Hazardous to Health (COSHH) assessments had been completed and regularly reviewed.

The storage of oxygen gas cylinders had been risk assessed and were stored in accordance with Health Technical Memorandum 02 (HTM02) guidance, including not being stored near to a defibrillator.

Ventilation was provided in treatment rooms by fresh air from open windows with fly screens in line with HTM 03-01, supplemented by air conditioning units.

The treatment rooms had coved floors, where the floor covering ran a smoothly up the wall for a few inches to enable better cleaning.

There were lockable medicine cabinets in each treatment room, which were locked when we checked.

Assessing and responding to patient risk

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

There was a proactive approach to anticipating and managing risks to patients by all staff. Staff completed risk assessments for each patient pre-operatively, during treatment and post operatively and reviewed this regularly, including after any incident. Initial assessments included psychological reviews, and medical history information. The service had an inclusions and exclusions policy which excluded patients with certain medical conditions or were taking certain medication.

Staff used a nationally recognised tool to identify deteriorating patients and escalated them appropriately. The National Early Warning Score (NEWS2) was embedded into the service and we saw pictorial posters displayed in all clinical areas for guidance and direction for staff. Staff were able to demonstrate a good understanding of looking for signs of deterioration in a patient and were able to describe the escalation process for those patients that required further assistance.

The service used the World Health Organisation (WHO) safe surgery checklist and we saw evidence this was embedded in the service.

Clinical observations of patients (obs) were recorded on the EPR and this was a mandatory field which meant it had to be completed before the software allowed the staff member to move on to another section. The hair transplant technicians were responsible for monitoring patient observations and their training was signed-off by a doctor.

The NEWS2, WHO checklist, patient observations and pain scores were audited quarterly as part of the audit of patient records.

Good

Surgery

Each patient underwent a pre-operative consultation with the transplant surgeon which was documented on the EPR. All patients were informed of any risks associated with the procedure and the realistic outcomes to be expected. The service implemented a two-week cooling off period after the consultation before the transplant could take place.

Post operatively patients were provided with an emergency contact number for the service which could be used 365 days between 9am and 9pm. All staff directly employed by the service to respond to patient queries were subject to the same mandatory training as patient facing staff. Patients were also provided with advice on what to do if for example, they had chest pains, shortness of breath or vomiting. A post-operative kit was provided which contained information and items such as a saline spray. The consultant made a follow up call to the patient five days after the procedure.

Records indicated all patient facing staff were trained in at least basic life support and they had received training in recognising sepsis.

Staffing

The service had enough staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed and adjusted staffing levels and skill mix.

The service had enough staff to keep patients safe and could adjust staffing levels daily according to the needs of patients.

All members of staff were employed by the service and it did not have any medical staff working on practising privileges. Instead, the service was registered with the General Medical Council (GMC) as a designated body (DB) with a named responsible officer (RO) in compliance with the Medical Profession (Responsible Officers) Regulations 2010.

The RO ensured regular appraisals were completed on all doctors and made recommendations to the GMC about their fitness to practise. In addition, as all medical staff were employed by the service on a part time basis, they also had a RO in their respective NHS trust.

At the start of their employment, all staff received an induction into the service, had their training credentials, practice licences and their disclosure and barring service (DBS) check verified. We saw evidence in the personnel matrix, which used the RAG system to highlight when any certificates or appraisals were nearing their expiry date. The process was set out in the Safer Recruitment policy.

Records

Staff kept detailed records of patients' care and treatment. Records were clear, up to date, stored securely and easily available to all staff providing care.

Patient notes were electronic, comprehensive and all staff could access them easily. We reviewed five sets of patients notes through their treatment journey. The records were comprehensive, detailed and current.

We saw evidence records contained templates for pre-operative, operative and post-operative stages with mandatory fields to be completed. The patient's capacity to consent was assessed through psychological assessments and we saw evidence risks were discussed along with diagrams of the procedure.

Good

Surgery

We saw evidence the patients' medical histories were documented, along with any allergies. Records contained the WHO checklist as well as details of local anaesthetic such as batch numbers and expiry dates for audit trail purposes. NEWS scores, as well as a pain scores were recorded throughout the patients' treatment. Consultant surgeons' notes were detailed.

We saw evidence audits were conducted every quarter and spot checks on three to five sets of notes were completed on a weekly basis. If any actions were identified these were discussed in the weekly team and monthly governance meetings.

We asked about photographs of patients pre and post treatment and the storage of personal data. We were shown a copy of the consent form which sought permission for non-identifiable photographs to be stored by the service. The consent form also informed patients of the service's intention to store their patient notes unless deletion was requested by the patient. Photographs taken by service staff on service equipment were automatically transferred straight to the same secure cloud storage where patient records were kept. This meant no photographs were stored on the device or onsite.

A letter could be sent to a patient's GP outlining the treatment performed if requested by the patient.

Medicines

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

Staff completed medicines records accurately and kept them up to date. Medicines were stored within each treatment room inside locked cabinets.

The service had an audit system in place, and all medicines close to their expiry date were quarantined in another locked cabinet in the manager's office prior to disposal. This was done to mitigate the risk of patients being given out of date medication.

If medication such as antibiotics were required by a patient post operatively, the surgeon signed the prescription on the day of surgery, and it was dispensed by a local pharmacy. The EPR system prevented any duplication of prescriptions with patient specific prescription numbers.

The service did not use or prescribe controlled drugs.

Doses of local anaesthetic used during the transplant procedure were recorded in the EPR.

We were shown an electronic medicine stock calculator, which was used to ensure required medications were always in stock.

Oxygen cylinders were stored safely in line with national guidance. The temperature of the medical fridges was checked and recorded daily and these and the medications were audited quarterly.

Incidents

The service managed patient safety incidents well. Staff recognised and reported incidents and near misses. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support. Managers ensured that actions from patient safety alerts were implemented and monitored.

Good

Surgery

The service had an incident policy tailored to the type of service provided with a named incident lead from the management team. The incident lead was also identified on the service's who's who list displayed in the corridors.

Staff were able to access this policy and all others via a mobile app as well as the connected service computers. The induction process for new members of staff ensured staff had read and could access all policies.

The service held a training workshop for staff to explain the incident escalation process, how to record incidents on the incident log and about duty of candour. Duty of candour was introduced as a regulation in 2014. The regulation puts a legal duty on all health and social care providers to be open and transparent with people using services, and their families, in relation to their treatment and care. Staff we spoke with were able to explain what duty of candour meant and how it related to incidents and complaints.

Incident logs were audited as part of the quarterly audit schedule. Incidents and related learning were a standing agenda item at the monthly governance meetings. Safety alerts and bulletins from organisations such as the National Institute for Health and Care Excellence (NICE) were discussed at monthly staff meetings. Emails were sent to staff not present.

Managers investigated incidents thoroughly. Staff were debriefed and supported after any serious incident. Two incidents had been reported at the time of inspection. We viewed the incident log and saw both had been investigated. The second had led to some re-training of staff and an update regarding notifications to CQC including a link to our guidance.

The service had a combined digital incident and accident record. No accidents had been recorded since the service had been registered in March 2021. Two incidents had been recorded in July 2021. One of the incidents required CQC to be notified under the Care Quality Commission (Registration) regulations 2009: Regulation 18 as the incident was reported to the police. The service made the notification.

Are Surgery effective?

Good

Evidence-based care and treatment

The service provided care and treatment based on national guidance and evidence-based practice. Managers checked to make sure staff followed guidance. The service met standards published by the Royal College of Surgeons.

The service had undertaken a comprehensive review and reworking of their policies, resulting in a fit for purpose location specific suite of policies. A standard part of each policy referenced how the policy complied with the CQC's fundamental standards. The fundamental standards define the basic standards of safety and quality that should always be met. In addition, each policy stated how and which of the CQC's key lines of enquiry, i.e. safe, effective, caring, responsive and well led, it related to.

The service ensured their policies, procedures and processes were compliant with the recommended clinical standards of the British Association of Hair Restoration Surgery (BAHRS).

Good

Surgery

The service used a quality compliance system to receive medical alerts which came through as notifications. The senior leadership team reviewed the alerts as a multi-disciplinary team and polices were customised with the new information. The updated information was cascaded through the online policy and discussed in team meetings. Staff were tested on policies through regular team workshops.

Resuscitation Council guidance was embedded into staff practice and in the resuscitation policy.

National Institute for Care Excellence (NICE) guidance was also embedded into the staff practice and in the clinical governance policy.

NEWS and the WHO surgical checklist were incorporated into the electronic patient record (EPR). Patients were asked about pain and this was also recorded within the EPR software.

The service ensured new staff had access to all the policies and understood them during their induction. Staff also had access to them via a mobile phone app.

Nutrition and hydration

Staff followed national guidelines to make sure patients fasting before surgery were not without food for long periods. The service made adjustments for patients' religious, cultural and other needs.

Staff made sure patients received enough food and drink to meet their needs including those with specialist nutrition and hydration needs. Patients were given breaks during the treatment and drinks and food were supplied.

The service was able to cater for nutrition and hydration for most religious, cultural or other needs.

The hydration levels of the patients were checked when observations were taken as part of the NEWS deteriorating patient protocols.

Pain relief

Staff assessed and monitored patients regularly to see if they were in pain and gave pain relief in a timely way. They supported those unable to communicate using suitable assessment tools and gave additional pain relief to ease pain.

Staff assessed patients' pain using a recognised tool (a visual pain chart) and gave pain relief in line with individual needs and best practice. We saw evidence in the records we reviewed, patients pain scores were recorded and managed.

Pain score posters were displayed throughout the clinic areas to guide staff.

The medical staff recorded the administration of local anaesthetic detailing type, batch number, expiry date, quantity and where applied in the EPR.

Patient outcomes

Staff monitored the effectiveness of care and treatment. They used the findings to make improvements and achieved good outcomes for patients.

Good

Surgery

The service monitored patient outcomes by following up after 18 months as results from treatment could be seen within this timeframe. This was in accordance with BAHRS guidance. Photographs of pre and post treatment were taken to make comparisons, as well as gaining patient feedback on the whole experience. The consultant completed a post-operative check with the patient with further consultations throughout the patient's journey. Patients were encouraged to provide feedback and patients we spoke with were able to clarify they had been involved and had reviewed their procedures as well as discussing outcomes.

All staff were actively engaged in activities to monitor and improve quality and outcomes as they carried out a comprehensive programme of repeated audits to check improvement over time.

We evidenced managers used information from the audits to improve care and treatment when reviewing the monthly governance meeting minutes.

Patient feedback was collected, and patients were encouraged to leave online reviews.

Post procedure infections were logged, and the service had a zero-percentage infection rate recorded for 2021 and to the date of inspection in 2022.

Competent staff

The service made sure staff were competent for their roles. Managers appraised staff's work performance and held supervision meetings with them to provide support and development.

Staff were experienced, qualified and had the right skills and knowledge to meet the needs of patients.

Managers gave all new staff a full induction tailored to their role before they started work. Staff had competency assessments, which were signed off by the doctors they were working with.

Managers supported staff to develop through yearly, constructive appraisals of their work. We saw evidence of a staff appraisal which discussed their knowledge and competency assessments as well as development plans for staff. Customer feedback was included in the appraisal process. A one to one supervision meeting was also held every six months.

Managers identified any training needs their staff had and gave them the time and opportunity to develop their skills and knowledge. Staff attended workshops where there were themed topics and they were tested at the end of the sessions. For example, we saw evidence of workshops on sepsis and FGM. Staff described these workshops as being engaging and helped develop their skills.

Staff had the opportunity to discuss training needs with their line manager and were supported to develop their skills and knowledge.

Staff were encouraged and empowered to develop through being responsible for certain areas within the service. For example, being champions in infection control checks and stock control.

The service was recognised as a designated body, and all doctor revalidation issues had been appraised by a responsible officer. All doctors who worked at the service were registered with the General Medical Council (GMC) and had indemnity insurance. All annual appraisals had been completed.

Good

Surgery

Multidisciplinary working

All staff worked together as a team to benefit patients They supported each other to provide good care.

Staff were committed to working collaboratively to provide a holistic approach to planning peoples' care and treatment. Staff held regular and effective multidisciplinary meetings to discuss patients and improve their care.

Monthly meetings were held for discussion on learning outcomes, concerns and any improvement ideas. This involved staff from different areas of the service.

Surgeons held monthly meetings to discuss current patient treatment and this was fed back to the senior leadership team.

Staff worked across health care disciplines and with other agencies when required to care for patients. The patients GP would be contacted with the patients consent if there were any health-related issues.

Seven-day services

Patients could contact the service seven days a week for advice and support after their surgery.

The service was opened Monday to Friday at varying times according to patient activity. Post operatively patients could access the service seven days a week between the hours of 9am and 9pm by contacting a patient co-ordinator.

Health promotion

Staff gave patients practical support and advice to lead healthier lives.

We saw relevant information promoting healthy lifestyles and support throughout the service. Patients were provided with health information on smoking and diet which could impact the outcomes of their treatment. Advice about hair shedding was also provided.

Staff assessed each patient's health when admitted and provided support for any individual needs to live a healthier lifestyle. Those patients with co-morbidities were provided with extra pre-operative appointments with the surgeon and information from other care providers was requested.

Consent and Mental Capacity Act

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

Consultant surgeons understood how and when to assess whether a patient had the capacity to make decisions about their care. Patients could be referred for counselling should the need arise.

Staff gained consent from patients for their care and treatment in line with legislation and guidance. We saw evidence consent was a two-stage process, the first being providing enough information, which included the risks for the patient to make an informed decision. The second stage involved gaining consent before treatment began during which the risks were explained to the patient again.

Good

Surgery

The service followed the Royal College of Surgeons (RCS) 'cooling off period' and it was built into the EPR as a mandatory field. This was a minimum period of two weeks between consultation and the start of treatment so patients could make an informed decision and in line with recommended guidance.

Staff made sure patients consented to treatment based on all the information available. Patients told us they had not been pressurised or coerced into deciding quickly and had been provided with an in-depth explanation of the treatment and risks associated with the procedure before reaching a decision to proceed.

Staff clearly recorded consent in the patients' records. We saw evidence from the five records we reviewed consent had been gained and enough time had been given between the first consultation and the start of treatment.

Even though the service did not treat patients under the age of 16 years staff were aware of the guiding principles of Gillick competence for patients.

All clinical staff were trained in the Mental Capacity Act 2005 and staff protected the rights of patients subject to the Mental Health Act and followed the Code of Practice. The EPR had capacity questions embedded into the consent process.

We noted topical mental health awareness week posters around the service.

Are Surgery caring?

Good

Compassionate care

Staff treated patients with compassion and kindness, respected their privacy and dignity, and took account of their individual needs.

Staff were friendly, discreet and responsive when caring for patients. We saw staff took time to interact with patients in a respectful and considerate way. Patients were supported and treated as individuals.

All the patients we spoke with told us they did not feel pressured in any way.

Patients said staff treated them well and with kindness. One patient described staff as 'excellent' and they had been treated well at all stages of their treatment.

Staff followed policy to keep patient care and treatment confidential.

Staff understood and respected the individual needs of each patient.

Staff understood and respected the personal, cultural, social and religious needs of patients and how they may relate to care needs. A quiet room was available for relatives if they wanted to use it.

After treatment patients were monitored for at least 40 minutes before being discharged.

Good

Surgery

Emotional support

Staff provided emotional support to patients to minimise their distress. They understood patients' personal, cultural and religious needs.

Staff gave patients and those close to them help, emotional support and advice when they needed it. Patients were given appropriate and timely support and information to cope emotionally with their care and treatment. Support services in the form of counselling could be provided for those patients that required it.

Patients told us they had been involved in the planning and making decisions about their care and treatment. They felt listened to, and their views respected

Staff understood the emotional and social impact that a person's care, treatment or condition had on their wellbeing and on those close to them.

Patients we spoke with said they had felt safe at the service and all of them had used the post-treatment telephone helpline. They all reported they felt reassured and supported by the service.

A chaperone service was available for patients and staff were trained to act as a chaperone if required.

Understanding and involvement of patients and those close to them

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

Staff made sure patients and those close to them understood their care and treatment. Patients we spoke with told us they did not feel pressurised to undertake treatment and had been given the time to reflect and make sure what the treatment involved. There was clear information given about the costs involved

Patients and their families could give feedback on the service and their treatment and staff supported them to do this.

Staff supported patients to make informed decisions about their care.

Patients gave positive feedback about the service and we saw evidence of the positive feedback via online review sites. We were told by staff that costs were explained and agreed prior to patients booking treatment. This was confirmed by patients we spoke with.

Are Surgery responsive?

Good

Meeting people's individual needs

The service was inclusive and took account of patients' individual needs and preferences. Staff made reasonable adjustments to help patients access services. There was a system for referring patients for psychological assessment before starting treatment, if necessary.

Managers planned and organised services, so they met the needs of their patients. The service was flexible, and people's needs, and preferences were met.

Good

Surgery

Continuity of care was considered. Patients were provided with the same surgeon throughout their treatment. If circumstances prevented the surgeon arranged at the appointment time being available, patients were able to re-schedule their treatment to stay with the same surgeon if they wished.

Managers monitored and took action to minimise missed appointments.

Facilities and premises were appropriate for the services being delivered and were in line with the Department of Health, Health Technical Memorandum (HTM) standards and design.

Staff understood and applied the policy on meeting the information and communication needs of patients with a disability or sensory loss. Staff had access to communication aids to help patients become partners in their care and treatment. The service provided a hearing loop service. This was advertised in the reception and we saw signs available in brail for visually impaired patients.

During the booking process reasonable adjustment requests could be made to assist patients in the consenting process. Alerts were then placed into the services booking system, so the patients requests could be accommodated throughout their treatment.

The service had information leaflets available in languages spoken by their patients. Managers made sure patients, relatives and carers could get help from interpreters when needed.

Patients were given a choice of food and drink to meet their cultural and religious preferences.

Staff completed equality and diversity training as part of their induction training. They were tested on their knowledge of equality and diversity during regular training workshops. We saw posters on equality and diversity displayed throughout the service.

The service could not provide access for patients using a wheelchair. However, there was an agreement to signpost patients to another service that provided wheelchair access.

A chaperone service was available and information on this service was displayed throughout the service. A chaperone policy was in place and was in date.

Access and flow

People could access the service when they needed it and received the right care.

Initial face to face or telephone consultations were held with patient co-ordinators who took patients through a range of options. If the patient wished to continue, they were then booked an appointment with a medical consultant. All procedures were booked in advance. There were no waiting times for consultations or procedures (following 14 day cooling off period). The service was able to flex appointment times to suit the patient's preference.

Patient co-ordinators managed the booking appointments and times for all patient appointments with the consultant. Automatic e-mails and texts were sent to patients to remind them of their appointments.

Cancellations were extremely rare, but if they did occur, the service could utilise bank staff at short notice, although they had not needed to at the time of reporting. The patient was always told beforehand if they had different staff and given the choice to alter their appointment if they preferred.

Good

Surgery

The contact centre was open seven days a week so patient requests could be escalated to a doctor if required.

Managers monitored waiting times and made sure patients could access services when needed and received treatment within agreed timeframes.

Learning from complaints and concerns

It was easy for people to give feedback and raise concerns about care received. The service treated concerns and complaints seriously, investigated them and shared lessons learned with all staff. The service included patients in the investigation of their complaint.

Patients, relatives and carers knew how to complain or raise concerns. The service clearly displayed information about how to raise a concern in patient areas.

There was a nominated complaint lead and staff understood the policy on complaints and knew how to handle them. Managers investigated complaints and identified themes.

Complaints were routinely discussed as part of the senior leadership teams' monthly meetings. Complaints were viewed as a way of improving the service. Learning from complaints was documented in a complaint log along with the meeting minutes which were then disseminated to staff.

Staff knew how to acknowledge complaints and patients received feedback from managers after the investigation into their complaint. Complaints were acknowledged within three days of receiving the complaint with investigation and response completed within 33 days in line with their complaints policy.

The service was in the process of consideration to join the Independent Sector Complaints Adjudication Service (ISCAS).

Are Surgery well-led?

Good

Leadership

Leaders had the skills and abilities to run the service. They understood and managed the priorities and issues the service faced. They were visible and approachable in the service for patients and staff. They supported staff to develop their skills and take on more senior roles.

Leadership was compassionate, inclusive and effective. Leaders had the experience, capacity and capability to ensure that the service's strategy could be delivered and risks to performance addressed.

Leaders had learnt from and taken onboard our previous inspection findings and actively engaged to improve and make sure the oversight of risks and quality were embedded into the service. The service was led by the registered manager and they demonstrated an in-depth knowledge of the requirements of the Health and Social Care Act and CQC fundamental standards.

Good

Surgery

Leaders understood the challenges of the service and had sought external expert advice to make sure they had the best systems in place to monitor and make improvements. During the inspection they demonstrated capability to manage the service.

There was regular review of the service's performance through governance meetings, audits and daily monitoring of key performance indicators. Leaders had included all staff in managing and monitoring outcomes of the service. For example, staff had oversight of a quality and performance board where daily monitoring information was displayed. This information had been collected by staff and they each had responsibility for ensuring these areas were compliant.

Vision and Strategy

The service had a vision for what it wanted to achieve and a strategy to turn it into action, developed with all relevant stakeholders. The vision and strategy were focused on sustainability of services and continuous improvement. Leaders and staff understood that and knew how to apply them and monitor progress.

There was a clear statement of vision and values, driven by quality and sustainability. This had been translated into a realistic five-year strategy and business plan.

The organisation's vision was to provide world class affordable care underpinned by a set of core values; courage, accountability, integrity, can do attitude, and patient centric.

Progress of the strategy was managed through their quality assurance and clinical governance framework and their newly adopted visual quality management system.

Staff involvement and collaboration in the development of the set of core values was conducted through vision traction organiser (VTO) days, a time management tool used to help simplify the strategic planning process through a set of key questions to get clarity.

Staff were aware of the values and their role in achieving them.

Culture

Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. The service promoted equality and diversity in daily work and provided opportunities for career development. The service had an open culture where patients, their families and staff could raise concerns without fear.

Leaders had a shared purpose to motivate staff to succeed. Leaders encouraged inclusive and supportive relationships amongst staff. There were high levels of staff satisfaction across the service.

Wellbeing was taken seriously. We saw a staff wellness board displayed throughout the service which provided information on health and wellness, for example healthy eating and exercise advice. Staff workshops provided opportunities for staff to feedback and have open and transparent conversations in a safe environment. Staff said they felt part of a family unit working for the service.

There was a strong collaboration of working together as a team to improve the quality of the service. Staff were empowered and encouraged to be 'champions' in their specific areas of work and regularly assisted in audits and improvement programmes.

Good

Surgery

There was a staff whistle blowing policy and workshops had been held to ensure staff knew what to do, should they want to raise a concern.

Risk assessments had been completed for staff to make sure their working environment was safe. These included, display screen equipment and working from home.

The service had policies to support staff which included a grievance and a bullying and harassment policy.

Staff feedback was positive on the 'teamwork' and support from each other. Staff said they were able to feedback and make suggestions on changes in an open and safe environment. Staff enjoyed the workshops and the learning and development they had received through interaction and testing of their knowledge.

Governance

Leaders operated effective governance processes, throughout the service and with partner organisations. Staff at all levels were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service.

There were effective governance systems in place to ensure there was oversight of safety, quality and performance. There was a strong collaboration of team working and support across all functions with a common focus of improving quality and sustainability. This was supported by the service's clinical governance policy.

The service had in-date policies tailored to the location. These were produced with references to the Health and Social Care Act, fundamental standards and CQC key lines of enquiry. The policies were version controlled and available to all staff at any time. Staff training took place to ensure staff understood them.

As part of the governance framework there were clear structures, processes and systems of accountability. All staff were clear about their roles and responsibilities, who they were accountable to and who to escalate concerns to.

The service utilised audits, risks assessments, yearly appraisals, supervisions, and patient feedback, supported by policies, to ensure sustainability of the service.

We saw evidence of the monthly governance meeting minutes with the senior leadership team (SLT). The meetings had set agenda items of risks, policies and procedures, staff mandatory training, audit related findings, infection control, complaints and patient feedback and incidents. Actions and updates were discussed. For example, the service had decided to continue with COVID-19 related IPC, as in checking patient's temperature on arrival and wearing PPE in non-clinical areas even though the latest public health guidance had changed.

External oversight and feedback on how the service was performing clinically was given by the doctor who was also GMC Responsible Officer for the service. Internally, the senior consultant who was the medical director had oversight. There were two other doctors on the SLT.

Outcomes from the governance meetings were cascaded to all levels of staff through regular team meetings.

Management of risk, issues and performance

Leaders and teams used systems to manage performance effectively. They identified and escalated relevant risks and issues and identified actions to reduce their impact. They had plans to cope with unexpected events.

Good

Surgery

We saw evidence of the service's risk register. Risks identified were monitored and managed through the monthly governance meetings. Risks were scored by the likelihood and impact of the risk and corrective actions listed.

Risk assessments had been completed, for example for fire extinguishers and external expert advice had been sought when required.

There was a systematic approach to performance and quality improvement. Various quality improvement projects had been undertaken with involvement from all staff. We saw evidence of a quality improvement project; staff sepsis education had made improvements within the service. By providing more visual aids on sepsis within the service they had seen an improvement in staff's identification, understanding and actions to take with sepsis. Seven random staff had been tested with five questions on sepsis and the service had seen a 10% increase in staff understanding of sepsis. Other quality improvement projects included infection control and a project on audits.

The service had started staff workshops as learning events. Staff feedback was very positive on the workshops. Workshops included topics on FGM, safeguarding, sepsis, policies, whistle blowing. Staff were tested at the end of the workshop.

We saw evidence of a workshop held for staff to upskill and improve their understanding of the Health and Social Care Act and the associated regulations.

Information Management

The service collected reliable data and analysed it. Staff could find the data they needed, in easily accessible formats, to understand performance, make decisions and improvements. The information systems were integrated and secure. Data or notifications were consistently submitted to external organisations as required.

The quality management system provided the service with key tools to manage performance.

Patient information was stored in a practice management software system specifically made for health clinics. This included patient photographs (stored in a secure cloud server) which were taken via the clinic's software. Patients were advised they could have their photographs removed without delay if they wished. An automated e-mail was sent to all patients to tell them how their personal information was stored. All systems were password protected and locked when not in use.

The service had an in date general data protection regulation (GDPR) policy.

All staff had completed information governance training and certificates of completion were kept in their personal files.

There were policies in place to ensure the patients privacy dignity and confidentiality was protected.

The registered manager knew how to submit data and notifications and would do so if necessary.

Engagement

Leaders and staff actively and openly engaged with staff and patients. They collaborated with partner organisations to help improve services for patients.

Good

Surgery

There was consistently a high level of engagement with staff and people who used the service. Patient feedback was encouraged and welcomed. A daily bar chart was displayed which showed how many patients had been asked for feedback and a feedback log was kept which recorded all patient feedback. Patients were able to feedback on staff and a star rating could be used. All comments we reviewed were extremely positive.

The service used a secure medical messaging app to communicate with staff, as well as verbal communication, meetings and e-mails. The messaging app was effective for instant messages if staff were on different floors within the location.

Learning, continuous improvement and innovation

All staff were committed to continually learning and improving services. They had a good understanding of quality improvement methods and the skills to use them. Leaders encouraged innovation and participation in research.

The service had sought professional external advice from a continuous improvement specialist and had implemented a quality management system supported by their quality assurance and governance policy. After our initial inspection on 14/15 September 2021, the service undertook a gap analysis and rigorously implemented its findings. A gap analysis is an examination and assessment of current performance for the purpose of identifying the differences between your current state of business and where you need to be.

An audit framework was now embedded in the service with oversight from the senior leadership team supported by a quality management system tool. There was good oversight of performance and quality.

Staff workshops provided continuous improvement opportunities for all staff with topics such as sepsis being discussed. Workshops included all staff solving hypothetical questions with end of session testing.