Harley Street Skin (Hannah House)

Quality Report

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This report describes our judgement of the quality of care at this location. It is based on a combination of what we found when we inspected and a review of all information available to CQC including information given to us from patients, the public and other organisations

Summary of findings

Letter from the Chief Inspector of Hospitals

Harley Street Skin – Hannah House is operated by Skin@harleystreet LLP. The service provides

cosmetic surgery and other cosmetic treatments to people over the age of 18 years. The clinic does not have in-patient beds. Facilities include two operating theatres and a three chaired pre assessment/recovery room. The outpatient consultation prior to the procedure itself is provided at the provider's main Harley Street Skin Clinic at Harley Street which is registered as a separate location and was not inspected as part of this process.

At our last comprehensive inspection of this service on 18 January 2017, we found the following issues that the service provider needed to improve:

• There was no system for checking the expiry date of medicines.

• There was no system for checking the expiry date of single-use items.

• Though there was a system for checking the resuscitation trolley, we found expired single-use items upon checking the trolley.

• There were no records of safety checks on portable equipment or evidence of equipment maintenance.

• The clinic did not use the World Health Organisation (WHO) safety checklist for day surgery cases and the '5 steps to safer surgery' were not used.

• There were very limited competency records held for nursing and theatre staff members.

• There was no evidence to show that staff had up to date safeguarding training.

• There were no formal meetings, including medical advisory committees (MACs) and governance meetings. There was no formal governance structure in place.

• The Disclosure and Barring Service (DBS) records of some of the clinical staff were not up to date.

• There was no clinical audit plan in place. Although consultants reviewed their own cases on a regular basis, there was no formal documentation audit or consent audit.

• There was no documented admission policy

The hospital was in breach of three regulatory requirements and we issued a Warning Notice on 3 April 2017 for the following breaches:

- Regulation 12 HSCA (RA) Regulations 2014. Safe care and treatment.
- Regulation 17 HSCA (RA) Regulations 2014. Good governance.
- Regulation 19 HSCA (RA) Regulations 2014 Fit and proper persons employed.

The purpose of this inspection was to check whether the provider had complied with the Warning Notice. We inspected this service using our focused inspection methodology, which included an unannounced visit to the clinic on 11 July 2017.

We found that the provider had made improvements to the service, which complied with the Section 29 Warning Notice.

Our key findings were as follows:

- There was a system in place for checking the expiry date of medicines.
- There was a system for checking the resuscitation trolley.

Summary of findings

- The provider had made significant progress with monitoring and keeping records of safety checks on portable equipment. There was evidence of equipment maintenance.
- The clinic used the World Health Organisation (WHO) safety checklist for day surgery cases.
- Staff told us safety huddles had been introduced before the start of every theatre list, led by the lead physician.
- There were sufficient competency records held for all nursing and theatre staff members.
- All staff had up-to-date safeguarding training.
- There was a system to follow up patients within 24 hours post-operatively.
- The provider had established a medical advisory committee (MAC) and initiated the process of formal meetings. We saw evidence of their first meeting, which was held on 18 May 2017.
- The Disclosure and Barring Service (DBS) records of the majority of the clinical staff were up to date. For any remaining staff, their applications were in process and we saw evidence of this.
- There was a clinical audit programme in place, which included a documentation audit and a consent audit.
- There was a documented admission policy in place.
- All staff had up-to-date mandatory training, including basic and advanced life support training.

However, the provider is still required to make further improvements regarding the following:

- There was an improved system for checking the stock and expiry date of single-use items. However, we still found some single-use items that were expired, although the provider told us that these were no longer in use.
- The pre-assessment questionnaires were not fully comprehensive and all aspects of a patient's history were not covered during the pre-assessment process. This included psychological assessment and mental capacity.
- There were gaps in assurance regarding the cleaning of the premises as we found dust on high surface areas.
- The provider's Medical Advisory Committee was not yet fully embedded.
- Staff team meetings had been introduced sine the last inspection, but were not held regularly.

Services we do not rate

- We regulate cosmetic surgery services but we do not currently have a legal duty to rate them. We highlight good practice and issues that service providers need to improve and take regulatory action as necessary.

Professor Edward Baker
Chief Inspector of Hospitals

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Surgery		We found that the provider had made improvements to the service, since last inspection. We found that: • There was a system in place for checking the expiry date of medicines. • There was a system for checking the resuscitation trolley. • The provider had made significant progress with monitoring and keeping records of safety checks on portable equipment. There was evidence of equipment maintenance. • There was a system to follow up patients within 24 hours post-operatively. • The provider had established a medical advisory committee (MAC) and initiated the process of formal meetings. • There was a clinical audit programme in place, which included a documentation audit and a consent audit. • All staff had up-to-date mandatory training, including safeguarding and basic and advanced life support training We regulate cosmetic surgery services but we do not currently have a legal duty to rate them.

Summary of findings

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Summary of this inspection

Background to Harley Street Skin (Hannah House)

Harley Street Skin – Hannah House is operated by Skin@harleystreet LLP. The clinic opened in 2010. It is a private skin clinic in Harley Street, London. The clinic accepts referrals from local independent GPs, and self-referrals from patients living in London and internationally.

All invasive surgical services take place at Hannah House in Manchester Street. However, their main outpatient clinic is based in Harley Street, at the Harley Street Skin Clinic. This includes the administrative team. Harley Street Skin Clinic is registered as a separate location and was not inspected this time.

The clinic provides day surgery and is registered to provide the following regulated activities:

- diagnostic and screening procedures;
- surgical procedures and
- treatment of disease, disorder or injury.

The registered manager for the clinic is Dr Michael Tee, who has been the registered manager and the nominated individual for this location since March 2014.

The clinic also offers cosmetic skin procedures such as dermal fillers and Botox. We do not regulate these services so we did not inspect that part of the service.

Our inspection team

The inspection was led by Izn Khan, CQC inspector, and by Katherine Kamola, CQC inspector.

The inspection was overseen by Michelle Gibney, Inspection Manager and Nicola Wise, Head of Hospital Inspection (London North).

How we carried out this inspection

This was a focused unannounced inspection to find out if the provider had taken actions to address the concerns outlined in the Warning Notice issued under section 29 of the Health and Social Care Act 2008 in April 2017. The need for significant improvements was identified as a result of the inspection, which took place in January 2017.

During the inspection, we visited the whole clinic and the main office. We spoke with six staff including; the lead physician, a registered nurse, a health care assistant, the theatre manager, the general manager and the non-clinical director of the service. During our inspection, we reviewed seven sets of patient records.

As this was a focused inspection to follow up on the action taken by the provider since we issued the Section 29 Warning Notice, we have not considered all of the key lines of enquiry.

Surgery

Safe	
Effective	
Well-led	

Are surgery services safe?

The main service provided by Harley street skin clinic at Hannah house (HSS) was surgery.

Incidents

- At the last inspection, we found that the provider incident log forms lacked any grading of incidents. There were no investigations, including root cause analysis (RCA) into the incidents reported. Learning from incidents was not routinely discussed in team meetings and some staff we spoke with were unaware of incidents that had taken place within the clinic. We also found that there was varying degree of understating among staff of what type of incidents could be reported. This indicated that staff may not have not been reporting all incidents that occurred.
- We found evidence of improvement at this inspection. The provider had updated their risk management policy in light of the concerns identified in our previous inspection. The policy included details of how to grade incidents according to severity. We spoke with the clinical nurse advisor, who was a registered manager at another HSS location. She had been specifically appointed, one day a week. The role included providing one-to-one training to staff in relation to incident management and reporting. The clinical nurse advisor had started these one-to-one sessions, or small team meetings, with theatre staff in order to go through each policy one at a time, so staff would have a better understanding.
- The clinical nurse advisor showed us the new incident reporting template that had been introduced. However, no incidents had been reported since the last inspection in January. We did not see any completed incident forms on the day of inspection. An incident relating to a missing controlled drug (CD) was identified one day prior to our unannounced inspection of 11 July 2017. This was reported to the lead physician in the morning safety huddle. The incident form was completed and submitted to us after the inspection. We saw that the staff member who identified the issue, did not complete this incident form and this was not in line with their policy. The incident was investigated, but there was no grading of severity completed on the form, as per their policy. This indicated that the practice of incident reporting and documentation was not yet fully embedded.
- We found four bags of expired single-use items on 11 July 2017, in the follow-up inspection. The theatre manager informed that these should not have been there as they don't use the machine anymore. Post-inspection evidence was submitted to us, which showed that incident was investigated and relevant staff members completed an incident form on 13 July 2017.

Cleanliness, infection control and hygiene

- At the last inspection we found that there was no mechanism to ensure that equipment was cleaned regularly. No record was kept of when the equipment was last cleaned. The pieces of portable equipment, such as the diathermy machine and suction machines stored in the rooms were not covered while not in use during the week.
- We found evidence of improvement at this inspection. The suction machine was now kept covered. The clinical nurse advisor informed us that they had ordered 'I am clean' stickers in April. However, the use of these was not rolled out yet. She told us that she would explain the process to staff at their next staff meeting.
- The provider commissioned an external expert to conduct the infection prevention and control (IPC) audit in April 2017. We saw evidence of detailed action plans, with nominated individuals to lead on each of these actions, within a set timeframe. For example, as part of the IPC audit, all staff received infection control training by the external provider.
- During the last inspection, we saw a centrifuge machine (a machine used to separate blood cells from plasma cells) in the dirty utility room, which should not be used

there as clinical waste bags were stored there. We found evidence of improvement at this inspection. We found that the centrifuge machine had been moved to the treatment room.

- At this inspection, we saw records of weekly cleaning audits of all areas completed by the theatre manager. These included checks of chairs, couches, sinks, replacement of hand cleaners and ensuring bins were emptied.
- We saw records of deep cleaning schedules and records completed for March 2016, November 2016, February 2017 and May 2017.
- However, we still found dust on the fluid warming machine and apron dispenser in the treatment room. There was also dust on the high surface areas within the theatre, including on the apron dispenser, on the wall side bars and on the hand gel dispenser within theatre. We informed the lead physician of our findings and he assured us that they would speak with the cleaning contractor.

Environment and equipment

- At the last inspection, we identified that none of the pieces of electrical equipment were safety tested. We found evidence of improvement at this inspection. All equipment was safety tested and each item had a sticker showing the last date it had been tested.
- At the last inspection, we found several expired single-use items in the resuscitation equipment trolley. We found evidence of improvement at this inspection. We reviewed the records of May, June and July 2017 and found daily checks were completed for all these months. We found that single-use item on the resuscitation trolley were all in-date.
- At the last inspection, we found several expired single-use items in the storage cupboard. We saw an improved system of storing single use items on this visit. However, we found four suction bags used for fat drainage, which were expired in the storage cupboard in the treatment room. The theatre manager informed us that these should have been removed, as the clinic did not use them anymore.
- A fluid warming machine was available within the clean treatment room. At our last inspection, we found that there were no records of checks to confirm the temperature of the fluid. In response to the warning notice, the provider informed us in May 2017 that they had commenced the checking and recording of the temperature of warming fluids. We were told that a thermometer had been introduced and corresponding records were kept. Evidence of this was submitted to us post- inspection.
- During the last inspection, we saw clinical waste bags stored where clinical staff were also doing their pre and post-operative paperwork, in the dirty utility. We found evidence of improvement at this inspection. We found that a separate room was now being used as an office by the nursing and clinical staff to complete their paperwork. Staff told us that they were in the process of placing a lock on the office door to ensure that documents could be kept locked and secure when the premises were not in use.
- At the last inspection we identified that the provider did not carry out regular risk assessments. At the inspection in July, we saw evidence that the clinical nurse advisor carried out a fire safety review in June 2017. However, on the day of inspection, we found that both fire exits were open and fire extinguishers were being used to keep the doors ajar. Staff informed us that there was external building work to the front of the building and due to scaffolding outside, they could not open the windows for ventilation.

Medicines

- During our last inspection, we identified that there was no monitoring of the room temperature to ensure the environment was optimal for the medicines stored in the cupboard there. During our follow up inspection in July 2017, we found that provider was actively working toward it. Staff informed us that a thermometer had been ordered for the room but were not sure of a specific date when the temperature monitoring system would be in place. However, following inspection, the non-clinical director informed us that this would be implemented in first week of August and would be audited regularly.
- At this inspection, we found that there were regular medicine stock and expiry checks and a medicine management audit completed by staff.
- At this inspection, we found that all medicines, including controlled drugs (CDs), were stored in a locked

cupboard, which the doctor on duty or nurse on duty held keys for. We found that the provider had introduced a separate locked box within the cupboard for additional security of the CDs. The lead physician, along with the theatre manager, checked CDs at each theatre list.

- On the day of our inspection, the lead physician told us that he was notified of a missing controlled drug (CD) by the theatre manager a day before. He informed us that there was one tablet of Tramadol 500 mg missing. This was a schedule three CD, which was exempt from safe custody regulation. We saw that the lead physician investigated this with the assistance of a nurse. A completed incident form was submitted to us post-inspection, which identified that the missing CD was given to a patient post-operatively but not recorded in the book at the dispensing stage. We saw evidence that all staff were reminded to obtain a second accuracy check by another member of staff prior to dispensing CDs to patients.
- At our last inspection, we found several medicines in both the medicine fridge and medicine cupboard that were out of date or not stored correctly. We were informed that the practice had changed when this was identified, with more stringent checks by the lead physician put in place. We found evidence of improvement at this inspection. We checked all medicines in the fridge and in the medicine cupboard and did not find any expired medicines. We saw the theatre manager now kept a detailed record of medicine expiry checks.
- However, we found one ampoule of chemical exfoliate solution, which expired in June 2017 and three ampoules with no expiry dates. We also found three bottles of a skin peel solution with no expiry dates and one bottle that had expired in April 2016. The lead physician told us that these solutions were not medicines and that some came to the clinic without expiry dates. We informed the provider that some did indeed have an expiry date, which had passed. We also informed the provider that any product to be used on a patient should have an expiry date. It was therefore their duty to procure and store solutions that have expiry dates.
- At our last inspection we saw that a blue filing box sealed with masking tape was used to store drugs required in the event of emergency or anaphylaxis (severe allergy). This was unsafe practice. We found evidence of improvement at this inspection. Emergency drugs on the resuscitation trolley were stored in a tamper-proof box. We reviewed the records and found that nursing staff checked medicines and oxygen cylinders regularly.
- At the last inspection, we identified that there was no Disposal of Old Pharmaceuticals (D.O.O.P) waste receptacle available. We found evidence of improvement at this inspection. Staff informed us that the waste receptacle was in place. The clinic had modified their medicine policy accordingly. We found that separate waste bins were used for the disposal of unwanted or expired medicines. These were compliant with the provider policy, which stated that 'the pharmaceutical waste bin will be of a type, which prevents the physical retrieval and re-use of the unwanted or expired medicine'.
- At the last inspection, we identified that there was no antibiotic policy in place. We found evidence of improvement at this inspection. An antibiotic policy had been introduced. We asked the lead physician if there had been any change in prescribing practice. We were told that they had reviewed their practice and discussed the matter with colleagues at other comparable clinics. All colleagues had agreed that the current practice was in line with the NICE guideline of antibiotic prescribing. The lead physician told us that their patient cohort was different to that of the NHS, with their patients being low-risk, who benefitted from this antibiotic cover post-surgery.

Records

- At our last inspection in January 2017, we saw the audit results of an operative notes audit (covering March 2016 to September 2016), which was undertaken in December 2016. The lead physician told us that there were plans to re-audit operative notes in March 2017. However, we did not see any formal plan for this re-audit. We found evidence of improvement at this inspection. We saw that three-monthly health records audit documentation was part of the quality assurance and audit programme 2017-2018, which was issued in May 2017.

Surgery

- At the last inspection in January, we found that each consultant kept their own individual theatre register. This meant there was no information to identify which theatre a procedure was carried out in. One consultant's theatre register was unavailable and was with the consultant, who was outside the country at that time. There was no copy kept by the office, so this information was provided to us at a later date. We identified that a theatre register for each theatre should be kept on site, with details of all surgical procedures carried out in each theatre. This would allow patients to be traced in the event of an infectious outbreak. At this inspection we found that provider had made improvement. The theatre logs now included the theatre location. In addition to this, the theatre manager had introduced a separate combined log of all patients who were operated on by every doctor, to ensure there was a central record. However, in one theatre register, we found several missing entries. For example, a nurse signature was missing in 27 entries, both a nurse signature and initial were missing in two entries, and a doctor's signature was missing on one occasion. The implementation of this system was at an early stage and further actions were required to audit theatre records to review the accuracy of the theatre register against the patients' notes.

Safeguarding

- The lead physician was now the nominated safeguarding lead for adults. All staff we spoke with were aware of this.
- At the last inspection, we found that only one clinical staff member had safeguarding training. We found evidence of improvement at this inspection. We reviewed eight staff files and found that all staff now had up-to-date safeguarding training and a better understanding of how to report any safeguarding concerns. We were assured that staff had safeguarding training relevant to their role.
- Following the inspection in January 2017, the provider told us that they had updated the policy for safeguarding adults for three key documents as identified by us. One was the intercollegiate document 'Safeguarding children and young people: roles and competences for healthcare staff' that was published by the Royal College of Paediatrics and Child Health in 2014. The second was 'Working together to safeguard Children,' updated in March 2015 and the Care Act 2014, which included key changes to information relating to adult safeguarding. The updated policy was submitted to us in April 2017. However, we found that the update was only related to the reference list within the policy. There were no changes in the actual body of the policy, with no mention of female genital mutilation (FGM) or appointing a nominated safeguarding lead for adults. A further updated policy was submitted to us after the July inspection, which showed improvement and included all relevant information.

Mandatory training

- At the last inspection, we were not assured that staff had up-to-date mandatory training. Effective monitoring systems in relation to staff mandatory training were not in place. We found evidence of improvement at this inspection. We saw evidence that staff had received training in safeguarding, fire safety, manual handling and equality and diversity.
- At this inspection we reviewed eight staff members' files and there were up-to-date mandatory training records in all relevant staff files.
- At the last inspection, we found that not all staff had up to date BLS or ALS (basic and advanced life support) training. The lead physician last attended a course in 2011. We were informed that his renewal date was scheduled for September this year, after his February course conflicted with his appraisal. The health care assistant (HCA) had no BLS training. The theatre manager's last certificate expired in January 2015. We were informed that the next training date was April 2017 for these staff members. However, no evidence of this was provided. We found evidence of improvement at this inspection. We saw evidence that all staff had up to date BLS and ALS training.
- At our last inspection, we found that the clinic did not provide information governance training. We found evidence of improvement at this inspection. We saw evidence at this inspection that all relevant staff had up-to-date data protection training.

Assessing and responding to patient risk (theatres, ward care and post-operative care)

- At the last inspection, we found that there was no guidance or scoring system for escalation of a

deteriorating patient and national early warning score (NEWS) to identify any 'at risk' patients following a procedure was not used. We found evidence of improvement at this inspection. We found that the clinic had developed a deteriorating emergency transfer policy and introduced NEWS.

- At the last inspection, the clinic had no service level agreements (SLAs) for emergency or non-emergency transfers with a local or independent acute hospital. The lead physician told us there had been no cases that required transfer in the 12 months prior to inspection. At this inspection, we saw evidence that the provider had contacted a number of local NHS and independent hospitals to arrange written service level agreements (SLAs) for emergency or non-emergency transfers of patients that may require an overnight stay. The clinical nurse advisor told us that they had not been able to achieve this, as there had been no response from the hospitals. There was a medical emergency policy in place. The provider assured us that in the case of an emergency, for example if a patient became ill during treatment, they would contact the emergency services without delay.
- At the last inspection, we found that there was no formal psychological assessment of the patient. Rather, the lead physician told us he included this in his overall assessment at the pre-surgery consultation. It is a requirement of the Royal College of Surgeons that this key aspect of consultation identifies any patients who are psychologically vulnerable and they are appropriately referred for assessment. We found no evidence of improvement at this inspection we reviewed seven patient records and none had a formal psychological assessment recorded. However, the lead physician informed us that they would be reviewing the assessment forms. This would include the anaesthetic and a psychological assessment form, aiming to have these in place by next month.
- At the last inspection, the provider was not using the World Health Organisation (WHO) safety checklist for day surgery cases. The checklist is a process recommended by the National Patient Safety Agency for every patient undergoing a surgical procedure. The process involves a number of safety checks before, during, and after surgery to avoid errors. We found evidence of improvement at this inspection. The WHO checklist was in use. We saw evidence of a completed WHO checklist in all seven records we reviewed.
- At the last inspection, there was no system to follow up patients within 24 hours post-operatively. We saw significant improvements with regard to post-surgery follow up of patients within 24 hours. There was a standard template used for post-surgical follow up. The theatre manager was the lead person responsible for this. She told us that she kept the forms in a separate file until a successful call had been made. We saw evidence of follow up calls being made and follow up forms of seven patients at various stages of completion in this file. We were informed that completed proformas were then filed into patient records.

Emergency awareness and training

- At the last inspection, we were informed that the fire and evacuation training was provided by the premises provider. However, none of the Harley street skin staff at Hannah House were able to tell us when they last had taken part in any fire drill. We found that none of the staff had attended a fire evacuation drill delivered by the premises provider. We were informed in May 2017 that three staff members attended a fire evacuation drill on 24 April 2017 and further training was arranged for August 2017. However, at the July inspection, the non-clinical director informed that this information was incorrect and in fact all relevant staff will attend the fire evacuation drill on 2 August 2017 along with the nurse clinical advisor.
- At the last inspection, we were not assured that staff had up-to-date fire safety training. At this inspection, we saw improvement that relevant staff had fire safety training. We saw evidence of training record in four staff members' files. One further staff member had fire warden training.

Are surgery services effective?

Evidence-based care and treatment

- During the last inspection, we identified that there was no clinical audit programme. Lead physicians told us that they reviewed their own patients' records to assess that documentation was in line with good practice.

However, there was no formal method of data collection, or review of this. The service did not conduct audits in areas such as consent or medicines management.

- At the last inspection, we found that there was no clinical audit programme. We found evidence of improvement at this inspection. The provider had developed a quality assurance and audit programme 2017-2018. This included regular three-monthly or annual audits, such as: health record, accidents, incidents and near misses monitoring, policies and procedures review and complaints monitoring. However, there were no clinical audits for consent, completion of the WHO checklist or patient surgical outcomes. We were assured that there were significant improvements in this regard and senior staff needed further time to ensure that the process was well embedded.
- At the last inspection, the provider had not audited their compliance with the Royal College of Surgeon's professional standards for cosmetic surgery and the clinic was unable to provide assurance of they were meeting the Royal College of Surgeon's professional standards for cosmetic surgery. We found evidence of improvement at this inspection. We saw evidence that the clinic had completed an overall audit of its compliance against these standards. We also saw evidence of two patient cases where the clinic audited its practice for these standards, in particular regarding communication, partnership and teamwork, and maintaining trust.
- At the last inspection, there was no formal admission policy. We found evidence of improvement at this inspection. We saw an admission policy had been developed and implemented.

Pain relief

- At our last inspection in January, we found that there was no pain management policy and no formal pain assessment tools were used by the clinic. We found evidence of improvement at this inspection. A pain management policy was developed and approved on 1 May 2017, which also introduced a verbal pain scoring scale of 0-10 for assessing patient pain. In this scale, zero meant no pain and 10 was extreme pain. Though staff we spoke with showed better understanding of assessing patient pain and scoring it, we found no evidence in the four patient records we reviewed of pain scoring. These patients had undergone surgery in May and June 2017. We were not assured that the system was well embedded into practice yet.

Patient outcomes

- At our last inspection, we found that there was no system in place to review patient outcomes on regular basis. We found evidence of improvement at this inspection. We saw that the provider had made initial progress in this regard, in developing a post-treatment assessment tool. This evidence was submitted to us. The tool included indicators such as clinical outcome, patient satisfaction, photographic assessment, surgical scars, patient concerns and complications. These would be assessed on the scale of 'excellent' to 'poor' outcome. In the action plan submitted to us on 4 July 2017, the provider informed that this tool had already been introduced. However, at the July inspection, senior staff told us that they would start using it from 17 July 2017, when it would be introduced to staff at their July staff meeting.
- We found the provider was planning to collect and submit information for Quality Patient Reported Outcome Measures (Q PROMS). The Royal College of Surgeons recommends Q PRMOS. They involve the patient completing a pre and post-operative satisfaction survey based on the outcome of their cosmetic surgery. Q PROMS are recommended for blepharoplasty (a surgical procedure of the eyelids) which was carried out at the clinic. The clinical nurse advisor told us that they were working on standardising the patient information packs and these questionnaires would be sent out in those packs, however no implementation date was given to us.
- At the last inspection, we found that the clinic had not been submitting data to the Private Health Information Network (PHIN) in accordance with legal requirements regulated by the Competition and Marketing Authority. The PHIN data is a defined set of performance measures and clinical quality indicators that should be collected from January 2016, submitted from September 2016, and for publication April 2017. We saw evidence that provider had been in contact with PHIN to explore the prospect of submitting data. However, no conclusive

decision had been made at the time of our follow-up inspection. After our inspection, the non-clinical director informed us that this would be discussed and agreed at the next MAC meeting, to be held in August 2017.

Competent Staff

- At the last inspection, we found that there were no arrangements in place to review practicing privileges and there was no policy in place that governed this. We found evidence of improvement at this inspection. We saw that there was now a practising privileges policy in place. Except one, all relevant clinicians had agreed to the terms and signed off the relevant paper work. The lead physician informed us that the remaining clinician's paperwork would be completed within the week.
- We saw evidence that the new process of renewing practicing privileges was discussed at the MAC meeting in May. The non-clinical director informed us that these would then be reviewed every 12 months or two years.
- At the last inspection, we found that disclosure and barring service (DBS) checks were not carried out for all staff and staff files were inconsistent. We found evidence of improvement at this inspection. We checked all relevant staff files and found DBS certificates. Where there was no certificate, we saw evidence that a DBS application had been submitted and the staff were waiting to receive the certificate in the post. We were assured that there were effective systems in place to check and monitor the DBS status of staff.
- At the last inspection we found that there was no Medical Advisory Committee (MAC). At this inspection, we found improvement. The provider had established a joint governance and Medical Advisory Committee (MAC). We saw minutes of their first meeting in May, attended by the senior leadership team and saw that the reviewing of practising privileges was a standing item on the agenda.
- At the last inspection, there was no record available of scrub competencies for nurses (including bank staff), the theatre manager and the health care assistant (HCA). The provider had made improvement and there was now a system in place to ensure scrub competencies for theatre staff. We saw evidence had been completed for the theatre manager and the HCA.

Are surgery services well-led?

Governance, risk management and quality measurement

- During our last inspection in January 2017, there was no formal governance and medical advisory committee (MAC) structure in place. The lead physician and director told us at that time that there were plans to start both committees by February 2017, and then hold quarterly meetings thereafter. We found evidence of improvement at this inspection. Senior staff told us that they had their first joint governance and MAC meeting on 18 May 2017 and we saw the minutes of the meeting. The meeting was attended by the senior leadership team and discussed complaints, incidents, infection control, mandatory training, clinical audit or patient outcomes, patient feedback and practising privileges. The lead physician and the non-clinical director assured us that the MAC would meet every three months, that the next meeting was arranged for August 2017 and minutes would be kept as evidence.
- Staff told us that safety theatre huddles had been introduced at the start of each theatre list, led by the lead physician. Staff we spoke with found this practice to be beneficial as it enabled them to plan for the day and be aware of any patient that may require additional support.
- At the last inspection we found that there was no risk register but a risk assessment (as part of the risk management policy) was completed by the theatre manager for the first time on 1 December 2016. However, there was no grading of severity of risks and no evidence of how this risk assessment was incorporated with the overall risk register of the provider. Not all the risks we identified during inspection were present on this risk assessment. At this inspection, we found that provider had made significant improvements in implementing a process of risk assessment. The risk management policy was further updated in May 2017, and now included a risk grading matrix. There were specific forms to use for each risk assessment. These risk assessments were discussed by the non- clinical director and clinical nurse advisor. We saw evidence that risk assessments were discussed at the first MAC held on 18 May 2017. We saw evidence of

12 risk assessments. For example: dealing with aggression, fire hazard, infection control and electrical systems equipment. However, we found that a risk assessment related to air quality and temperature control identified that there were already measures in place to reduce this risk. This was not correct as staff told us that they were not yet monitoring the treatment room temperature, as the thermometer was not in place. We were not assured that this practice was well embedded yet.

Staff engagement

- During the last inspection in January, staff told us that there were some staff meetings for administrative staff at the main clinic. However, these were informal and no minutes were recorded. The theatre staff members did not have separate team meetings. We found evidence of some improvement at this inspection. In May 2017, we were informed that the provider had reviewed the frequency of staff meetings and commenced weekly staff meetings. Minutes would be kept of each meeting. At the follow up inspection in July, we found that provider had made improvement. Staff told us that there had been regular staff meetings and they found these meetings useful. We found that there had been three meetings since the previous inspection, two in April 2017 and one in June 2017. Senior staff told us that there had been emphasis on ensuring that staff were aware of the new policies and changes that had been implemented. Hence, there had been separate weekly meetings of theatre staff with clinical nurse advisor to discuss all the policies.
- We identified at the last inspection that though it was a relatively small team, there was no formal meeting where staff feedback was discussed. We found evidence of improvement at this inspection. The provider had now committed to collect staff feedback every six months. This was included in its quality assurance and clinical audit programme 2017-2018, developed in May 2017

Outstanding practice and areas for improvement

Areas for improvement

Action the provider SHOULD take to improve

- The provider should ensure that the practice of holding a regular governance/MAC meeting is well embedded.
- The provider should ensure that staff meetings are held regularly and evidence of these meetings is kept.
- The provider should ensure that their pre-assessment questionnaires are fully comprehensive and that all aspects of a patient's history are covered during the pre-assessment process, including psychological assessment and mental capacity.
- The provider should ensure that the pain management policy is well embedded in practice.
- The provider should ensure that all systems and processes operate effectively, in accordance with good governance and are well embedded.
- The provider should strengthen governance and reporting arrangements.
- The provider should continue to address the gaps in assurance, regarding cleaning and infection control.