THMG Limited

THMG Harley Street Clinic

Inspection report

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Overall summary

We carried out an announced comprehensive inspection on 21 March 2016 to ask the service the following key questions; Are services safe, effective, caring, responsive and well-led?

Our findings were:

Are services safe?

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

Are services effective?

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

Are services caring?

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

Are services responsive?

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

Are services well-led?

We found that this service was providing well-led care in accordance with the relevant regulations.

Background

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

The Harley Street Clinic provides a private doctor consultation service for cosmetic surgery.

The clinic is open 8am to 8pm Monday to Friday and 8.30am to 6.30pm Saturday and Sunday.

The clinic hosts five cosmetic surgeons, several nursing staff and patient advisors. Pre and post-operative consultations and assessments take place in the clinic. Consultations for cosmetic surgery include breast augmentation, rhinoplasty, abdominoplasty, rhytidoplasty and blepharoplasty. Surgical procedures do not take place at the clinic but are provided at private hospitals in London.

The clinic is located over several floors in premises shared with another business. The reception and waiting area is on the ground floor; treatment rooms are at basement level and consulting rooms are located on the second and third floors.

This service is registered with CQC under the Health and Social Care Act 2008 in respect of some, but not all, of the services it provides. There are some exemptions from regulation by CQC which relate to particular types of service and these are set out in Schedule 2 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Summary of findings

We do not regulate procedures that do not involve a cut to the body or if there is no equipment inserted. This includes procedures such as Botox, dermal fillers, chemical peels or laser hair removal.

As part of our inspection we asked for CQC comment cards to be completed by patients prior to our inspection. We received two comment cards which were both positive about the standard of care received. We spoke with six people on the day of inspection who also provided positive feedback about the service.

Our key findings were:

- Medicines were safely managed.
- There were systems in place for identifying, investigating and learning from incidents relating to the safety of patients and staff members.
- The service had clearly defined and embedded systems, processes and practices in place to safeguard patients from abuse.
- The staffing levels were appropriate for the provision of care and treatment offered by the clinic with a good staff skill mix across the service.
- Risk management processes were in place to manage and prevent harm.
- The clinic had an infection control policy and procedures were in place to reduce the risk and spread of infection.
- Patient outcomes were reviewed as part of audits or quality improvement.
- Staff had the relevant skills, knowledge and experience to deliver the care and treatment offered by the clinic.
- The clinic shared relevant information with other services appropriately and in a timely way.
- Staff understood the relevant consent and decision-making requirements of legislation and guidance, including the Mental Capacity Act 2005.
- Staff treated patients with dignity and respect.
- Patients were involved in decisions about their care and treatment.
- The service was offered on a private, fee-paying basis only and was accessible to people who chose to use it.
- The diverse staff group employed at the clinic meant translation services were available for patients for whom English was not a first language.
- The service offered flexible opening hours and appointments to meet the needs of their patients.
- There was a system in place which ensured a clear response to complaints with learning disseminated to staff about the event.
- The clinic had a governance framework that supported the delivery of quality care.
- There was a clear leadership structure and scheme of delegation in place.
- The service encouraged and valued feedback from patients, the public and staff.

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

- Review the suitability of using consulting rooms where patients are examined, but which do not have wash hand basins installed and staff rely on hand sanitiser gel dispensers.
- Remove or replace damaged patient examination couches to prevent cross infection between patients.
- Ensure that staff document whether patients are given a copy of the consent form.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?

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

- Medicines were safely managed.
- There were systems in place for identifying, investigating and learning from incidents relating to the safety of patients and staff members.
- The service had clearly defined and embedded systems, processes and practices in place to safeguard patients from abuse.
- The staffing levels were appropriate for the provision of care and treatment offered by the clinic with a good staff skill mix across the service.
- Risk management processes were in place to manage and prevent harm.
- The clinic had an infection control policy and procedures were in place to reduce the risk and spread of infection.

Are services effective?

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

- Patient outcomes were reviewed as part of audits or quality improvement.
- Staff had the relevant skills, knowledge and experience to deliver the care and treatment offered by the clinic.
- The clinic shared relevant information with other services appropriately and in a timely way.
- Staff understood the relevant consent and decision-making requirements of legislation and guidance, including the Mental Capacity Act 2005.

Are services caring?

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

- Staff treated patients with dignity and respect.
- Patients were involved in decisions about their care and treatment.

Are services responsive to people's needs?

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

- The service was offered on a private, fee-paying basis only and was accessible to people who chose to use it.
- The diverse staff group employed at the clinic meant translation services were available for patients for whom English was not a first language.
- The service offered flexible opening hours and appointments to meet the needs of their patients.
- The provider made a timely and objective response to complaints and learning from complaints was shared among staff.

Are services well-led?

We found that this service was providing well-led care in accordance with the relevant regulations.

- The clinic had a governance framework that supported the delivery of quality care.
- There was a clear leadership structure and scheme of delegation in place.
- The service encouraged and valued feedback from patients, the public and staff.

THMG Harley Street Clinic

Detailed findings

Background to this inspection

We carried out an announced comprehensive inspection at THMG Harley Street Clinic on 21 March 2016 as part of the independent doctor consultation service inspection pilot.

The inspection was led by a CQC inspection manager accompanied by a specialist nurse advisor.

Before visiting, we reviewed a range of information we hold about the service, which included notifications received from the service and information provided from a pre-inspection information request to the provider.

During our visit we:

- spoke with a range of staff including the chief executive, training and clinical services director, clinical manager, nursing and administrative staff.
- spoke with patients to obtain feedback about the service.
- reviewed records and documents.
- reviewed comment cards where patients and members of the public shared their views and experiences of the service.

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

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

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

Are services safe?

Our findings

Reporting, learning and improvement from incidents

- The clinic had a system in place for recording adverse incidents relating to the care and treatment of patients. Staff told us they would inform the service manager of any incidents and there was also a recording form available on the clinic's computer system.
- The provider maintained a central electronic record of adverse events. Information from the provider recorded 14 adverse incidents in 2015/16.
- We saw evidence of trend analysis of incidents. The clinical services manager identified haematoma, seroma (a pocket of clear serous fluid that sometimes develops in the body after surgery) and delayed wound healing as the most frequently occurring adverse incidents among surgical patients.
- The service carried out a thorough analysis of the incidents and the outcomes of the analysis were shared at staff and management meetings. Clinical and administrative staff confirmed this when we spoke with them.
- When there were unintended or unexpected safety incidents, patients received reasonable support, truthful information, a verbal and written apology and were told about any actions to improve processes to prevent the same thing happening again. The service kept written records of verbal interactions as well as written correspondence.
- The training and clinical services director was the nominated 'Candour Champion' for the clinic and the HR manager was the nominated 'Speak up' Guardian.
- The provider was aware of and complied with the requirements of the Duty of Candour. The service encouraged a culture of openness and honesty.
- The Care Quality Commission (Registration) Regulations 2009 make requirements that the details of certain incidents, events and changes that affect a service or the people using it are notified to CQC. The clinic has submitted zero statutory notifications in the last 12 months.

Reliable safety systems and processes (including safeguarding)

- The service had clearly defined and embedded systems, processes and practices in place to safeguard patients from abuse.
- Policies reflected relevant legislation and local requirements and were accessible to all staff.
- Staff demonstrated they understood their responsibilities when we spoke with them and most had received training relevant to their role. Information given to us by the provider showed 79% of nursing and administrative staff had received safeguarding adults training, which included Mental Capacity Act (MCA) 2005. Training was scheduled for new staff and for those staff requiring an annual update.
- Information provided by the clinic confirmed that four of the seven medical staff working in the clinic had current adult safeguarding training. We saw an electronic 'flagging' system in use which identified staff requiring updates. Medical staff received their safeguarding training in the hospitals they worked in and provided the clinic with certification of the training.
- There was a lead member of staff for safeguarding and senior staff formed the clinic's 'safeguarding team'.
- Contact details for local authority safeguarding links were displayed in the reception of the clinic.
- Patients were chaperoned by trained customer advisors, customer co-ordinators or a nurse during all consultations with medical staff.
- We looked at the personnel files of six staff, including administrative, clinical and surgical roles and found that recruitment checks had been undertaken prior to employment. These included proof of identification, two references, proof of qualifications, registration with the appropriate professional body and the appropriate checks through the Disclosure and Barring Service (DBS). A system was in place to 'flag' when checks were due to be renewed. The HR manager for the clinic demonstrated this during the inspection visit.

Medical emergencies

- Basic equipment and emergency medicine (pocket mask and 'epi-pen') for resuscitation were stored in

Are services safe?

each treatment room and were accessible to all staff. Records completed showed regular checks were undertaken to ensure the equipment and emergency medicine were safe to use.

- The service had trained first aiders and first aid kits.
- Training records showed that all nursing staff had current basic life support training (BLS).
- Telephones linked to an internal system were available in consulting and treatment rooms to call for assistance in an emergency. Staff we spoke with demonstrated they knew how to respond if a patient suddenly became unwell; nursing and administrative staff said a '999' telephone call would be made if a patient collapsed.

Staffing

- Five consultant doctors and two general practitioners worked in the clinic.
- Records completed by the provider confirmed each medical practitioner was up to date with revalidation. (Revalidation is the process by which alllicensed doctors are required to demonstrate on a regular basis that they are up to date and fit to practise in their chosen field and able to provide a good level of care.) The service provider at THMG was not the designated body for any of the medical practitioners at the clinic; revalidation was with their main employer. The clinic's practicing privileges policy stated that all surgeons are required to provide evidence of a valid indemnity policy. This was monitored by the company with an alert being sent to the Surgical Operations Director three months in advance of an insurance policy going out of date.
- The clinic employed five registered nurses (3.8 whole time equivalent). Systems were in place to check Nursing and Midwifery council (NMC) registration.
- There was a large team of administrative staff including customer co-ordinators and advisors.
- Staffing for the clinic was planned around the patient appointments scheduled to ensure staffing levels and skill mix were matched to the number and type of new and follow-up appointments. A senior manager was on duty during clinic opening hours.
- Nurse agency usage was zero. The clinic's own staff worked overtime to cover absence.
- We reviewed five personnel files and found that appropriate recruitment checks had been undertaken prior to employment.

Monitoring health & safety and responding to risks

- The clinic had a health and safety policy, which was accessible by all staff. Procedures were in place for monitoring and managing risks to patient and staff safety.
- We saw evidence that risk assessments were completed. For example, the clinic office risk assessment included slips trips and falls; working at height; display screen use and electrical fault.
- A fire risk assessment had been completed and bi-annual fire drills were undertaken in the clinic. The last drill was in October 2015 and the next was scheduled for April 2016.
- There were effective arrangements in place to meet the Control of Substances Hazardous to Health 2002 (COSHH) regulations. We looked at the COSHH file and found risks (to patients, staff and visitors) associated with substances hazardous to health had been identified and actions taken to minimise them. Training records showed 79% staff had undertaken COSHH training. Training was scheduled for new staff and for those staff requiring an annual update.
- Records showed 79% staff had completed 'introduction to working safely' training. Training was scheduled for new staff and for those staff requiring an annual update.

Infection control

- The clinic had an infection control policy and procedures were in place to reduce the risk and spread of infection.
- We saw evidence of monthly infection control audits undertaken by the clinic's nominated lead nurse for infection control.
- We looked at the treatment rooms where patients were examined and treated. Most rooms and equipment appeared clean, uncluttered and well-lit with good ventilation.
- There were two treatment rooms used primarily by nursing staff for pre and post-operative assessment of

patients and wound care. These rooms had washable wall and floor coverings and examination couch.Hand washing basins were installed and hand gel dispensers were available.

- Consulting rooms where doctors met and examined patient were wallpapered and carpeted. Hand gel dispensers were available but there were no hand washing basins in the rooms.
- We saw records showing visual infection control checks were completed weekly. We noted that rips in the couches in two consulting rooms were identified in July 2015 and reported for repair. Repairs or replacements were not made as the weekly checklists continued to record the issue up to February 2016.
- The clinic had a cleaning schedule in place that covered all areas of the premises.
- We saw that 'Bare below the elbow' policies were adhered to and gloves, aprons, and other personal protective equipment (PPE) were readily available to staff.
- The clinic had an on-going contract with a clinical waste contractor. We saw different types of waste were appropriately segregated and stored including clinical waste and safe disposal of sharps.
- Records showed 85% staff had completed infection training. Training was scheduled for new staff and for those staff requiring an annual update.
- Records showed a risk assessment process for Legionella with appropriate processes in place to prevent contamination. We saw evidence of legionella sampling which had identified no contamination.

Premises and equipment

- The clinic is located over several floors in premises shared with another business. There are steps up to the front door, but we were told a ramp was available if necessary.
- The reception and waiting area is on the ground floor; treatment rooms are at basement level and consulting rooms are located on the second and third floors. The Harley Medical Group head office was located on the fourth floor.
- There is a lift in the building, but it was not operating on the day of our visit and had been out of action for several days.
- Staff told us they had sufficient access to equipment they required.

Safe and effective use of medicines

- Medicines were stored in a locked, steel cupboard in a room accessible by staff only via a keypad. The clinic's medication management policy stated that access should be restricted to nursing staff as authorised key holders. However, the key to the medicine cupboard was stored in a key safe, which all clinic staff had access to; this compromised medicine security. When we raised the issue during the inspection, senior clinic staff changed the system immediately so that access to the medicine keys was limited to nurse and duty manager only, with the key being signed in and out and documented in the key register.
- There was a clear audit trail for prescribing and dispensing medicine. The records we looked at related to these procedures were accurately and fully completed.
- There was a clear audit trail for the ordering, receipt and disposal of medicines. The records we looked at related to these procedures were accurate and fully completed.
- We saw the clinic's formulary for dressings used by nursing staff.
- The clinic did not store controlled drugs (CD's).

Are services effective?

(for example, treatment is effective)

Our findings

Assessment and treatment

- All patients using the service had an initial consultation with a (non-clinical) patient advisor. Patients were given written information about treatment and a copy of their chosen surgeon's CV.
- The clinic used The Harley Medical Group's pre-operative patient assessment form, which was initiated at the initial consultation. The assessment form included a 'traffic light' system for identifying risks.
- Patients then attended an appointment for consultation with their surgeon. Once agreed, surgery was booked in one of the three hospitals used by surgeons working at the clinic. Surgery was booked a minimum of two weeks after patients' appointment with their surgeon to provide a "cooling off" period. Patients then attended a pre-operative assessment with a nurse at the clinic, which included blood tests and screening for MRSA.
- Following surgery, patients had a check with a nurse seven days post operatively with a further appointment at 14 days if necessary.
- The clinic provided an 'out of hours' advice line staffed by a nurse to respond to patients' postoperative concerns.
- Clinical audits undertaken included monitoring surgical revision rates and complications such as infection and seroma.

Staff training and experience

- The clinic provided an induction programme for newly appointed staff that covered such topics as safeguarding, infection prevention and control, fire safety, health and safety and confidentiality. There was an induction log in each staff file, signed off when completed. There was also role specific induction training which ensured staff were competent for the role to which they had been appointed.
- We saw records that showed training relevant to staff roles was provided. Staff had access to and made use of e-learning training modules, in-house training and external training.
- An appraisal system was in use to ensure competency was demonstrated and reviewed. Staff told us they had regular 'one to one' supervision with their line manager and annual appraisal was scheduled. The provider confirmed Annual appraisals were not conducted last year as they were restructuring the clinic for several months, however monthly supervisions were completed and all clinic staff were scheduled to have an annual appraisal before the end of May 2016.
- We saw there was a process to assure the organisation that its registered staff remained registered with relevant professional bodies. Staff and managers were advised when clinic records indicated registration was due for renewal and re-registration was verified.
- Nursing staff had access to a wound formulary in the clinic. An external tissue viability (TV) nurse specialist provided the clinic with training, advice and guidance on wound management.
- We saw evidence of 6 monthly surgeon review meetings where each surgeon's performance was reviewed by the Medical Director, Chief Executive and Director of Surgical Operations.

Working with other services

- Clinic staff worked together as a multidisciplinary team to meet patients' needs and to assess and plan ongoing care and treatment.
- Patient information such as assessments, medical records, investigation and test results were shared with the hospitals where surgical procedures were undertaken.
- There was no routine sharing of information with NHS GP services or general NHS hospital services. The clinic relied solely on the patient offering their medical history freely during a consultation as they did not have routine access to medical or hospital records. We saw evidence in patient records where surgeons had contacted other health professionals involved in the care of individual patients. For example, a surgeon contacted a psychologist for their opinion on the suitability of the patient for a surgical procedure.

Consent to care and treatment

- We found staff sought patients consent to care and treatment in line with legislation and guidance. Staff understood the relevant consent and decision-making

Are services effective?

(for example, treatment is effective)

requirements of legislation and guidance, including the Mental Capacity Act 2005. The clinic's surgical booking policy stated patients were required to have a period of reflection prior to undergoing a surgical procedure; for this reason a period of 14 days must elapse from the date of the patient's surgeons consultation appointment to the date of the procedure.

- We looked at the care records of 10 surgical patients who had procedures carried out in the last 12 months. Patient consent forms were completed fully and signed appropriately in all the records we reviewed.
- In seven out of 10 records we reviewed, staff had not documented whether the patient had been given a copy of the consent form. The service had identified this shortfall in a recent consent form audit and an action plan was developed for improvement.

Are services caring?

Our findings

Respect, dignity, compassion & empathy

- We observed staff were respectful and courteous to patients.
- Staff gave matters of dignity due consideration. For example, doors were closed during consultations and staff knocked on doors and waited for permission before entering.
- All the patients we spoke with were positive about the care and treatment they received and emotional support provided by staff.
- We observed staff responding to people in a kind and compassionate manner.
- Patients completed CQC comment cards to tell us what they thought about the service. Comments were positive about the service experienced.

Involvement in decisions about care and treatment

- Patients we spoke with said they felt listened to and supported by staff and had sufficient time during consultations to make an informed decision.
- We saw evidence that discussions about procedures and outcomes were recorded in patients' records. Written information was available about the surgical procedures offered.
- 'Before and after' photographs of surgical procedures were available for patients to look at. Samples of breast implants were available to show patients various options.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting patients' needs

- Equipment and materials needed for consultation or assessment were available when patients attended their appointments.
- Comprehensive information about the services provided was available on the clinic's website. Written information (pamphlets) about specific procedures was available for patients.
- The clinic provided an 'out of hours' advice line staffed by a nurse to respond to patients' postoperative concerns.

Tackling inequity and promoting equality

- The service was offered on a private, fee-paying basis only and was accessible to people who chose to use it.
- The clinic offered appointments to anyone who requested one and did not discriminate against any client group.
- The diverse staff group employed at the clinic meant translation services were available for patients for whom English was not a first language. Languages spoken included Lithuanian, Russian, Italian, French, Danish, Spanish, Portuguese, Urdu, Farsi, Yoruba and English
- The clinic was located over several floors in premises shared with another business. There were several steps up to the front door; we were told a portable ramp was available if necessary. The reception and waiting area is on the ground floor; treatment rooms are at basement level and consulting rooms are located on the second and third floors. There was a lift between floors, but it was out of service on the day of our inspection visit which had been reported and awaiting maintenance.

Access to the service

- The service offered flexible opening hours and appointments to meet the needs of their patients. The range of services was kept under review to meet demand.
- The provider told us the average wait time from initial contact to first appointment at the clinic was 7.8 days. Appointments offered more than two weeks after initial contact was nearly always at the patients' request.
- In the last 12 months, 26% of all appointments at the clinic were cancelled or rescheduled, however the vast majority of these were at the patient request. 7% of all appointments were cancelled due to the clinic's operational issues with the biggest reason being colleague sickness. (These figures include rescheduling patients into a different practitioner to accommodate them on the same day as unable to split this data).
- Staff reported the service scheduled enough time to assess and undertake patients' care and treatment needs. Staff told us they did not feel under pressure to complete procedures and always had enough time available to prepare for each patient.

Concerns & complaints

- There was a complaint policy, which provided staff with information about handling formal and informal complaints from patients.
- Comprehensive information for patients about how to make a complaint was available in the on the service website. This included details of other agencies to contact if a patient was not satisfied with the outcome of the service investigation into their complaint.
- The service received 33 complaints related to surgical consultation in the last 12 months. The main themes were 'dissatisfied with aesthetic outcome' and customer service issues such as rescheduling of appointments. here was a system in place, which ensured there was a clear response to complaints with learning disseminated to staff about the event.

Are services well-led?

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

Our findings

Governance arrangements

- The clinic had a governance framework, which supported the delivery of quality care. The clinic was part of a large organisation with several clinics nationally with policies and procedures in place for activities undertaken. Policies were available to all staff.
- The provider had developed and produced a comprehensive 'Governance Manual' for clinic managers. This outlined the tasks which needed to be undertaken at intervals defined by the provider to help ensure compliance with its own policies, applicable legislation and regulation.
- A programme of audits was in place to monitor quality and to make improvements. We saw evidence of clinical audits monitoring outcomes for patients such as wound infection, surgical revision, medicine and records audits from which improvement action plans were developed.
- There were arrangements in place to identify and manage risks. We saw evidence of environmental risk assessments and the providers' health and safety policy.

Leadership, openness and transparency

- There was a clear leadership structure and scheme of delegation in place. Day to day running of the clinic was the responsibility of the registered manager. The clinic manager had left post in February 2016 and a new general manager was recruited in March. At the time of our inspection, the new clinic manager was engaged in the provider's induction programme and had initiated the process for registration with CQC.
- We saw evidence of regular meetings including monthly clinical management, executive and board meetings, triannual senior management meetings and biannual Medical Advisory Committee (MAC) meetings.
- Staff felt supported by management. Staff told us management were approachable and always took the time to listen to them. Staff told us regular team meetings were held and we saw minutes of meetings. Staff said there was an open culture within the service and they had the opportunity to raise any issues at team meetings.
- The provider was aware of and complied with the requirements of the Duty of Candour. When there was unexpected or unintended safety incidents the service gave affected patients' reasonable support, truthful information and a verbal and written apology. They kept written records of verbal interactions as well as written correspondence.

Learning and improvement

- The Harley Medical Group supported staff learning through its induction and training programme for staff.
- The provider scheduled bi-annual clinic inspection using the CQC inspection framework. We saw evidence of a comprehensive and objective internal governance inspection of the clinic undertaken in September 2015. This review used CQC's key lines of enquiry to measure how the service performed across the five key domains (safe, effective, caring, responsive, well led). The inspection identified areas requiring improvement and we saw evidence of action implemented to drive the necessary improvement.
- Continuous improvement was also driven by adverse incident analysis and learning from complaints.

Provider seeks and acts on feedback from its patients, the public and staff

- The service encouraged and valued feedback from patients, the public and staff. It proactively sought patients' feedback post consultation about the delivery of the service. The provider used a patient feedback system called 'Listen 360'. Each customer was invited to participate in an online survey and results were collated and analysed. All customer responses identified as a 'detractor' were followed up by a call from clinic staff inviting them to discuss it further to promote continuous improvement. We saw evidence of 'Voice of the Customer' themes which showed high customer satisfaction with staff, courtesy and professionalism and lower patient satisfaction where time related; for example, cancelling and rearranging appointments.
- The service had also gathered feedback from staff through staff meetings, discussion and an annual staff survey.