The Harley Street Hair Clinic Limited

The Harley Street Hair Clinic

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	Inadequate
Are services safe?	Inadequate
Are services effective?	Inadequate
Are services responsive to people's needs?	Requires Improvement
Are services well-led?	Inadequate

Summary of findings

Overall summary

The Harley Street Hair Clinic Limited specialises in hair transplantation for male pattern baldness, alopecia and hair loss. The treatment consists of Follicular Unit extraction (FUE) and implantation (Hair transplant procedures) and is carried out by a doctor under local anaesthetic with the patient fully conscious and awake throughout the entire procedure.

The service is registered to provide the following regulated activities:

- Surgical Procedures

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

We inspected this service using our comprehensive inspection methodology. We carried out an unannounced inspection on 09 June 2022. During the inspection we visited reception areas, waiting areas, treatment and consultation rooms. We spoke with five members of staff, including the registered manager. We spoke with one member of administrative staff.

The key questions we asked during this inspection were, was the service safe, effective, responsive and well-led. We have inspected this service twice previously, although this is the first time a rating has been awarded. Due to low patient activity on the day of inspection, the caring key question could not be inspected, nor rated.

Following the on-site inspection, we contacted the registered manager with a number of concerns which are being addressed through an action plan. We will seek assurances and progress through our continual engagement and monitoring of the service.

We are placing the service into special measures. Services placed in special measures will be inspected again within six months. If insufficient improvements have been made such that there remains a rating of inadequate overall or for any key question or core service, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating the service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. The service will be kept under review and, if needed, could be escalated to urgent enforcement action.

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Surgery	Inadequate 	

Summary of findings

Contents

Summary of this inspection

Background to The Harley Street Hair Clinic

We have not previously rated this service. We rated it as inadequate because:

- The provider did not have suitable arrangements for staff to follow, which protected patients from the risk of harm related to the taking of and use of photography.
- The provider did not have effective systems in place for managing risk.
- The provider did not have a service specific complaints policy and it was unclear what the process for raising a complaint was.
- The provider was unable to demonstrate a systematic approach to the annual performance review process and regular staff reviews.
- There were no clear processes in place for investigating incidents. There was no demonstrable learning from any incidents we reviewed.
- The provider did not have policies relevant to the service.
- The provider did not ensure all staff members were up to date with their mandatory training.

However:

The registered manager has shown a willingness to learn, improve and develop the service following feedback from this inspection.

How we carried out this inspection

The inspection team consisted of one inspector and one assistant inspector.

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.

Areas for improvement

Action the provider MUST take is necessary to comply with its legal obligations. Action a provider SHOULD take is because it was not doing something required by a regulation, but it would be disproportionate to find a breach of the regulation overall, to prevent it failing to comply with legal requirements in future, or to improve services.

Action the service MUST take to improve:

- The provider must ensure mandatory safety training is completed by all staff, that it is checked and reviewed regularly.
- The provider must ensure they have suitable arrangements for staff to follow, which protect patients from the risk of harm related to the taking of and use of photography.
- The service must ensure staff members understand their responsibilities with regards to identifying and raising safeguarding concerns and incidents.
- The service must ensure there is an active audit schedule in place to assess, evaluate and improve the service.
- The service must ensure there are relevant, service specific policies in place using the latest best practice guidance.
- The provider must ensure there are effective systems in place for managing risks.

Summary of this inspection

- The provider must ensure complaints are handled in line with their own policy and demonstrate concerns are taken seriously and are investigated sufficiently.
- The provider must ensure outcomes of the investigation of complaints is shared with all staff.
- The provider must demonstrate a systematic approach to the annual performance review process and regular staff reviews.
- The provider must ensure a policy for monitoring a deteriorating patient is developed and outlines what staff should do when recognising someone becoming unwell.
- The provider must ensure there are clear processes in place for recording, reporting and investigating incidents. Learning from such investigations must be shared with staff.
- The provider must ensure polices are relevant to the service and contain updated information.
- The provider must ensure patient records are integrated into a single clinic record which is easily accessible to all staff and contains all relevant information relating to patients.

Action the service SHOULD take to improve:

- The provider should ensure pain scores are taken regularly and recorded in the patients record.
- The provider should ensure the National Early Warning Score (NEWS) is accurately recorded and kept in the patients record.

Our findings

Overview of ratings

Our ratings for this location are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Surgery	Inadequate	Inadequate	Not inspected	Requires Improvement	Inadequate	Inadequate
Overall	Inadequate	Inadequate	Not inspected	Requires Improvement	Inadequate	Inadequate

Inadequate

Surgery

Safe	Inadequate
Effective	Inadequate
Responsive	Requires Improvement
Well-led	Inadequate

Are Surgery safe?

Inadequate

Mandatory training

The service could not demonstrate that all staff had completed mandatory safety training.

- All staff members were employed directly by the service and the registered manager told us there was an expectation staff would complete mandatory training to enable them to work there. However, during the inspection, the service was unable to demonstrate that all staff were compliant with their training.
- The service was unable to demonstrate which training subjects staff were required to complete, for each role. There was no system set up to clearly manage the monitoring of staffs completion of mandatory training.
- There was general confusion amongst staff we spoke with regarding how mandatory training was accessed, when they last completed mandatory training and the subjects, they were required to complete. We spoke with five members of staff, none of whom could demonstrate how they logged onto and used any mandatory training system.
- Post-inspection, the registered manager told inspectors they had recognised the need for staff to complete mandatory training and were working through a programme of training completion with all staff, however, no supporting evidence was provided. Through our continual engagement and monitoring of this service, we will seek assurances that all staff complete mandatory safety training.

Safeguarding

The provider did not show an understanding of how to protect patients from abuse. Staff were unaware of any safeguarding policy and procedure in use at the service.

- During the inspection, staff were unaware of any safeguarding policy in use at the service. Staff were mixed in their views on how to raise safeguarding concerns. Two members of staff told us they would tell the registered manager and two other members of staff told us they would complete an incident form or speak with a doctor at the service. One member of staff we spoke with had difficulty in their understanding of what constituted a safeguarding concern.
- Post-inspection, we asked the registered manager to supply us with a copy of their adult safeguarding policy and procedure and evidence staff had completed mandatory safeguarding training. A policy was provided post-inspection and contained relevant information regarding adult safeguarding. The policy highlighted how to make a referral to the local safeguarding authority for the area.

Cleanliness, infection control and hygiene

The service-controlled infection risk well. Equipment and the premises were visibly clean.

- Staff followed infection control principles related to COVID-19, including the use of personal protective equipment (PPE). During our visit, all staff were wearing protective face coverings. There was hand sanitiser in the reception area and each room for staff and patients to use.
- Post-inspection, the registered manager provided inspectors with a copy of an Infection Prevention and Control (IPC) policy. The policy outlined measures staff should take to minimise infection risk, such as the correct way to wash hands, cleaning products which should be used and information regarding PPE.
- The registered manager told us they advised patients to perform a lateral flow test to identify any COVID-19 positive patients, however, this was advisory only.
- The registered manager told us that patients and staff had their temperatures taken upon entering the clinic. We saw evidence of these checks being recorded.
- We saw completed hand hygiene audits completed in the previous 12 months before the inspection visit. However, it was not always clear who completed the audits and some audits were not completed every month. The manager on the day of inspection was unable to explain the sporadic nature of the audits and whose responsibility it was for their completion.
- We did not see any evidence of a cleaning schedule or completed checklists of cleaned equipment. However, for specialist equipment, this was cleaned by staff employed within the service who had knowledge on how that equipment should be cleaned. All equipment inspectors looked at appeared visibly clean. There was evidence of an external cleaning company being used at the service.
- Some items of equipment were not for single use, and these were sent to an external company for cleaning and re-sterilisation. We saw evidence of the contract for the sterilisation agreement between the clinic and the company, however, this contract was not signed nor dated, there was no review date recorded.
- Staff reported they felt there was always enough equipment to use in the clinic.

Environment and equipment

The design, maintenance and use of facilities, premises and equipment did not keep people safe.

- It was unclear if the service had an equipment policy. Not all equipment had evidence it had been recently tested, for example, air conditioning units in each treatment room did not have any sticker on them indicating they had been portable appliance tested (PAT). The provider did not keep a log of equipment checks.
- Staff carried out daily safety checks of specialist equipment such as machines used for sterilising surgical instruments.
- There was resuscitation equipment, including oxygen and an Automatic External Defibrillator (AED). There was also an anaphylaxis kit, for use in the event of a patient having a severe allergic reaction. We checked these items and confirmed they were in working order and in-date.
- There was no signage to indicate that medical gases were held on site. The gases were not separate from other storage items. The storage of medical gases (oxygen) did not comply with the Health and Safety Executive HTM02 guidance. Warning notices should be placed near medical gases to prohibit smoking and naked lights within the vicinity of the storage. Post-inspection, the registered manager provided evidence of warning signs placed near oxygen cylinders.
- All stock and single-use items were stored in a locked room and regular stock checks were done. The registered manager told us there was a contract with a third-party company for the safe disposal of waste, including clinical and non-clinical waste. However, no information has been supplied to evidence a contract in place.
- The design and layout of the environment followed national guidance, which made it suitable for the services being provided.
- Post-inspection, we asked the provider to demonstrate all equipment had been tested and maintained appropriately. Information was sent by the registered manager to evidence equipment had now been PAT tested.

Assessing and responding to patient risk

Staff completed and updated risk assessments for each patient. The service was using a consistent approach to assessing patient risk.

Inadequate

Surgery

- The service did not use the National Early Warning Score (NEWS). NEWS is a tool developed by the Royal College of Physicians which improves the detection and response to clinical deterioration in adult patients and is a key element of patient safety and improving patient outcomes. This was not in routine use; we could not be reasonably assured that staff would both recognise and respond as expected in the event of a patient becoming unwell.
- The pre-operative screening of patients to identify any potential risks was not routinely undertaken and recorded appropriately. We viewed four patient records which had minimal details relating to the patients' medical history and had no evidence of any clinical observations (blood pressure, heart rate, BMI etc) being undertaken. This was not in line with the National Institute for Health and Care Excellence (NICE) routine preoperative tests for elective surgery guidance.
- A review of four patient records showed that clinical observations during surgery were recorded inconsistently. Two records showed clinical observations had been taken throughout surgery, whilst two records showed no recording of clinical observations. The manager on the day of inspection told us that clinical observations should be taken at varying intervals throughout surgery. However, there was no policy or guidance for staff in use, and therefore no directive as to the frequency clinical observations should be taken.
- All surgical notes were recorded on paper and then uploaded onto an electronic record platform.
- We saw no evidence of venous thromboembolism (VTE) assessments being carried out on patients. Venous thromboembolism (VTE), also known as blood clots, is a disorder that includes deep vein thrombosis and pulmonary embolism and can occur when patients are immobile for several hours.
- The provider was not using the World Health Organisation (WHO) safer surgery checklist. We asked the manager in charge if there were any other procedures in place for reducing unnecessary surgical harm and complications. They told us there were no other procedures in place. The WHO safer surgery checklist is recommended for use in reducing errors and adverse events and improving communication between staff members during any surgical procedure.
- There were no service level agreements with the NHS if patients became unwell and needed to be transferred for treatment. The manager told us staff would call 999 and ask for an ambulance in the event of a patient becoming unwell.
- Post operatively, patients had access to a patient co-ordinator who could contact their operating surgeon in the event of any post-surgical complications or advice. This service was available during business hours. Patients were instructed to contact an out-of-hours doctor or A&E outside of these hours if they had any concerns.

Staffing

The provider ensured clinical support staff had the right qualifications, skills, training and experience to keep patients safe from avoidable harm.

- The service employed all members of staff and did not have any medical staff working on practising privileges arrangements.
- The service was registered as a designated body in accordance with The Medical Profession (Responsible Officers) Regulations 2010.
- The service had enough staff to keep patients safe and did not use any bank or agency staff.
- All staff received an induction into the service on commencement of employment. This included an orientation of the building and opportunities to shadow colleagues.
- Staff had their training credentials and practice licences checked prior to employment.
- There were four hair transplant surgeons working for the service. The surgeons did not work in NHS practice.
- The service was unable to demonstrate a systematic approach to annual appraisals or staff reviews. We saw some evidence of appraisals for clinical staff; however, these were inconsistent in their format and it was not evident when staff were next due for an appraisal.

Inadequate

Surgery

Records

Staff kept records of patients' care and treatment. Records were not always clear or detailed. However, they were stored securely.

- Patient notes were inconsistent in their style and detail. We reviewed four patient records and noted that all of them detailed differing degrees of patient information. All four of the records we reviewed detailed very little notes throughout, including a lack of medical history, allergies and medications the patient currently takes.
- Patient notes were held electronically using a third-party management record system. There was no patient record policy in place at the service. The manager on the day did not know how long patient records were held for and who had access to these records outside of the service using them. Post-inspection, the registered manager told us they would be developing and implementing a patients record policy which will include information regarding retention of patient details.

Medicines

The service used systems and processes to safely prescribe, administer, record and store medicines. However, it was unclear if staff had received medicines management training.

- The service used controlled drugs. At the time of inspection, staff were unaware of a medicines management policy and could not recall attending medicines management training.
- Controlled drugs were kept in lockable storage and access was granted to clinical staff only. The registered manager had overall responsibility for the safe storage and use of controlled drugs.
- The service had a controlled drugs book which staff used to keep a check on the stock of controlled drugs. We saw this completed accurately. However, due to the large quantity of medication held at the service, it was unclear if the number of stock recorded in the controlled drugs book was accurate and in accordance with how much medication was at the location.
- If medication was required following hair transplant surgery, the operating doctor signed a prescription on the day of surgery, which was given to the pharmacy dispensing the medication on the day of surgery.
- Post-inspection, the registered manager provided evidence of a medicines management policy which outlined how controlled drugs should be stored, managed and disposed of. The registered manager also informed us they were implementing medicines management training to all staff.

Incidents

The process surrounding incident reporting was not robust, we were not assured staff would be able to recognise and report incidents and near misses.

- There was no assurance regarding the reporting of incidents and types of incident that should be reported. The manager on the day of inspection was unable to demonstrate how incident reporting worked in the service. There was confusion amongst staff about how incidents were reported. One staff member told us there was an incident logbook, however, no staff member was able to provide evidence of this on the day of inspection.
- Staff were unaware of any incident reporting policy in place at the service. However, post inspection, the registered manager produced an incident reporting policy, which detailed how staff should report any incidents or near misses. The policy also clearly outlined different types of incidents.
- The service informed us there had been no serious incidents or never events.
- The service did not monitor incident themes or trends or share learning from incidents with staff.
- Post inspection, the registered manager produced completed incident forms. These had been completed throughout 2021-2022. There was little information in the incident description, and it was unclear if any immediate actions had

been taken following an incident. We also saw that no action had been taken to minimise or reduce the reoccurrence of the incident. There had been two incidents relating to a needle stick injury which happened within a six-month period and no shared learning from these. We also saw incidents had not been fully investigated and there was no learning to reduce a reoccurrence.

Are Surgery effective?

Inadequate

Evidence-based care and treatment

The service did not provide care and treatment based on national guidance or evidence-based practice.

- All staff we spoke with were unaware of how to access policies in use at the service, where the policies were located or name any policy, they thought the service used. We did not see evidence of any policies or procedures during the on-site inspection.
- Post inspection, policies had been sent to inspectors by the registered manager. Policies had not been adapted or revised to ensure they fitted the scope of the service. Information contained in several policies showed they were more relevant to a hospital setting.
- The service had not instigated a process to evidence and record that staff had read and understood all policies.
- We found no evidence that the service used relevant national guidance for cosmetic surgery or hair transplant surgery. Staff were unable to tell us which guidance they used to ensure procedures were using the latest best practice evidence. In the absence of policies, we could not be assured the service was using national guidance to inform and improve patient treatment.

Nutrition and hydration

Staff gave patients enough food and drink to meet their needs.

- As procedures could last over prolonged periods, patients were given a break during treatment for food and drink.

Pain relief

We did not see evidence that patients had their pain assessed and recorded. We could not be assured patients had access to pain relief in a timely way.

- It was not clear from four patient records we reviewed that staff had assessed patients' pain using any recognised tool, such as a numerical rating scale (NRS). (0 being no pain and 10 being extreme pain). We were not assured staff gave pain relief in line with individual needs and best practice.
- All four patient records reviewed during inspection evidenced that staff had recorded the administration of local anaesthetic detailing type, batch number, amount, expiry date and site of administration.
- We did not see evidence of pain relief being routinely prescribed for patients to take home. Staff were unable to provide any information which would be given to patients, post-surgery, which detailed what to do in the event of experiencing pain or discomfort around the treatment site.
- We were not reasonably assured from our discussion with the registered manager that the provider, fully understood the requirements of registration to participate and undertake audit practice to monitor and improve patient outcomes. For example, we did not see any evidence of audits related to pain assessment and other expected standards within the service.

Inadequate

Surgery

Patient outcomes

The provider did not monitor the effectiveness of care and treatment and audit practice was not fully developed or carried out in practice. The provider did not actively monitor post-surgical infection rates.

- We did not see evidence the provider held meetings with staff to discuss audits or review performance. Staff we spoke with told us they did not attend team meetings.
- It was unclear if all patients were followed up post-surgery or at which stage, they may have been followed up. From four patient records we reviewed we could see three patients had been contacted by the service in the days following surgery. However, clear documentation of this conversation was not recorded.

Competent staff

The service did not ensure staff were competent for their roles. Managers could not demonstrate that staff undertook appraisals or that staffs work performance was assessed.

- During inspection we asked the manager to support us in looking for evidence of staff appraisals or anything similar which took place to ensure staff had learning goals and objectives completed. Staff we spoke with could recall having an appraisal but were unsure of the structure, scope and outcomes of these. Staff also appeared confused whether they had undertaken a formal appraisal or an informal discussion with an external consultant/advisor.
- Post-inspection, the registered manager sent evidence of staff appraisals. However, each appraisal appeared to have a significant difference in detail with some appraisals outlining future objectives and others not detailing this information. One appraisal was completed in 2019, it was unclear if this was the latest appraisal for this member of staff.
- There was no evidence non-clinical staff had their work evaluated. This did not form part of their annual appraisal.
- During the inspection, we were unable to review any staff files, as the manager on the day did not have access to these. We asked the registered manager to provide us with evidence that all staff have a valid and current Disclosure and Barring Service (DBS) certificate in place. At the time of this report, no evidence has been provided. We will seek timely assurance regarding this through our continual monitoring and engagement with the service.
- Medical staff working for the service were on the General Medical Council (GMC) register with the necessary qualifications and experience relevant to their role.
- We did not see any evidence hair transplant support staff had undergone any formal training. One member of staff told us they had been through a detailed training programme, although they were unable to provide evidence of this.

Multidisciplinary working

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

- We saw evidence that staff worked well together in the best interest of patients. All members of staff we spoke with told us that team working was well established within the service and they had no issues working with their colleagues.

Seven-day services

- The service was open Monday to Saturday at varying times depending on patient activity.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

Staff supported patients to make informed decisions about their care and treatment. They followed national guidance to gain patients' consent.

- Consent was obtained in line with the Royal College of Surgeons (RCS) Professional Standards for Cosmetic Surgery (April 2016) which states that, consent should be gained by the doctor who will be delivering treatment, 14 days prior to treatment, to ensure the patient has a cooling-off period. Of the four patient records we reviewed, all records showed that a minimum of 14 days had been achieved between initial consultation and procedure.

Inadequate

Surgery

- The patient had a face to face initial consultation with the operating surgeon. There was limited information documented regarding the initial consultation, although on all records we reviewed we did see risks of the procedure were discussed.

Are Surgery responsive?

Requires Improvement

Service delivery to meet the needs of local people

The service planned and provided care in a way that met the needs of local people and the communities served.

- Facilities and premises were appropriate for the services being delivered.
- Managers ensured that patients who did not attend appointments were contacted.
- Patients were provided with post-discharge care information, which included clinic contact details for post-operative advice and specific instructions about hair care.
- There was no parking available at either location but both locations were easily accessible from public transport.

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.

- The clinic provided treatment for male, female and trans-gender patients.
- The appointment system appeared easy to use and supported people to access appointments. Patients could arrange an appointment by telephone or make an enquiry using the clinic's website.
- We were informed there was a lift within the building with wheelchair friendly access available at the clinic. We did not see evidence of a hearing loop available within the clinic.
- The service was able to access written information in other languages but had not signed up for a telephone interpreter service. The majority of patients were English speaking and the manager told us an interpreter service would be used if needed.
- There was no audit process in place to ensure each patient had received appropriate treatment based on an assessment of their needs and preferences.

Access and flow

People could access the service when they needed it and received the care in a timely way.

- Initial face to face consultations were held with patients who were explained a range of options and a discussion regarding finance and cost. During the initial consultation the patient would be given pre-operative information and their expectations regarding the results of treatment were discussed. If the patient wished to continue from here, the patient was booked in for treatment.
- All procedures were booked in advance. Once the procedure was confirmed with the surgeon, staffing was arranged to support the procedure.
- There were no waiting times for consultations or procedures.

Learning from complaints and concerns

The complaints procedure was not displayed or explained to patients as to how they could give feedback and raise concerns about care received.

Inadequate

Surgery

- The service had a complaints policy. However, the policy did not clearly outline the process patient's should follow to raise a complaint. It also did not detail the process staff should follow when dealing with a complaint.
- The service did not display information about how to raise a concern in patient areas.
- Post-inspection, the registered manager provided evidence of information given to patients post-surgery, these included information on how to provide feedback on their treatment.
- We did not see evidence that managers investigated complaints and identified themes. We asked to see evidence of complaints investigation; which was not produced during the inspection. Post-inspection, the registered manager told us there had been no complaints received into the service in the previous 12 months.
- It was unclear if staff knew how to acknowledge complaints and we did not see evidence that patients received feedback from managers after the investigation into their complaint.
- Staff could not give examples of how they used patient feedback to improve daily practice.
- It was unclear if the service was registered with the Independent Sector Complaints Adjudication Service (ISCAS) which provides independent adjudication on complaints for independent healthcare providers registered with them. Post inspection, the registered manager told us they had considered ISCAS registration but due to the low number of complaints received into the service, they did not feel registration with ISCAS was necessary at this time.

Are Surgery well-led?

Inadequate

Leadership

Leaders did not have the necessary skills and abilities to run the service. They did not always understand and manage priorities and issues the service faced.

- The leadership team consisted on the registered manager, a director and a medical lead. All members of the leadership team were full time employees of the service.
- The registered manager was responsible for ensuring compliance by the provider with the fundamental standards of care. The registered manager was responsible for recruiting staff.
- During and post inspection the registered manager did not demonstrate an understanding of the obligations placed on them by their role as registered manager, and, how compliance with the fundamental standards of care helped to ensure maintenance of quality at the location and continuous improvement.
- There were other managerial staff with responsibility for daily oversight of the running of the service.

Vision and Strategy

The service did not have a vision for what it wanted to achieve and no formally written strategy.

- The registered manager was unable to provide any vision or strategy for the service and did not have any set future plans or objectives relating to the service.
- Staff we spoke with were unsure on the future vision of the service and were unable to tell inspectors what they thought the key priorities for the service were.
- Due to the lack of service strategy there was no ability to measure progress.

Culture

Staff we spoke with felt respected, supported and valued. Staff told us they focused on the needs of patients receiving care.

Inadequate

Surgery

- Staff working at the service felt the culture of the service was one which encouraged openness, honesty and teamwork. However, staff commented that they would like to see the implementation of staff team meetings to ensure there was consistent messaging across the service.
- Staff appeared happy and content in their roles. Staff we spoke with said they enjoyed their roles and felt well supported by their colleagues.

Governance

Leaders did not operate effective governance processes. Staff did not have regular opportunities to meet, discuss and learn from the performance of the service.

- There was no evidence of effective structures, processes and systems of accountability to support the delivery of service improvement and to ensure good quality sustainable care and treatment.
- We saw three sets of meeting minutes from a patient safety and risk committee. The minutes of these meetings showed there were discussions regarding financial viability, quality of care delivered and national emerging themes and trends in the hair transplantation sector. It was unclear from these minutes whether any changes to practice had been evaluated and/or improved as a result of these meetings. There was no terms of reference provided with the minutes, as it was unclear which members of staff were required to make the committee quorate.
- We did not see evidence that all staff had opportunity to meet, discuss and learn from the performance of the service. We did not see evidence of team meetings throughout the previous year.
- Post inspection, the provider told us they had now introduced a structured approach to staff engagement and meetings. The provider stated they would be willing to share minutes from staff meetings once the changes had been implemented and embedded.

Management of risk, issues and performance

It was unclear if any system was used to identify local risks and there was no clear plan to eliminate or reduce them. However, the recognition and management of corporate risks were clear and well documented.

- We saw limited evidence that the service used systems to manage performance effectively. Leaders of the service did not demonstrate they had the knowledge or experience to fully embed systems to manage performance.
- The service did detail high-level corporate risks relating to the service. The service had a risk register in place which highlighted commercial issues and matters relating to the absence of a mandatory training system. No issues relating to clinical risks were noted on the risk register and did not reflect the concerns found during the on-site inspection.
- Risk assessments were not clear or routinely considered as part of everyday practice. It was unclear who carried out risk assessments and if staff understood the purpose of them.

Information Management

The information systems were integrated and secure. However, the provider could not demonstrate photographs were being taken in accordance with General Data Protection Regulation (GDPR) rules.

- Photographs of patients' treatment were taken, with consent, and uploaded to the patient record. It was unclear how the storage or deletion of the original photograph was managed. There was no image retention policy or similar which outlined how long images would stay on the clinic's system. The registered manager was unable to tell us how long images would be held for before being deleted. We were not reasonably assured the service was taking and securely storing photographs in line with General Data Protection Regulation (GDPR) requirements.
- Post-inspection, we asked the registered manager to demonstrate how they were compliant with GDPR requirements. At the time of this report, no further evidence had been provided; however, we will seek assurances through our continual monitoring and engagement of the service.

Inadequate

Surgery

- Post-inspection, the registered manager sent CQC a copy of an Information Governance and Life Cycle Policy. This policy outlined that once records are no longer required for operational purposes; they will be sent to a secure off-site storage facility. However, no staff members, including the registered manager, was able to articulate this at the time of inspection.
- The service had invested in antivirus and firewall protection software. All computers we saw in use were password protected and locked when not in use.

Engagement

Leaders did not actively and openly engage with staff. We did not see evidence of any patient engagement.

- During the inspection, we did not see any evidence that staff had opportunities to meet and discuss the service. Four members of staff we spoke with told us they did not have routine team meetings, although they specified this is something they would like in future.
- There was no evidence of staff involvement in the planning of the service. We did not see evidence of routine collection of patient feedback.
- We saw there was a website which gave information about the service

Learning, continuous improvement and innovation

There was no evidence of innovation at the service.

- During the inspection we did not see or hear about any examples of continuous learning, improvement or innovation. The service did not participate in any research projects or recognised accreditation schemes.

This section is primarily information for the provider

Enforcement actions

Action we have told the provider to take

The table below shows the legal requirements that were not being met. The provider must send CQC a report that says what action they are going to take to meet these requirements.

Regulated activity	Regulation
Surgical procedures	Regulation 17 HSCA (RA) Regulations 2014 Good governance Following the on-site inspection, we contacted the registered manager with a number of concerns which are being addressed through an action plan. We will seek assurances and progress through our continual engagement and monitoring of the service.