National Slimming Centres (Sheffield)

Inspection report

1 Tudor Square
67-69 Surrey Street
Sheffield
South Yorkshire
S1 2LA
Tel: 08009179334
www.nscclinics.co.uk

Date of inspection visit: 03/03/2020
Date of publication: 26/05/2020

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	Requires improvement
Are services safe?	**Inadequate**
Are services effective?	**Requires improvement**
Are services caring?	**Good**
Are services responsive?	**Good**
Are services well-led?	**Requires improvement**

Overall summary

This service is rated as Requires improvement **overall.** (Previous inspection 2017 not rated)

The key questions are rated as:

Are services safe? – Inadequate

Are services effective? – Requires improvement

Are services caring? – Good

Are services responsive? – Good

Are services well-led? – Requires improvement

We carried out an announced comprehensive at National Slimming Centres (Sheffield) as part of our inspection programme to rate the service.
National Slimming Centres (Sheffield) is a private clinic which provides weight loss services for adults, including prescribing medicines and dietary advice to support weight reduction.

The clinic doctor is also the registered manager. A registered manager is a person who is registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

19 people provided feedback about the service via comment cards and we spoke to one person on the day of inspection. All the feedback was positive. Patients told us that staff were caring and treated them with respect.

Our key findings were :

- Patients felt supported and said that staff were professional.
- The clinic was in a good state of repair, clean and tidy.
- Policies and protocols had not been updated or reviewed and were not followed by staff.
- Risk assessments were not comprehensive and needed updating.

The areas where the provider **must** make improvements as they are in breach of regulations are:

- Ensure care and treatment are provided in a safe way.
- Establish effective systems and processes to ensure good governance in accordance with the fundamental standards of care
- Ensure recruitment procedures are established and operate effectively to ensure only fit and proper persons are employed.
- Ensure patients are protected from abuse and improper treatment by assessing the need for chaperoning at the service and staff training requirements.

(Please see the specific details on action required at the end of this report)

The areas where the provider **should** make improvements are:

- Only supply unlicensed medicines against valid special clinical needs of an individual patient where there is no suitable licensed medicine available.
- Where medicines are supplied outside of prescribing guidelines a clinical reason should be noted.
- Review procedures for calibration of equipment including weighing scales.
- Improve the audit process to identify issues and to include the assessment of weight loss.
- Clearly document how the service responds to patient feedback.

The practice suspended services for the foreseeable future due to COVID 19 and enforcement action was not progressed at this time.

Dr Rosie Benneyworth BM BS BMedSci MRCGP
Chief Inspector of Primary Medical Services and Integrated Care

Our inspection team

Our inspection team was led by a CQC Pharmacist Specialist. The team also included a member of the CQC medicines team.

Background to National Slimming Centres (Sheffield)

National Slimming Centres (Sheffield) is based on the first floor of a shared building and is located near Sheffield city centre.

The service comprises of a reception, office area and one clinic room. A toilet facility is available on the clinic premises. There is a doctor and two receptionists and another member of staff that looks after compliance work at the service.

The service is open Tuesday 1.30pm to 3pm, Thursday 1.30pm to 3pm and Saturday 9.30am to 12.30 noon. Slimming and obesity management services are provided for adults over 18 years of age by appointment.

How we inspected this service

Prior to the inspection we reviewed information about the service, including the previous inspection report and information from the provider. We spoke to the manager and two members of staff. We also reviewed a range of documents. We received 19 comment cards. To get to the heart of patients' experiences of care and treatment, we always ask the following five questions:

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.

Inadequate

Are services safe?

We rated safe as Inadequate because:

There were gaps in risk assessments and policies and protocols had not been updated. The process for staff recruitment was not followed.

Safety systems and processes

The service did not have clear systems to keep people safe and safeguarded from abuse.

- The provider conducted some safety risk assessments; however, these were not comprehensive. It had some safety policies, which had not been reviewed since 2016 and it was not clear how they had been communicated to staff. One member of staff did not have a record of any training or induction. There were no new or updated training records since 2009.
- The service had some systems to safeguard children and vulnerable adults from abuse.
- Staff told us how they would protect patients from abuse, neglect, harassment, discrimination and breaches of their dignity and respect.
- The provider carried out some staff checks at the time of recruitment. One member of staff had no references as part of their recruitment. Disclosure and Barring Service (DBS) checks were undertaken at the time of recruitment, however there was no risk assessment or evidence that these were updated on an ongoing basis where appropriate. (DBS checks identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable).
- Only the doctor, who was also the registered manager had any formal safeguarding training although staff told us that they knew how to identify and report concerns. Staff who acted as chaperones, had not been trained for the role.
- The systems to manage infection prevention and control needed to be reviewed. There was no legionella risk assessment. (Legionella is a term for a particular bacterium which can contaminate water systems in buildings.)
- The premises were clean and tidy and there was evidence of cleaning.
- There was no system in place to ensure that equipment was maintained according to manufacturers' instructions. For example, there was no record of calibration of the weighing scales. There was no system for safely managing healthcare waste.
- The provider carried out some environmental risk assessments, which considered the profile of people using the service and those who may be accompanying but these were not sufficiently detailed to mitigate the risks.

Risks to patients

There were limited systems to assess, monitor and manage risks to patient safety.

- There were arrangements for planning and monitoring the number and mix of staff needed.
- There was no induction system for staff tailored to their role.
- Staff understood their responsibilities to manage emergencies and to recognise those in need of urgent medical attention.
- This is a service where the risk of needing to deal with a medical emergency is low. There was a risk assessment in place for which medicines would be stocked dated 2017 but the medicines listed were not available and the risk assessment had not been updated.
- When there were changes to services or staff the service assessed and monitored the impact on safety.
- There were appropriate indemnity arrangements in place

Information to deliver safe care and treatment

Staff did not have the information they needed to deliver safe care and treatment to patients.

- Individual care records were not always written and managed in a way that kept patients safe. The care records we saw did not always show the information needed to deliver safe care and treatment was available to relevant staff in an accessible way. In two out of the ten records we looked at the patient information was not fully completed. We also saw two other records where there was no evidence that the medical history had been checked and the person had not reconsented to treatment after a break in line with the provider's policy.

Inadequate

Are services safe?

- The service had systems for sharing information with staff and other agencies to enable them to deliver safe care and treatment. Patients were given letters that they could take to their General Practitioner (GP).
- The service had a system in place to retain medical records in line with Department of Health and Social Care (DHSC) guidance in the event that they cease trading.
- Clinicians made appropriate and timely referrals in line with protocols and up to date evidence-based guidance.

Safe and appropriate use of medicines

The service did not have reliable systems for appropriate and safe handling of medicines.

- The systems and arrangements for managing medicines, including controlled drugs, emergency medicines and equipment did not always minimise risks.
- The service carried out regular medicines audit to ensure prescribing was in line with best practice guidelines for safe prescribing, however the clinical records audit was not effective and did not identify issues we found. The clinical governance quality assurance audit had not been completed at the frequency detailed in the provider's policy.
- The service did prescribe Schedule 3 controlled drugs, (medicines that have additional levels of control due to their risk of misuse and dependence) these were managed safely.
- Staff prescribed or supplied medicines to patients and gave advice on medicines, however this was not always in line with legal requirements and current national guidance. Where there was a different approach taken from national guidance and the provider's policy it was not clear from patient notes what the rationale was. For example, out of the ten records we looked at three patients did not have a break in treatment after 12 weeks and four patients did not have their blood pressure monitored monthly. This meant we could not be assured that this protected patient safety.
- Processes were in place for checking medicines and staff kept accurate records of medicines
- There were protocols for verifying the identity of patients, however in two out of the ten records we looked at there was no evidence that identity had been checked.
- Some of the medicines this service prescribes for weight loss are unlicensed. Treating patients with unlicensed medicines is higher risk than treating patients with licensed medicines, because unlicensed medicines may not have been assessed for safety, quality and efficacy. These medicines are no longer recommended by the National Institute for Health and Care Excellence (NICE) or the Royal College of Physicians for the treatment of obesity. The British National Formulary states that 'Drug treatment should never be used as the sole element of treatment (for obesity) and should be used as part of an overall weight management plan'.

Track record on safety and incidents

The service had a good safety record.

- The service had some risk assessments in relation to safety issues, however these were not comprehensive or updated when changes occurred.
- There was no evidence that the service monitored and reviewed activity, however staff said that there had been no recent incidents.

Lessons learned and improvements made

The service learned and made improvements when things went wrong.

- There was a system for recording and acting on significant events. Staff understood their duty to raise concerns and report incidents and near misses. The manager said they would be supported if they did so.
- There were adequate systems for reviewing and investigating when things went wrong. The manager told us that the service had a process in place to identify themes and act to improve safety in the service.
- The provider was aware of and complied with the requirements of the Duty of Candour. The provider encouraged a culture of openness and honesty. The service had systems in place for knowing about notifiable safety incidents.
- The service acted on and learned from external safety events as well as patient and medicine safety alerts. The service had an effective mechanism in place to disseminate alerts to all members of the team where necessary.

Requires improvement

Are services effective?

We rated effective as Requires improvement because:

There was limited evidence of monitoring care and treatment to assess if it was in line with current guidance. Records did not demonstrate that staff had the skills, knowledge and experience to carry out their roles.

Effective needs assessment, care and treatment

The provider had systems to keep clinicians up to date with current evidence-based practice. Clinicians were not always able to evidence assessment of needs to deliver care and treatment in line with current legislation, standards and guidance (relevant to their service)

- Patients' immediate and ongoing needs were not fully assessed. We saw evidence that patient record forms were not fully completed with their clinical needs, height weight and body mass index (BMI) for five out of the ten records we looked at. There was no evidence that this was reassessed for two patients after breaks in treatment in line with the provider's policy.
- We saw no evidence of discrimination when making care and treatment decisions.
- Arrangements were in place to deal with repeat patients, however we found these were not followed in practice. For example, we saw records that showed two out of the ten patient records we looked at regularly attended appointments and obtained a supply of medicines earlier than was due. This had not been picked up by the prescriber.

Monitoring care and treatment

The service was not actively involved in quality improvement activity.

- The service completed a variety of audits, but we saw no evidence to show that clinical audit had a positive impact on quality of care and outcomes for patients. For example, weight loss and compliance with BP monitoring were not covered in the audits we saw.
- The completed clinical records audit did not identify any issues which was not consistent with the records we looked at.

Effective staffing

Records did not show that staff had the skills, knowledge and experience to carry out their roles.

- There was no recent evidence of staff training. There was no formal induction programme for all newly appointed staff as detailed in the provider's policy.
- Relevant professionals were registered with the General Medical Council (GMC) and were up to date with revalidation.
- There were no systems in place to review the learning needs of staff and provide protected time and training to meet them. Records of skills, qualifications and training were not maintained. There were no systems in place to give staff opportunities to develop.

Coordinating patient care and information sharing

Staff worked together, and worked well with other organisations, to deliver effective care and treatment.

- Patients received coordinated and person-centred care.
- Before providing treatment, doctors usually ensured they had adequate knowledge of the patient's health and their medicines history, although we found that some records did not have the patient history completed.
- All patients were asked for consent to share details of their consultation and any medicines prescribed with their registered GP. Where patients did not consent to a letter being sent, they were given a letter that they could take to their GP.

Supporting patients to live healthier lives

Staff were consistent and proactive in empowering patients and supporting them to manage their own health and maximise their independence.

- Where appropriate, staff gave people advice so they could self-care. Patients were given a leaflet that covered aspects of diet and exercise.
- Risk factors were identified, highlighted to patients and where appropriate highlighted to their normal care provider for additional support.

Consent to care and treatment

The service obtained consent to care and treatment in line with legislation and guidance .

- Staff understood the requirements of legislation and guidance when considering consent and decision making.

Requires improvement

Are services effective?

- Staff supported patients to make decisions. Where appropriate, they assessed and recorded a patient's mental capacity to make a decision.
- The service monitored the process for seeking consent appropriately, however we saw that information was given to a relative of a patient without a record of written consent to share information in line with the provider's policy.

Good

Are services caring?

We rated caring as Good because:

Kindness, respect and compassion

Staff treated patients with kindness, respect and compassion.

- The service sought feedback from patients, but it was not clear what action had been taken in response to patient comments.
- Feedback from patients was positive about the way staff treat people
- Staff understood patients' personal, cultural, social and religious needs. They displayed an understanding and non-judgmental attitude to all patients.
- The service gave patients timely support and information.

Involvement in decisions about care and treatment

Staff helped patients to be involved in decisions about care and treatment.

- There were currently no interpretation services available for patients who did not have English as a first language. The doctor told us that they would not treat patients if they could not be sure that information could be correctly communicated.
- Patients told us through 19 comment cards, that staff were always helpful and that they were treated with respect.

Privacy and Dignity

The service respected patients' privacy and dignity.

- Staff recognised the importance of people's dignity and respect.
- Staff knew that if patients wanted to discuss sensitive issues or appeared distressed they could offer them a private room to discuss their needs.

Good

Are services responsive to people's needs?

We rated responsive as Good because:

Responding to and meeting people's needs

The service organised and delivered services to meet patients' needs. It took account of patient needs and preferences.

- The provider understood the needs of their patients and told us they would listen to patients requests for improved services.
- The facilities and premises were appropriate for the services delivered.

Timely access to the service

Patients were able to access care and treatment from the service within an appropriate timescale for their needs.

- Patients had timely access to initial assessment and treatment.
- Waiting times, delays and cancellations were minimal and managed appropriately.
- The clinic mainly ran on an appointment system. Patients reported that the appointment system was easy to use.

Listening and learning from concerns and complaints

The service took complaints and concerns seriously and responded to them appropriately to improve the quality of care.

- Information about how to make a complaint or raise concerns was available. Staff were able to describe how they would treat patients who made complaints compassionately.
- Staff told us that patients would be informed of any further action that may be available to them should they not be satisfied with the response to their complaint.
- The service had complaint policy and procedures in place. The service had no recent complaints.

Requires improvement

Are services well-led?

We rated well-led as Requires improvement because:

The audit process was not effective and did not identify the issues we found in clinical records. Some risk assessments needed updating.

Leadership capacity and capability;

Leaders did not always have the capacity and skills to deliver high-quality, sustainable care.

- Leaders were not fully aware about issues and priorities relating to the quality and future of services. They did not fully understand the challenges to be able to address them.
- Leaders at all levels were visible and approachable. They worked closely with staff and others to make sure they prioritised compassionate and inclusive leadership.
- The manager said that meetings were held with staff, however the outcomes of these were not fully documented. For example, it was noted that patient feedback audits would be discussed at the staff meeting but this discussion and outcome was not documented in the meeting notes.

Vision and strategy

The service had a clear vision and credible strategy to deliver high quality care and promote good outcomes for patients.

- There was a clear vision and set of values. The service had a realistic strategy and supporting business plans to achieve priorities.
- The service developed its vision, values and strategy jointly with staff and external partners (where relevant).
- Staff were aware of the vision, values and strategy and but did not fully understand their role in achieving them.

Culture

The service had some aspects of their culture that supported high-quality sustainable care but this was not reflected in their staff appraisal system.

- Staff felt respected, supported and valued. They were proud to work for the service.
- The service focused on the needs of patients.
- Openness, honesty and transparency were described by the provider when asked about responding to incidents and complaints. The provider was aware of and had systems to ensure compliance with the requirements of the duty of candour.
- Staff told us they could raise concerns. They had confidence that these would be addressed.
- There were no processes for providing all staff with the development they need. The last appraisals were in 2017 and one member of staff had not had any appraisal. Staff met the requirements of professional revalidation where necessary.
- The service was aware of equality and diversity. There was no evidence workforce inequality. Staff felt they were treated equally.
- There were positive relationships between staff and teams.

Governance arrangements

There were not always clear responsibilities, roles and systems of accountability to support good governance and management.

- Structures, processes and systems to support good governance and management were clearly set out but were not always understood and effective. For example, we looked at three of the records that had been audited by the service in December 2019 and found that all records had issues that raised safety concerns that had not been identified.
- The governance and management of partnerships, joint working arrangements and shared services would promote interactive and co-ordinated person-centred care. However, on the day of inspection we saw limited evidence on the current support from partner organisations and a limited capacity to take over all of the required roles.
- Staff were clear on their roles and responsibility however this was not always in line with policies or legislation. For example, medicine disposal was not in line with national guidance or provider policy.
- Leaders had established proper policies and procedures, however activities did not always ensure safety or provided assurance that they were operating as intended.

Managing risks, issues and performance

Requires improvement

Are services well-led?

There was limited clarity around processes for managing risks, issues and performance.

- The process to identify, understand, monitor and address current and future risks including risks to patient safety was not effective.
- The service had some processes to manage current and future performance. Performance of clinical staff should be demonstrated through audit of their consultations, prescribing and referral decisions. However, the audit system was not robust and had not identified any issues which was not consistent with our findings. Leaders had oversight of safety alerts, incidents, and complaints.
- Clinical audit did not have a positive impact on quality of care and outcomes for patients as this was not effective. There was no clear evidence of action to change services to improve quality.

Appropriate and accurate information

The service did not have appropriate and accurate information.

- We did not see that quality and operational information was used to ensure and improve performance.
- We were told that quality was discussed in relevant staff meetings, however we saw evidence of meetings but not details of what was discussed or outcomes.
- The information used to monitor performance and the delivery of quality care was not accurate therefore there were no plans to address any weaknesses.
- The arrangements in line with data security standards for the availability, integrity and confidentiality of patient identifiable data, records and data management systems was not robust. We saw information given to a patient representative without written authorisation this was not in line with the provider policy.

Engagement with patients, the public, staff and external partners

The service involved patients to support sustainable services.

- The service encouraged and heard views and concerns from patients. We saw that patient surveys were completed every six months, all were positive, but some mentioned early or late appointments. The action document said that this would be discussed at staff meetings, but we did not see this evidenced or any outcome.
- The service was transparent and open with stakeholders about performance.

Continuous improvement and innovation

There was no evidence of systems and processes for learning, continuous improvement and innovation.

- There was no focus on continuous learning and improvement for non-medical staff.
- The service had a process to review internal and external reviews of incidents and complaints, however there had been no incidents in the last 12 months.
- We saw no evidence of staff reviewing individual and team objectives, processes and performance.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

The table below shows the legal requirements that the service provider was not meeting. The provider must send CQC a report that says what action it is going to take to meet these requirements.

Regulated activity	Regulation
Services in slimming	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment The provider did not have an effective system to ensure that prescribing was in line with current national guidance or local policy. The clinical audit process did not effectively monitor prescribing and record keeping against national guidance or local policy.

Regulated activity	Regulation
Services in slimming	Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment The provider did not have an effective system to ensure that staff had received appropriate levels of safeguarding training to meet their role with regard to chaperoning patients

Regulated activity	Regulation
Services in slimming	Regulation 17 HSCA (RA) Regulations 2014 Good governance The provider did not have an effective system in place to monitor the quality of the service. The provider did not have systems in place to monitor, update and implement policies and procedures at the service.

Regulated activity	Regulation
Services in slimming	Regulation 19 HSCA (RA) Regulations 2014 Fit and proper persons employed

This section is primarily information for the provider

Requirement notices

The provider did not have a robust recruitment process including undertaking any relevant checks.