Harley Street Healthcare - 96 Harley Street

Inspection report

96 Harley Street
London
W1G 7HY
Tel: 07825515001

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

Ratings

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

Overall summary

This service is rated as Good overall.

The key questions are rated as:

Are services safe? – Requires improvement

Are services effective? – Good

Are services caring? – Good

Are services responsive? – Good

Are services well-led? – Good

We carried out an announced comprehensive/focused inspection at Harley Street Healthcare - 96 Harley Street on 8 June 2022. We conducted this inspection to follow up on breaches of regulations at our previous inspection held14 & 15 September 2021.

At the September 2021 inspection, the provider was found to be in breach of Regulation 17 of the Health and Social Care Act (Regulated Activities) 2014. In addition, we served the provider an urgent notice under section 31 of the Health and Social Care Act 2008, which resulted in the suspension of the providers' registration in respect of the regulated activities conducted for a period of four weeks.

At this inspection our key findings were:

- The service had systems in place which kept patients safe. These included checks on patients attending the service and risk assessments conducted to ensure staff and patients were safe whilst attending the centre.
- Mandatory training had been undertaken by staff at the service.
- The provider understood the needs of their patients and provided services in response to those needs.
- Not all patient records we viewed contained a detailed account of advice given to patients.
- The service had embedded a comprehensive quality improvement activity programme to assist in the management of the service.
- The provider and senior management team had the knowledge and skills to facilitate the delivery of quality care.

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

- Provide safe care and treatment.

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

- Continue with the quality improvement activity in relation to the provider auditing of patient records. With reference to the quality of record keeping and detail of information contained in record.

I am taking this service out of special measures. This recognises the significant improvements that have been made to the quality of care provided by this service.

Overall summary

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 lead inspector**.** The team included a CQC GP specialist adviser.

Background to Harley Street Healthcare - 96 Harley Street

Harley Street Healthcare – 96 Harley Street provides consultations with dermatologists from premises located at 96 Harley Street, London, W1G 7HY. The service offers mole and cyst removal, as well as consulting on other skin conditions.

This fee-paying service provides the above range of health services to children and adults.

The service is registered with the Care Quality Commission to undertake the regulated activities for the provision of surgical procedures, diagnostic and screening procedures and the treatment of disease, disorder or injury.

The service is located is a three-storey building with the entrance on the ground floor and a lift which allows for easy access for those with mobility issues. The service is based on the 2nd floor. The service has a clinical consultation room, a treatment room, a service manager's office and the patient waiting room. The reception area is the entrance to the service.

The registered manager of the service is the service provider. Consultations and treatment are undertaken by three dermatologists who are all registered with the General Medical Council (GMC). Other staff working at the service include two healthcare assistants (who also undertake minor administrative duties) and a commercial manager.

Appointments at the service are flexible and services are conducted according to demand.

How we inspected this service

Throughout the pandemic CQC has continued to regulate and respond to risk. However, considering the circumstances arising as a result of the pandemic, and in order to reduce risk, we have conducted our inspections differently.

This inspection was carried out in a way which enabled us to spend a minimum amount of time on site. This was with consent from the service and in line with all data protection and information governance requirements.

During our inspection we:-

- Looked at the systems in place relating to safety and governance of the service.
- Viewed key policies and procedures.
- Conducted interviews with staff.
- Reviewed clinical records.

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.

Requires Improvement

Are services safe?

We rated safe as Requires improvement.

At our last inspection in September 2021, the provider was rated as inadequate for providing safe services. During the September 2021 inspection, the provider was unable to provide the inspection team with adequate evidence that mandatory safety training had been undertaken, that there were no measures in place to limit the spread of Coronavirus and staff were unable to identify the signs patient risk with regards to deteriorating health of a patient or how to identify a potential safeguarding concern.

At this inspection held on 8 June 2022, we found that the provider taken action to rectify the issues identified at the last inspection (as part of the previous service). This included embedding systems within the service to ensure that infection and prevention control measures were in place to limit the spread of Coronavirus, mandatory safety training had occurred and evidence that staff had undertaken safeguarding training.

However, at this inspection, the inspection team had concerns regarding the level of advice given to patients with severe acne who had been prescribed a specific type of medicine. In addition, we were concerned with the quality of patient consultation notes which varied in quality amongst the dermatologists working at the service.

As a result of the issue highlighted in the preceding paragraph, we have rated key question safe as requires improvement.

Safety systems and processes

The service had clear systems to keep people safe and safeguarded from abuse.

- The provider conducted safety risk assessments. It had appropriate safety policies, which were regularly reviewed and communicated to staff including locums. They outlined clearly who to go to for further guidance. Staff received safety information as part of their induction and refresher training. The service had systems to safeguard children and vulnerable adults from abuse. The senior leadership team were trained to safeguarding level three and all other staff were trained to safeguarding level two. There was a designated safeguarding lead at this location.
- The service had systems in place to assure that an adult accompanying a child had parental authority. Treatment would only be given to a patient aged under 16 as long as the accompanying adult could provide proof that they were the child's legal guardian. The location would verify this by requesting relevant documentation such as a birth or adoption certificate if it included the child's address or a letter from the child's doctor or school on headed paper with the child's address, date of birth, and name of the child's guardian.
- The service worked with other agencies to support patients and protect them from neglect and abuse. Staff took steps to protect patients from abuse, neglect, harassment, discrimination and breaches of their dignity and respect. The process regarding who and when to contact relevant local stakeholders in relation to safeguarding concerns were stored on the provider's secure computer shared drive. All staff working at this location had access to this. The provider also had these details placed in all rooms and the reception area at this location.
- The provider carried out staff checks at the time of recruitment and on an ongoing basis where appropriate. Disclosure and Barring Service (DBS) checks were undertaken where required. (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). This policy applied to all members of staff working at the service.
- All staff received up-to-date safeguarding and safety training appropriate to their role. They knew how to identify and report concerns. Staff who acted as chaperones were trained for the role and had received a DBS check.
- There was an effective system to manage infection prevention and control. On the day of inspection, we noted the rooms, waiting and reception areas on the floor that the provider ran their service from was visibly clean and tidy. The provider had employed a separate cleaning company (to the rest of the building) to provide cleaning to NHS national

standards of healthcare cleanliness 2021. Cleaning logs were completed daily by the cleaners and signed off by a member of staff at the location. Although national guidelines relating to Covid-19 had been removed, the service required visitors to have their temperature checked and hand gel applied in the reception area before entering the waiting area. Mask wearing was mandatory at the service (including staff) unless a medical exemption applied.

- The provider ensured that facilities and equipment were safe and that equipment was maintained according to manufacturers' instructions. We saw relevant calibration certificates for clinical equipment in use. There were systems for safely managing healthcare waste. The provider employed a specialist company to ensure the safe removal of clinical waste.
- The provider carried out appropriate environmental risk assessments, such as IPC audits, fire risk assessments and Legionella controls which took into account the profile of people using the service and those who may be accompanying them.

Risks to patients

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

- There were arrangements for planning and monitoring the number and mix of staff needed. The provider employed enough staff to ensure that any possible gaps in the service would be covered.
- Staff understood their responsibilities to manage emergencies and to recognise those in need of urgent medical attention. They knew how to identify and manage patients with severe infections, for example sepsis.
- When there were changes to services or staff the service assessed and monitored the impact on safety.
- There were suitable medicines and equipment to deal with medical emergencies which were stored appropriately and checked regularly. However, not all medicines as identified in national guidance were not kept at this location and no risk assessment had been undertaken (or recorded) to inform this decision.

Information to deliver safe care and treatment

Staff had the information they needed to deliver safe care and treatment to patients but did not always manage this information appropriately.

- Individual care records were not always written well and managed in a way that kept patients safe. We viewed five patient records and found that there was not a consistent approach in written patient consultation notes. Two sets of patient notes were sufficiently completed, while the remaining three other had minimal information. An example of this was a record we viewed which showed limited consultation notes completed by the clinician before a patient was prescribed repeat medication for severe acne. The medication prescribed for the patient did not note any patient discussion regarding some of the notable side-effects of the medication prescribed and only made reference to the patient's mood. There was no clarity as to whether the patient's mood referred to their mood on the day or during the time since the last consultation.
- All patient records used at this location could only be access through an individual user ID and secure password to the bespoke system that kept patient records. The provider told us that the system was encrypted and was backed-up to a remote location at regular periods, to prevent loss of records.
- The service had systems for sharing information with staff and other agencies to enable them to deliver safe care and treatment. The provider told us that patient information would only be shared with other agencies with the agreement of the patient.
- 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.

Requires Improvement

Are services safe?

- Clinicians made appropriate and timely referrals in line with protocols and up to date evidence-based guidance. We saw evidence that clinical staff at the service made referrals, however not all referrals were followed up in timely manner. We viewed two patient records where patient records showed that blood tests were requested, but on one record it was not specified what type of testing was required and on the second record, the request to the patient's GP requesting blood tests was not sent by the service to the patient's GP.

Safe and appropriate use of medicines

The service had reliable systems for appropriate and safe handling of medicines.

- The systems and arrangements for managing medicines, including emergency medicines and equipment minimised risks. The service kept prescription stationery securely and monitored its use.
- The service carried out regular medicines audit to ensure prescribing was in line with best practice guidelines for safe prescribing.
- Staff prescribed, administered or supplied medicines to patients and gave advice on medicines in line with legal requirements and current national guidance, however the patient records we viewed did not always record the advice given to patients when medicines had been prescribed. Processes were in place for checking medicines and staff kept accurate records of medicines. The service had a system in place to check the expiry dates of medicines kept at this location. Where a medicine was near to its expiry date, it was removed from existing stock and kept separately for disposal.

Track record on safety and incidents

The service had a good safety record.

- There were comprehensive risk assessments in relation to safety issues. The service had an incident policy as part of its suite of policies and procedures. The procedure set what staff were expected to do if an incident occurred. There was also an incident log where all incidents were to be recorded and a named lead within the senior management team who was responsible for investigating incidents that occur at the service.
- The service monitored and reviewed activity. This helped it to understand risks and gave a clear, accurate and current picture that led to safety improvements. The provider held monthly meetings with the senior leadership team where activity relating to safety within the service was a standing agenda item and discussed where relevant. Any outcomes or changes as a result of these meetings were shared with all staff at the next all staff meeting or by email.

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. Leaders and managers supported them when they did so. The provider did not have any significant events relating to patient safety recorded at this location during the last 12 months.
- 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. Staff at the service had duty of candour training included as part of their induction programme.
- The service acted on and learned from external safety events as well as patient and medicine safety alerts. Safety alerts and bulletins from organisations such as the Royal College of Dermatology, the Health and Safety Executive (HSE) and

Requires Improvement

Are services safe?

the Department of Health and Social Care (DHSC) were discussed at monthly staff meetings. However, there was no discussion regarding alerts received from the Medicines and Healthcare products Agency (MHRA) and no evidence that these were circulated amongst clinical staff. After the inspection, we received a template from the provider showing the new process for ensuring all clinical staff acknowledge receipt of these alert from the service manager.

Good

Are services effective?

We rated effective as Good.

At our last inspection in September 2021, the provider was rated as inadequate for providing effective services. During the September 2021 inspection, the provider was unable to provide the inspection team with adequate evidence that care and treatment was being delivered according to national guidance, that a programme of clinical audits or quality improvement activity was in place and that there was a system in place to verify that staff at the service were competent for the role they were employed to do.

At this inspection held on 8 June 2022, we found that the provider taken action to rectify the issues identified at the last inspection (as part of the previous service), including the introduction of a programme of audits and quality improvement activity, evidence of the competence of staff through information held in staff files and that the service obtained consent to care and treatment in line with legislation and guidance.

Effective needs assessment, care and treatment

The provider had systems to keep clinicians up to date with current evidence based practice. We saw evidence that clinicians assessed and delivered care and treatment in line with current legislation, standards and guidance (relevant to their service).

- Patients' immediate and ongoing needs were fully assessed. Where appropriate this included their clinical needs and their mental and physical wellbeing. We saw evidence via patient records that we viewed that clinical staff at the service made appropriate assessments regarding patients physical and mental wellbeing.
- Clinicians had enough information to make or confirm a diagnosis.
- We saw no evidence of discrimination when making care and treatment decisions.
- Arrangements were in place to deal with repeat patients. Patients receiving ongoing treatment were given follow-up appointments to ensure that required monitoring took place.
- Staff assessed and managed patients' pain where appropriate.

Monitoring care and treatment

The service was actively involved in quality improvement activity.

- The service used information about care and treatment to make improvements. The service made improvements using completed audits. The provider was able to talk with us about a schedule of quality improvement activity that was in place at the service. This activity included quarterly audits on a number of internal processes and procedures to ensure the systems had been embedded into the running of the service. An example of this was an audit we viewed that focused on the hand hygiene of staff involved with clinical procedures. The audit was undertaken by a member of the senior management team, observing a staff member to confirm that internal policy was adhered to. Due to the length of time that the service had been running in its current form, the provider had limited evidence that quality improvement activity had a positive impact on quality of care and outcomes for patients. The provider had undertaken quality improvement activities which looked at the quality of patient records and how clinical samples were logged and forwarded on to an external laboratory, but neither outcomes of these activities could provide evidence of a positive impact on patient care and outcomes as only one cycle of quality improvement activity had been undertaken in each area.

Effective staffing

Good

Are services effective?

Staff had the skills, knowledge and experience to carry out their roles.

- All staff were appropriately qualified. The provider had an induction programme for all newly appointed staff. The induction process for new members of staff ensured staff had read and could access all policies.
- Relevant clinical professionals were registered with the General Medical Council and were up to date with revalidation. The service was recognised as a designated body, and all doctor revalidation issues had been appraised by a responsible officer. All doctors who worked at the service were registered with the General Medical Council (GMC) and had indemnity insurance. Annual appraisals were undertaken for all other members of staff. Appraisals involved discussions about their knowledge and competency within their role, as well as identifying any skills gaps, which would be included in their development plan for the coming year.
- The provider understood the learning needs of staff and provided protected time and training to meet them. Up to date records of skills, qualifications and training were maintained. Staff were encouraged and given opportunities to develop. The provider spoke with us regarding learning events which are held regularly involving staff who work at this location and one other healthcare location that the provider is responsible for. These learning events are devised to allow the provider to gauge (on the day of training) that participants have understood (and are able to put into practice) the learning gained.

Coordinating patient care and information sharing

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

- Patients received coordinated and person-centred care. Staff referred to, and communicated effectively with, other services when appropriate. The service had contracts with external blood testing laboratories to ensure that required testing could be completed in a timely manner when required.
- Before providing treatment, doctors at the service ensured they had adequate knowledge of the patient's health, any relevant test results and their medicines history.
- All patients were asked for consent to share details of their consultation and any medicines prescribed with their registered GP when they used the service.
- The provider had risk assessed the treatments they offered. They could identify medicines that were not suitable for prescribing if the patient did not give their consent to share information with their GP or if they were not registered with a GP. For example, medicines liable to abuse or misuse. Where patients agreed to share their information, we saw evidence of letters sent to their registered GP in line with GMC guidance.
- Patient information was shared appropriately (this included when patients moved to other professional services), and the information needed to plan and deliver care and treatment was available to relevant staff in a timely and accessible way.

Supporting patients to live healthier lives

Staff were generally 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. The service telephone lines were open between 9am to 9pm every day allowing patients to contact them if they had any issues following any procedures undertaken.
- Risk factors were identified but we were unclear if these factors were highlighted to patients during all consultations as the patient records we looked at did not always state this. We were told that where appropriate the patient was able to contact the service or their normal care provider for additional support.
- Where patients needs could not be met by the service, staff redirected them to the appropriate service for their needs.

Good

Are services effective?

Consent to care and treatment

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

- Clinical staff understood the requirements of legislation and guidance when considering consent and decision making. Consent was undertaken using a two-stage process which involved in the first instance the completion of the patient information form and the second stage during consultation before treatment commenced.
- Staff supported patients to make decisions. Where appropriate, they assessed and recorded a patient's mental capacity to make a decision.
- The provider had a variety of quarterly audits which were undertaken to improve the quality of service provided, which included a patient records audit. The inspection team did not observe that as part of this audit the provider monitored the process for seeking consent was undertaken as required.

Good

Are services caring?

We rated caring as Good

Kindness, respect and compassion

Staff treated patients with kindness, respect and compassion.

- The service sought feedback on the quality of clinical care patients received. Patients were encouraged to give feedback on the care they received and way they were treated when they attended the service.
- 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.

- Interpretation services were available for patients who did not have English as a first language. Patients were also told about multi-lingual staff who might be able to support them. Information leaflets were available in easy read formats, to help patients be involved in decisions about their care.
- Patients told us through comment cards, that they felt listened to and supported by staff and had sufficient time during consultations to make an informed decision about the choice of treatment available to them.
- Staff communicated with people in a way that they could understand, for example, easy read materials were available.

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.

At our last inspection in September 2021, the provider was rated as requires improvement for providing responsive services. During the September 2021 inspection, the provider was unable to provide the inspection team with adequate evidence that patient individual needs were being taken in account when providing access as part of the previous service. In addition, the provider could not evidence that staff at the service had the relevant training to allow them to provide a chaperone to patients when required. Finally, the inspection team could not assure themselves that learning was gained by the provider following actioning complaints received.

At this inspection held on 8 June 2022, we found that the provider had embedded systems within the service to ensure that delivery of services considered patient requirements and needs. In addition, the provider was able to evidence that the service learnt from complaints and concerns to make improvements in service provision and delivery of care.

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 improved services in response to those needs. The services provided at this location generally were delivered approximately three times a week, with appointments starting late afternoon so that people in work could attend the service after work.
- The facilities and premises were appropriate for the services delivered. There was a lift at this location and portable ramps were available for patients with mobility issues.
- A chaperone could be requested by a patient if required. Staff had undergone relevant training to fulfil this function. There were signs in the service informing patients that a chaperone service was available.

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, test results, diagnosis and treatment.
- Waiting times, delays and cancellations were minimal and managed appropriately. The provider told the inspection team that where possible staff members provided cover for each other to minimise delays and cancellations for patients.

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 treated patients who made complaints compassionately. The service had a designated complaint lead and complaints handler.
- The service informed patients of any further action that may be available to them should they not be satisfied with the response to their complaint. The service had a complaints leaflet which gave information on who to contact if a patient complaint could not be resolved with the service.

Good

Are services responsive to people's needs?

- The service had complaint policy and procedures in place. The service learned lessons from individual concerns, complaints and from analysis of trends. It acted as a result to improve the quality of care. We saw an example of this during our review of the service's complaints log where a patient had attended the service for a scheduled clinic which had been cancelled. The service had not informed the patient that the service was closed, but subsequently spoke with the patient (prior to the complaint being received) to inform them what options were available to the patient. The service was able to resolve the complaint and learning from the complaint was discussed with staff and new in-house procedure implemented as a result of the complaint.

Good

Are services well-led?

We rated well-led as Good.

At our last inspection in September 2021, the provider was rated as inadequate for providing well-led services. During the September 2021 inspection, the provider was unable to evidence a consistent understanding regarding their responsibilities in leading the service, to provide evidence of systems used to identify and mitigate risk which could reduce or eliminate potential risk(s) and finally, there was no evidence of continuous improvement activity undertaken by the provider at the service.

At this inspection held on 8 June 2022, we found that the provider we found that the provider taken action to rectify the issues identified at the last inspection (as part of the previous service). We found that the provider and the senior management team were aware of issues and priorities at the service, that there was a clear strategy which sat alongside the vision and values of the service. Staff at the service were valued and trained as part of ongoing personal development. Finally, there was evidence of continuous improvement through ongoing training and quality improvement activity.

Leadership capacity and capability;

Leaders had the capacity and skills to deliver quality, sustainable care.

- Leaders were knowledgeable about issues and priorities relating to the quality and future of services. They understood the challenges and were addressing them. Following our previous inspection finding in September 2021, the provider had made substantial changes to the running of the service which included improved oversight of risks and implementation of a quality improvement programme which helped embed change within the service.
- 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 provider told us that there were daily meetings with the senior leadership team to continually monitor the provision of service and to ensure that it was run effectively.

Vision and strategy

The service had a clear vision and credible strategy to deliver 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. The service's vision was to provide world class affordable care underpinned by a set of core values; courage, accountability, integrity, can do attitude, and focus on the care and delivery of service to patients.
- Staff were aware of and understood the vision, values and strategy and their role in achieving them
- The service monitored progress against delivery of the strategy. This was achieved using the service's quality management system as a tool to measure the service progress in achieving its strategy.

Culture

The service had a culture of quality sustainable care.

- Staff felt respected, supported and valued. They were proud to work for the service. The provider was keen and focused on empowering staff to deliver a quality service. Staff worked together as a team to continually improve the quality of the service.

Good

Are services well-led?

- The service focused on the needs of patients. This was evidenced in the service's values statement.
- Leaders and managers acted on behaviour and performance inconsistent with the vision and values.
- Openness, honesty and transparency were demonstrated when responding to incidents and complaints. Evidence of this was seen in the service response to complaints that we viewed. 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 and were encouraged to do so. They had confidence that these would be addressed.
- There were processes for providing all staff with the development they need. This included appraisal and career development conversations. All staff received regular annual appraisals. Staff were supported to meet the requirements of professional revalidation where necessary and this could be achieved in-house as the service is a designated body with a responsible officer. Clinical staff were considered valued members of the team. They were given protected time for professional time for professional development and evaluation of their clinical work.
- There was a strong emphasis on the safety and well-being of all staff.
- The service actively promoted equality and diversity. It identified and addressed the causes of any workforce inequality. Staff had received equality and diversity training. Staff felt they were treated equally. There was a staff whistle blowing policy and workshops had been held to ensure staff knew what to do, should they want to raise a concern.
- There were positive relationships between all members of staff.

Governance arrangements

There were 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, understood and effective. The service had a comprehensive set of in-date policies. Policies were produced with aligned with relevant sections of the Health and Social Care Act 2008, fundamental standards and CQC key lines of enquiry. The policies were version controlled and available to all staff online. Training events took place to ensure staff understood systems and processes and how policies were devised based on legislation.
- Staff were clear on their roles and accountabilities. There was a clear management structure and staff knew when and who to escalate issues or concerns to.
- Leaders had established proper policies, procedures and activities to ensure safety and were generally able to assure themselves that they were operating as intended. The exception to this was the lack of continued provider oversight on the quality of clinical record keeping.
- The service used performance information which was reported and monitored and management and staff were held to account.
- The information used to monitor performance and the delivery of quality care was accurate and useful. There were plans to address any identified weaknesses.
- The service submitted data or notifications to external organisations as required. The provider was responsible for this.
- There were robust arrangements in line with data security standards for the availability, integrity and confidentiality of patient identifiable data, records and data management systems.

Managing risks, issues and performance

There were clear and effective processes for managing risks, issues and performance.

Good

Are services well-led?

- There was an effective, process to identify, understand, monitor and address current and future risks including risks to patient safety. The service had a risk register which was monitored, managed and discussed at senior leadership team meetings.
- The service had processes to manage current and future performance. Performance of clinical staff could be demonstrated through audit of their consultations, prescribing and referral decisions. Leaders had oversight of safety alerts, incidents, and complaints.
- The provider had plans in place and had trained staff for major incidents. The service had a comprehensive business continuity plan which detailed what to do in the event of a disruption of service.

Appropriate and accurate information

The service acted on appropriate and accurate information.

- Quality and operational information was used to ensure and improve performance. Performance information was combined with the views of patients. The service undertook its own patient survey to gain their views.
- Quality and sustainability were discussed in relevant meetings where all staff had sufficient access to information.

Engagement with patients, the public, staff and external partners

The service involved/did not involve patients, the public, staff and external partners to support high-quality sustainable services.

- The service encouraged and heard views and concerns from the public, patients, staff and external partners and acted on them to shape services and culture. In addition to the patient surveys conducted by the service, the service encouraged patients to give feedback on the service and its staff. This feedback could be given in-house or by rating the service on a well-known verified feedback website.
- An audit/quality improvement activity framework was now embedded in the service with oversight provided by the senior leadership team. There was good oversight of performance and quality through the quality management system tool used at the service.
- The service was transparent, collaborative and open with stakeholders about performance.

Continuous improvement and innovation

There were evidence of systems and processes for learning, continuous improvement and innovation.

- There was a focus on continuous learning and improvement. Following the September 2021 inspection, the provider employed a continuous improvement specialist to help the service improve its systems and the way it functioned.
- The service made use of internal and external reviews of incidents and complaints. Learning was shared and used to make improvements. We saw evidence of learning following complaints via team meeting minutes that we viewed.

There were systems to support improvement and innovation work. Training workshops were held for staff to improve their knowledge on relevant topics such as being able to identify the signs of a person with sepsis. These workshops included questions, quizzes and testing to ensure the training had achieved its aim of equipping staff with practical knowledge that they could apply in their day-to-day role.

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 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
Diagnostic and screening procedures Surgical procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment The provider had not fully assessed the risks to the health and safety of service users of receiving care or treatment. This is in relation to inconsistent record keeping to identify whether patient discussion had taken place to inform patients of side-effect medication prescribed by the service. This was in breach of Regulation 12 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.