St. Michael's Clinic

Inspection report

St. Michael's Street
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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?	Good
Are services effective?	Good
Are services caring?	Good
Are services responsive?	Good
Are services well-led?	Good

Overall summary

This service is rated as Good **overall.** The service had previously been inspected in November 2013 but had not been rated. We therefore carried out an announced full comprehensive inspection at St Michael's Clinic as part of our inspection programme, to provide the service with a rating.

The key questions are rated as:

Are services safe? – Good

Are services effective? – Good

Are services caring? – Good

Are services responsive? – Good

Are services well-led? – Good

We carried out an announced comprehensive inspection at St Michael's Clinic as part of our inspection programme, to provide the service with a rating.

St Michael's Skin Clinic is based in Shrewsbury, Shropshire and provides a dermatology service to NHS patients within Telford and Wrekin, Shropshire and Powys.

The service is registered with CQC under the Health and Social Care Act 2008 in respect of some, but not all, of the services it provides. There are some exemptions from regulation by CQC which relate to particular types of regulated activities and services and these are set out in and of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. St Michael's Skin Clinic provides a range of non-surgical cosmetic interventions, for example botulinum toxin injections and dermal fillers which are not within CQC scope of registration. Therefore, we did not inspect or report on these services.

As a provider of Independent Healthcare, the service is able to offer a private dermatological service to patients within those areas offered to the NHS and beyond those geographical boundaries.

The service is managed from St Michael's Skin Clinic Shrewsbury, and the directors of the company are Dr Stephen Murdoch and Mrs Alison Murdoch.

Dr Stephen Murdoch is 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.

In preparation for the inspection, the service had been sent blank comment cards and a small collection box from CQC. The team had encouraged patients to fill these in and we received a total of 18 completed comment cards which, included patients who had received diagnosis or treatment. All 18 of the cards were positive about the service and care received. Feedback obtained clearly demonstrated positive outcomes for patients. Patients spoke highly of the care and treatment they had received. They described staff as friendly, efficient, helpful and caring. They also commented that their care was better at the service than at any hospital they had been to.

We spoke with two patients during the inspection, both told us that the staff were nice and one of the patients told us they knew what to expect during their ongoing treatment; the other was at the beginning of the consultation process. Staff we spoke with told us they were well supported in their work and were proud to be part of a team which provided a high-quality service.

Our key findings were :

- Patients received detailed and clear information about their proposed treatment which enabled them to make an informed decision.
- Patients were offered convenient, timely and flexible appointments.
- Staff helped patients to be involved in decisions about their care.
- There were effective procedures in place for monitoring and managing risks to patient and staff safety. For example, there were arrangements to prevent the spread of infection. There were written arrangements in place between the service and the local hospital for transferring the care of patients with a cancer diagnosis. There were written transfer agreements in place should a patient require urgent transfer to hospital.
- The service had a structured programme of quality improvement activity and routinely reviewed the effectiveness and appropriateness of the care provided.

Overall summary

- There was effective leadership, management and governance arrangements in place that assured the delivery of high-quality care and treatment.
- The areas where the provider should make improvements are:
- Review the Significant Event reporting policy and procedure.
- Complete root cause analysis and all significant event forms.
- Further develop the system for managing safety alerts.
- Formalise the procedure for using and managing contact allergens.
- Develop a structured audit plan.
- Review the process for recording complaints.
- Complete supervision documents.

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 specialist advisor.

Background to St. Michael's Clinic

- St Michael's Skin Clinic is based at St Michael's Road Shrewsbury SY1 2HE. The clinic is registered with CQC for treatment of disease, disorder or injury; surgical procedures; diagnostic and screening procedures and is an Independent Healthcare Company. The provider has a clinic located in Much Wenlock, Shropshire which, is registered separately with CQC and was not inspected as part of this inspection.

The service is led by a director partnership who own the business and the Shrewsbury premises from which they provide service.

The service employ a further two dermatology consultants, and three speciality doctors working on a sessional basis. They have five GPs with a special interest working on an arranged sessional basis and a team of 18 nurses, two of whom are Clinical Nurse Specialists who run nurse led clinics. The clinical team are supported by a team of 21 administrative staff. The service employ a dedicated NHS business manager.

- The service is a dermatology service which functions as an independent provider to the NHS for 83% of its work. The service is commissioned by three Clinical Commissioning Groups (CCG's) which are either in or on the border of Shropshire, Powys, and Telford and Wrekin. They also take out of area referrals in line with NHS Tariff.
- The service was set up in 2003 and moved into its current premises in 2011.
- The clinic offers a dermatology service to children over 12 years of age and adults.
- The clinic is open between 9am and 8pm Monday to Thursday and 9am to 5pm on Friday.
- The clinic does not offer weekend appointments.
- Further details about the clinic can be found on their website:

How we inspected this service

We inspected St Michael's Skin Clinic on 16 December 2019 as part of our inspection programme. Our inspection team was led by a Care Quality Commission (CQC) Lead Inspector. The team included a GP specialist advisor. Before visiting we viewed all of the information we hold about the service and asked the provider to send us a range of information. This included information about the complaints they had received in the last 12 months and the details of their staff members, their qualifications and training. On the day of inspection, they also provided information which included audits and policies. We sent patient comment cards two weeks prior to the inspection to gain feedback from people who used the service. During the inspection we spoke with a range of staff including dermatologists, nurses, business managers and administration staff.

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.

Good

Are services safe?

We rated safe as Good because:

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

Safety systems and processes

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

- The service had clear systems to keep patients safe and safeguarded from abuse. Staff had received training in safeguarding and equality and diversity. However, not all staff had received the level of safeguarding training required for their role. We saw that the appropriate training had been sourced and was scheduled to take place the week following our inspection. Staff understood their responsibilities and had access to a safeguarding policy. A Consultant Dermatologist was identified as the designated safeguarding lead. When we reviewed the safeguarding policies, they contained most but not all of the required areas. These were updated during the inspection.
- The service had systems in place to assure that an adult accompanying a child had parental authority.
- The clinic used software compatible with the NHS and had suitable data sharing protocols in place. This enabled the provider to check the identity and details of patients on the NHS electronic database. Staff confirmed these details when they contacted patients to arrange appointments.
- The provider carried out staff checks on recruitment and on an ongoing basis, including checks of professional registration where relevant. Disclosure and Barring Service (DBS) checks were undertaken for all staff employed and routinely repeated every three years. (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). We reviewed a sample of the recruitment records held for staff and found organised indexed files with the required information within them. The service documented staff's health and wellbeing and reported that no staff had required time off or support for mental health issues.
- Information displayed within both waiting and reception areas informed patients that staff were available to act as chaperones. Designated 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 (IPC). A lead nurse was the designated infection prevention and control lead and was responsible for spot checking handwashing techniques and carrying out IPC audits. The clinic had been encouraged by Shropshire Clinical Commissioning Group to use its Check to Protect process. This was a very detailed suite of evidence based IPC audits. Health and Social Care providers were encouraged to use these and if the score was less than 100% directed to generate an action plan. More frequent auditing was encouraged by the process if the scores were low. We reviewed the IPC audits carried out by the clinic throughout 2019 which showed the clinic was fully compliant with IPC procedures. Risk assessments for the prevention and control of infection were being developed and written at the time of inspection. Staff had access to an infection control policy and had received training. External cleaners were contracted to maintain the cleanliness within the building and cleaning schedules were in place. Risk assessments and processes were in place to reduce the risk of waterborne infections, such as Legionella.
- Clinics were carried out in a number of buildings that were not owned or managed by the provider. There were comprehensive arrangements and written agreements in place to ensure staff working at these sites to had access to all emergency equipment and medicines if required. The cleaning and stocking arrangements for the rooms used were also specified.
- The provider ensured that their facilities and equipment were safe and that equipment was maintained according to manufacturers' instructions. There were systems for safely managing healthcare waste.
- The provider had undertaken risk assessments for the Shrewsbury site. These included a health and safety, fire and legionella risk assessments. All electrical equipment was checked to ensure that it was safe to use, and clinical equipment was checked to ensure it was working properly. Fire checks and drills were carried out at regular and suitable intervals.

Good

Are services safe?

Risks to patients

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

- The provider had arrangements in place to respond to emergencies. All staff had completed training in emergency resuscitation and life-support to ensure they were able to respond appropriately to any changing risks to patients' health and wellbeing during their treatment.
- There were written arrangements in place between the clinic and the local hospital for transferring the care of patients with a cancer diagnosis. Clinicians attended the local skin cancer multidisciplinary meeting regularly. Written transfer agreements were also in place between the clinic and emergency services to ensure that should a patient at the clinic require urgent transfer to hospital they were responded to within minutes.
- Clinicians made appropriate and timely referrals in line with protocols and up to date evidence-based guidance.
- The service had systems for sharing information with staff and other agencies to enable them to deliver safe care and treatment.
- 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.
- Emergency medicines and equipment were easily accessible to staff and stored securely. Suitable risk assessments were in place for medicines or equipment not used. The clinic had emergency resuscitation equipment available including an automatic external defibrillator (AED). Records completed showed regular checks were carried out to ensure the equipment and emergency medicine was safe to use. The clinic had recently purchased a pulse oximeter which arrived on the day of the inspection.
- Staff told us they knew the location of the emergency medicines and equipment at each of the sites used for clinics. This information was documented and available to staff at all times.
- Staffing levels and the skill mix of staff were planned and reviewed to ensure patients received safe care and treatment. Each clinic was colour coded and the skill mix of staff required was then matched accordingly. The record was available on the shared computer system so that all staff had access to it. The clinic had its own bank staff should they require an additional member of staff for any reason. Arrangements were in place to cover holidays.
- Professional indemnity arrangements were in place for the staff who worked at the service. All clinical staff were up to date with their professional registration and revalidation.

Information to deliver safe care and treatment

Staff had the information they needed to deliver safe care and treatment to patients.

- The service received completed referral forms for each NHS and some private patients from other healthcare professionals. When patients had self referred the practice sought suitable consent to contact their GP.
- Individual care records were written and managed in a way that kept patients safe. The service maintained electronic records for patients. Any historical paper records from returning patients were scanned onto the electronic system.
- Any medicine administered was only done with an accompanying prescription by a doctor.
- The service shared information with the patient's GP by receiving referral letters detailing the

patient's condition and personal circumstances and always communicating with them after a

procedure had been carried out. Consent was sought from non NHS referred patients to

contact their GP and share information about diagnosis and treatment. The service recorded

information electronically on a compatible system with that of the local GPs.

Track record on safety

The service had had a good safety record.

- There were comprehensive risk assessments in relation to safety issues, which included written requirements for multi-disciplinary team meetings (MDT) at the hospital and handover arrangements for patients with cancer diagnoses.

Good

Are services safe?

- The practice monitored and reviewed activity. This helped leaders to understand risks and gave a clear, accurate and current picture that led to safety improvements.

Lessons learned and improvements made

The service learned and made improvements when things went wrong.

- There was a system and procedure for recording and acting on significant events and incidents however, this was not always effective. We saw staff had access to a policy and standard form to record and report adverse incidents and events. However, the policy did not inform practice and forms were available both electronically and paper format. This resulted in several paper forms not being completed. There was no evidence of the root cause analysis process used or the outcome of events detailed on the forms. We discussed this with the provider. They were able to demonstrate through clinical governance meeting minutes that all incidents at the clinic had been captured, investigated and discussed and learning shared with staff. The provider assured us that they would review their policy and process as a matter of priority over the next few weeks.
- The service had six significant events recorded in the previous 12 months. We looked at these in detail and found that appropriate action had been taken but was not always correctly recorded on the incident forms. A log of significant events was not maintained to apply learning from events and to monitor any trends over time.
- Significant events were often identified through feedback from patients. We saw that significant events were discussed at the bi-monthly clinical governance meetings, which were attended by key clinical staff, recorded and shared.
- The provider did not maintain a log of significant events, which would enable them to apply learning from events and to monitor events overtime for any trends.
- 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 gave affected people reasonable support, truthful information and a verbal and written apology.
- The provider had an effective system for receiving and dealing with safety alerts. However, the alerts were collected and stored in a hard copy file which made it less easy to identify any repeat actions that could be required. The provider used the computer system to task all members of staff to whom an alert was relevant and this assured them staff had received the alert and acted when required.

Safe and appropriate use of medicines

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

- The service had a comprehensive medicines policy which detailed that all medicine fridges and cupboards were kept locked. However, during the inspection we found that all but one of these were unlocked. Staff took immediate action to secure all medicine fridges and cupboards and assured us that they did keep them locked.
- The process for patch testing took place in a very warm room. All contact allergens are required to be stored at below four degrees centigrade. We saw a large number of contact allergens on top of a trolley and one of these was out of date. During the inspection the provider raised this as a significant event and assured us this would be investigated. Immediately after the inspection the provider was able to provide evidence that prior to our inspection, a decision was recorded that this out of date contact allergen could have reduced efficacy, but no harmful effects and that the patients would be given a full explanation and choice about it being used. The clinic could demonstrate that they had ordered the contact allergen so that they did not use an out of date product and that the order was late. They have since advised us that they have reviewed their ordering process and ensured that additional time has now been added to this process to prevent recurrence. The provider told us they would review the process for keeping contact allergens cool.
- Patients who were prescribed medicines for acne were reviewed every four weeks. All teenage patients had their treatment schedule explained before treatment commenced and were asked to commit to the number of appointments over the time period required.

Good

Are services safe?

- When psychological support was required for patients whose conditions had impacted adversely on their mental health; GPs were contacted and requested to make onward psychological referrals.
- The service kept prescription stationery securely and monitored its use.
- Staff prescribed, administered or supplied medicines to patients and gave advice on medicines in line with legal requirements and current national guidance. Processes were in place for checking medicines and staff maintained accurate records of medicines.
- There were effective protocols for verifying the identity of patients including children.

Good

Are services effective?

We rated effective as Good because:

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 needs and delivered care and treatment in line with current legislation, standards and guidance for example they referred to guidance from the National Institute for Clinical Evidence (NICE) and the British Association of Dermatologists (BAD).
- Patients' immediate and ongoing needs were fully assessed. Where appropriate this included their clinical needs and their mental and physical wellbeing.
- Clinicians had enough information to make or confirm a diagnosis.
- We saw no evidence of discrimination when making care and treatment decisions.

Monitoring care and treatment

The service was actively involved in quality improvement activity.

- The service used information about care and treatment to make improvements. For example, they had taken steps to get teenage patients attending for a specific acne treatment to commit to the number of appointments and length of time the treatment would require prior to being offered a specific treatment. Young people who were unable to make this commitment were then considered for alternative treatment.
- The service made improvements through the use of completed audits. Clinical audit had a positive impact on quality of care and outcomes for patients. There was clear evidence of action to resolve concerns and improve quality. The service had carried out a wide range of treatment specific audits, most of which had received a second audit. However, the audit plan and record was not constructed to quickly identify which audits required a further cycle.
- The practice reported to its commissioners every quarter and included patient experience, waiting times, significant event, complaints, issue of discharge letters, number of referrals and finance.

Effective staffing

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. All doctors interested in working at the clinic were required to have a minimum additional qualification of the dermatology diploma.
- Relevant professionals (medical and nursing) were registered with the General Medical Council (GMC)/ Nursing and Midwifery Council and were up to date with revalidation.
- 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.

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. Staff referred to, and communicated effectively with, other services when appropriate. For example, the local hospitals and GPs.
- 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. We saw examples of patients being signposted to more suitable sources of treatment where this information was not available to ensure safe care and treatment. We saw that the practice had near patient testing for a specific blood test, for how long it took their blood to clot. This gave a real time reading which meant that patients whose treatment depended on the results were able to have their treatment at the time.
- All patients were asked for consent to share details of their consultation and any medicines prescribed with their registered GP on each occasion they used the service.

Good

Are services effective?

- The provider had risk assessed the treatments they offered. Where patients agreed to share their information, we saw evidence of letters sent to their registered GP in line with GMC guidance.
- Care and treatment for patients in vulnerable circumstances was coordinated with other services. For example, when children had not been brought for treatment we saw that this had been recorded, monitored, discussed with the patients' GP and with the safeguarding team at the local authority when appropriate.
- 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. There were clear and effective arrangements for following up on people who had been referred to other services.

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.
- The service offered health promotion on a range of topics such as smoking, and alcohol consumption, and focused on these activities affected skin.

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.
- Staff supported patients to make decisions. Where appropriate, they assessed and recorded a patient's mental capacity to decide.
- The service monitored the process for seeking consent appropriately.
- Care and treatment for patients in vulnerable circumstances was coordinated with other services. For example, patients with learning difficulties were encouraged to have a representative with them during the consultation. The service provided a dedicated doctor with specialist experience to support all patients with a learning disability.

Good

Are services caring?

We rated caring as Good because:

Kindness, respect and compassion

Staff treated treat patients with kindness, respect and compassion.

- The service sought feedback on the quality of clinical care patients received through ongoing patient surveys.
- All of the 18 of patient Care Quality Commission (CQC) comment cards we received were very positive about the service patients experienced.
- 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 larger print formats, to help patients be involved in decisions about their care.
- Patients told us through CQC 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.
- For patients with learning disabilities or complex social needs family, carers or social workers were appropriately involved.
- Staff communicated with people in a way that they could understand, for example, communication aids 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 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 improved services in response to those needs. The service demonstrated that it offered timely appointments for NHS patients who would have to wait longer for an appointment in a secondary care dermatology clinic.
- The facilities and premises were appropriate for the services delivered. The service had wide easily accessible corridors on both the ground and first floor. A lift was in place between the ground and first floor.
- Reasonable adjustments had been made so that people in vulnerable circumstances could access and use services on an equal basis to others. For example, the service ensured that a dedicated doctor saw all patients with a learning disability.

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.
- Patients with the most urgent needs had their care and treatment prioritised.
- Patients reported that the appointment system was easy to use.
- Referrals and transfers to other services were undertaken in a timely way as the service had clearly written protocols and arrangements in place for referrals.

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 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 complaint policy and procedures in place. The service learned lessons from individual concerns and complaints. However, it had only received one complaint in the last twelve months. The service had not formally recorded all of the informal concerns, and staff told us that they dealt with these on the spot and reported them to management. The practice were considering recording all informal concerns in order to further inform the quality of care provided.

Are services well-led?

We rated well-led as Good because:

Leadership capacity and capability;

Leaders had the capacity and skills to deliver high-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.
- 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 had effective processes to develop leadership capacity and skills, including planning for the future leadership of the service.

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.
- 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.

Culture

The service had culture of high-quality sustainable care.

- Staff felt respected, supported and valued. They were proud to work for the provider.
- The service focused on the needs of patients.
- 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. For example, a full refund had been offered in response to a recent complaint. 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 had received regular annual appraisals in the last year. Staff were supported to meet the requirements of professional revalidation where necessary. Clinical staff, including nurses, were considered valued members of the team. They were given protected time for professional time for professional development and evaluation of their clinical work. Doctors provided nurses with planned supervision. Although there was a clear schedule that this was planned it was not always recorded as completed.
- 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 were positive relationships between staff and teams.

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 and understood. The governance and management of partnerships, joint working arrangements and shared services promoted interactive and co-ordinated person-centred care.
- Staff were clear on their roles and accountabilities.
- Leaders had established proper policies, procedures and activities to ensure safety. Not all of these policies informed practice as intended. However, the service had responded promptly when policies that did not inform practice effectively were identified.

Are services well-led?

Managing risks, issues and performance

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

- There was an effective, process to identify, understand, monitor and address current and future risks including risks to patient safety.
- 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.
- Clinical audit had a positive impact on quality of care and outcomes for patients. There was clear evidence of action to change services to improve quality. For example, changes to the protocol for acne treatment had improved the compliance of teenagers with the treatment programme, which in turn had led to better results.

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.
- Quality and sustainability were discussed in relevant meetings where all staff had sufficient access to information.
- 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.
- 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.

Engagement with patients, the public, staff and external partners

The service involved 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. For example, the service had quarterly meetings with its NHS commissioners. The service ran a continuous patient satisfaction survey which recorded high patient satisfaction with care and treatment received.
- Staff could describe to us the systems in place to give feedback. Complaints leaflets were readily available and staff encouraged patients to discuss any immediate concerns at the time of their consultation or treatment. The service encouraged staff to speak out if they had concerns and staff we spoke with told us they felt comfortable to raise any concern.
- The service was transparent, collaborative and open with stakeholders about performance.

Continuous improvement and innovation

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

- There was a focus on continuous learning and improvement.
- The service made use of internal and external reviews of incidents and complaints. Learning was shared and used to make improvements.
- Leaders and managers encouraged staff to take time out to review individual and team objectives, processes and performance.

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 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. We took enforcement action because the quality of healthcare required significant improvement.