Just Health

Inspection report

156 Colne Road
Burnley
BB10 1DT
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Date of inspection visit: 17 May 2022
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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	Requires Improvement
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?	Requires Improvement

Overall summary

This service is rated as Requires improvement 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? – Requires improvement

We carried out an announced comprehensive inspection, as part of our inspection programme on 17 May 2022 at Just Health, which is located at 156 Colne Road Burnley Lancashire BB10 1DT.

This was the service's first CQC inspection.

This service is registered with CQC under the Health and Social Care Act 2008 in respect of some, but not all, of the services it provides. There are some exemptions from regulation by CQC which relate to particular types of regulated activities and services and these are set out in Schedule 1 and Schedule 2 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Just Health provides a range of driver medical checks such those required to drive a heavy good vehicle (HGV) or a taxi. The activities undertaken in relation to this type of service are not within CQC scope of registration. Therefore, we did not inspect or report on these services.

Mr Yasir Jaleel is the nominated individual and the registered manager for the provider SSYNS Limited. 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.

Our key findings were:

- The provider offered a range of different services. Some of which were not within the scope of CQC registration.
- Those services that were within CQC scope were offered on a private, fee-paying basis only and were accessible to patients who chose to use it.
- Services offered at the time of this inspection were hay fever treatments and baby circumcisions. The website for the service provided comprehensive information about these services and included details of fees.
- Specific feedback for the services offered was not proactively requested. However patients had opportunities to post online reviews.
- Circumcision procedures were safely managed and there were effective levels of patient support and post-operative care.
- A risk assessment for the safe movement of the child following the circumcision procedure from the clinical room up a set of stairs to the recovery room was not in place.
- Systems to identify parental identity and obtain written consent for the circumcision service was effective. Written consent was also obtained for the provision of the hay fever treatment.

Overall summary

- The service shared relevant information with a patient's own GP as appropriate, although patients opted in to, rather than out of sharing information with their GP following the hay fever treatment.
- The staff team was small but team members were aware of their own role and responsibilities and told us they felt supported.
- Staff recruitment records were incomplete. However we received additional recruitment records after the inspection.
- The provider was unable to demonstrate clearly that non clinical staff were trained appropriately. A system to provide an overview of staff training was not in place. There was no evidence available to show that all staff had received training in fire safety, infection prevention and control, and up to date training in safeguarding adults and children. The manager provided certificates of this training for staff. This showed training was undertaken in these areas on the day of the inspection and the day after the inspection. Training in equality and diversity and chaperoning had not been undertaken, however the provider confirmed after the inspection that staff had read policies on these.
- Some policies and procedures were not available, including responding to a medical emergency, a recruitment policy and a business continuity policy. These were provided after the inspection.
- An infection prevention and control (IPC) policy and audit was available. The placement and cleanliness of the sharps bin used for surgical instruments did not comply with IPC good practice standards.
- The service had a quality management statement in place but the inspection identified some areas where the standards identified were not achieved.

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

- Establish effective systems and processes to ensure good governance in accordance with the fundamental standards of care

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

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

- Amend the medicine monitoring record to reflect the name of the medicine, the stock and expiry date for each medicine.
- Implement a risk assessment to mitigate potential risk of carrying a small child up and down stairs following a surgical procedure.
- Re-word the patient consent form used for the treatment of hay fever so that patients are automatically opted into notifying their GP of this treatment.
- Develop formal systems to obtain patient feedback regarding the provision of regulated activities to inform the quality of the services provided.

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 GP specialist adviser.

Background to Just Health

Just Health is registered with the CQC as an independent healthcare service for regulated activities from the Just Health clinic, located at 156 Colne Road, Burnley, Lancashire, BB10 1DT.

The provider, SSYNS Limited employs a private GP and a registered pharmacist who is also trained as a non-medical prescriber. The provider offers a range of services that require a fee to be paid. These include non therapeutic circumcision for baby boys up to the age of 14 months, private GP services and private treatment for hay fever.

The web address for the service is www.just-health.co.uk

The service is located within an older stone building. This had been adapted to provide an accessible service to people. The refurbishment of the building retained some of the original features, allowed access to those who had mobility issues and offered spacious clinical rooms.

The service is registered with the CQC to provide the following regulated activities:

Surgical procedures

Treatment of disease, disorder and injury

Diagnostic and screening procedures

Services in slimming clinics

At the time of this inspection the service was not providing services in slimming clinics and submitted an application to remove this regulated activity from their registration. Other services offered that were outside the scope of CQC registration included offering a range of health care medicals by hosting a network of medics to support people nationally.

Regulated activities are undertaken by the GP and the pharmacist who is registered with the General Pharmaceutical Council (GPhC). The pharmacist is registered as a non-medical prescriber and can therefore prescribe treatments for hay fever.

The website for www.just-health.co.uk allows people to book appointments on line or via the telephone. The website states telephone contact availability is from 7am until 10pm seven days each week. The Just Health clinic opens in response to patient demand for a service and usually offers the circumcision service on the first Monday of each month.

How we inspected this service

As part of the inspection we reviewed some of the service's policies, procedures and other documentation and carried out a site visit to the location of the service where we spent time with the registered manager and the private GP.

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 because:

We identified a safety concern that was rectified soon after our inspection. The likelihood of this happening again in the future is low and therefore our concerns for patients using the service, in terms of the quality and safety of clinical care are minor. (See full details of the action we asked the provider to take in the Requirement Notices at the end of this report).

Safety systems and processes

Some systems to keep people safe and safeguarded from abuse were not fully effective.

- The provider had some safety policies available and conducted safety risk assessments. These were reviewed and updated. The available polices were generally easy to read and follow and this signposted staff to further guidance.
- The service employed a very small staff team of five staff including the registered manager and a private GP. The staff files we looked at included those for two reception staff and the health care assistant (HCA), two of these files contained evidence that a fire safety induction was undertaken in 2018. The staff file for the newest staff member did not contain evidence of induction. Other evidence to show staff had received fire safety training was not available at the time of the inspection. The manager told us that the pandemic restrictions had impacted the provision of training for staff. Within 48 hours of the inspection visit the registered manager supplied fire safety e-learning training certificates dated the same day as the inspection for two staff members. (One staff member was away on long term leave).
- Evidence that all staff had received up-to-date safeguarding training was not available. The training certificates available were dated from 2018 for two staff members and the registered manager's certificate was dated from 2019. However the manager sent e-learning training certificates in safeguarding for children and adults two days after the inspection. The certificate showed the training was undertaken after the inspection. Up to date or refresher training for the HCA was not provided. The registered manager for the service undertook face to face consultations with patients and we discussed at the inspection that children's safeguarding level 3 training was needed to comply with the Intercollegiate document on safeguarding guidance. The safeguarding policy for the service had not been comprehensively updated and referred to the safeguarding lead as being a GP who was not employed by the service. The provider sent us a copy of the amended policy after the inspection.
- The service had effective systems in place to assure that an adult accompanying a child had parental authority to consent to treatment.
- 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.
- We reviewed staff files for three employees and found that evidence of comprehensive recruitment checks were not available. We discussed this with the manager and we were advised that some records were available but were stored on the desk top computer. Following the inspection the manager sent us a number of recruitment documents for the staff employed at the service. A copy of the service's recruitment policy was requested and provided.
- The staff files we examined contained evidence that Disclosure and Barring Service (DBS) checks were undertaken and where a DBS was not available a risk assessment was in place. (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). The registered manager confirmed a risk assessment process had not been undertaken in response to issues identified on one of the DBS certificates.
- Staff did on occasion provide a chaperone service and these staff had an appropriate DBS in place. The registered manager confirmed that staff had not received any training for this. After the inspection the manager confirmed that staff had read the chaperone policy.

Requires Improvement

Are services safe?

- There was a system to manage infection prevention and control (IPC). There were policies and procedures available and an audit had been undertaken in December 2021. The manager provided evidence that all the staff including the GP had undertaken IPC e-learning the day after the inspection. One staff member had received specialised accredited training to undertake COVID-19 swab taking in 2021 and this included infection prevention and control and the use of personal protective equipment.
- A clinical waste contract and a system for safely managing healthcare waste was in place. However, the clinical waste sharps box in the clinical room used for disposable surgical equipment was situated on the floor, was not dated and lid was stained with what appeared to be dried blood.
- Maintenance certificates were available and there was a legionella risk assessment policy in place and water temperature checks were undertaken

Risks to patients

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

- There were arrangements for planning and monitoring the number and mix of staff needed.
- Staff understood their responsibilities to manage emergencies and to recognise those in need of urgent medical attention. The registered manager had received training in sepsis. We requested a copy of the clinic's policy regarding responding to medical emergencies. This was supplied after the inspection.
- A risk assessment to reduce any potential risk to a baby being carried up and down stairs to the recovery room following circumcision surgery was not available.
- When there were changes to services or staff the service assessed and monitored the impact on safety.
- There were appropriate indemnity arrangements in place including professional and public liability.
- Oxygen and adrenalin to respond to medical emergency such as anaphylaxis was available and this was checked regularly.

Information to deliver safe care and treatment

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

- Individual care records were written and managed in a way that kept patients safe. The care records we saw showed that information needed to deliver safe care and treatment was available to relevant staff in an accessible way.
- 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.
- 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 had reliable systems for appropriate and safe handling of medicines.

- The systems and arrangements for managing medicines, including emergency medicines and oxygen minimised risks.
- Staff prescribed, administered or supplied medicines to patients and gave advice on medicines in line with legal requirements and current national guidance.

Requires Improvement

Are services safe?

- Processes were in place for checking medicines however, the record for this consisted of a signature every quarter. We discussed with registered manager that a detailed log of the medicines held should as per the services' policy include the drugs name, expiry date, stock level and batch number.
- Where there was a different approach taken from national guidance there was a clear rationale for this that protected patient safety. For example, the medicine prescribed to treat hay fever was not recommended by the National Institute for Health and Care Excellence (NICE). However, the patients' records we viewed contained detailed medical history, a clear detailed explanation of the risks associated with this medication, a consent form and a request for consent to notify the patients' GP. We discussed how to re-word the request to notify the patient's GP so this became an opt out as opposed an opt in process.

Track record on safety and incidents

The service had a good safety record.

- There were risk assessments available in relation to safety issues. The premises were well maintained and safety checks such as those relating to electrical installation had been completed and documentation relating to these checks available.
- 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.

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. At the time of this inspection there had not been any incidents or near misses
- There were adequate systems for reviewing and investigating when things went wrong. The registered manager provided an example whereby they responded to an issue with the service they received from a laboratory and changed the laboratory to ensure people who had attended for COVID-19 swab taking received their results quickly without delay (COVID-19 swab taking is an activity which is not within the CQC scope of registration).
- The provider was aware of the requirements of the Duty of Candour. The provider encouraged a culture of openness and honesty.
- The registered manager was a pharmacist and received, acted on and learned from external safety events as well as patient and medicine safety alerts.

Good

Are services effective?

We rated effective as Good because patients were provided with an effective standard of clinical care.

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 (relevant to their service).

- The provider assessed needs and delivered care in line with relevant and current evidence based guidance and standards. For example best practice guidance from the World Health Organisation (WHO) and the British Medical Association was used to keep up to date with circumcision and the National Institute for Health and Care Excellence (NICE) best practice guidelines were used for the safe usage of the medicine used to treat hay fever.
- Patients' immediate and ongoing needs were fully assessed. Where appropriate this included their clinical needs and their mental and physical wellbeing.
- Clinicians ensured they had enough information to make or confirm the requested treatment.
- 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.
- The service attempted to make improvements through the use of completed audits. The service was closed at times in accordance with government guidance throughout the pandemic and this had impacted on the range and demands for the services they offered. There was one cycle of clinical audit available and this reviewed the circumcisions between September 2021 and March 2022. The outcome of the audit showed that out of 26 procedures there had been one episode of bleeding post procedure and no instances of infections reported.
- At the time of this inspection the registered manager confirmed an audit to monitor the effect and outcomes for patients following the hay fever injection had not been undertaken as there had not been sufficient uptake as yet to review this effectively.

Effective staffing

Evidence to demonstrate the training of staff to carry out their roles was not readily available.

- The registered manager was a pharmacist and a non-medical prescriber. In addition training certificates were available to show the manager had had training in clinical assessment skill and history taking; vaccination and e-learning for travel health.
- One receptionist had received on the job training and mentoring to complete a UCAS assessment to become a COVID-19 swab taker. This was not within the scope of CQC registration.
- We observed that records of staff skills, qualifications and training were either not available, or not up to date or logged using a consistent format. For example, the staff files we viewed for the reception staff and health care assistant did not provide consistent evidence of induction training, fire safety, infection prevention and control and up to date or refresher training in safeguarding. However evidence that staff had received training in all these areas at the time of the inspection or the day after was provided within two days of our visit.

Good

Are services effective?

- Recorded evidence that the health care assistant (HCA) had received training in supporting the GP to undertake the circumcision procedure was not available. However the GP told us that the HCA had accompanied them on their original consultant led training for the procedure over five years previously. The GP advised the HCA supported the circumcisions and had over five years' experience doing this.
- The provider was able to give examples of where staff were encouraged to develop and the manager was looking for courses to train two staff members in phlebotomy.
- Relevant professionals (medical and pharmacy) were registered with the appropriate professional registration bodies and were up to date with revalidation.

Coordinating patient care and information sharing

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

- Whilst opportunities for working with other services was limited, we saw the service did so when this was necessary and appropriate. For example, the service communicated with the patient's own GP to inform them the procedure had been undertaken.
- Before providing treatment, the provider ensured they had adequate knowledge of the patient's health, any relevant test results and their medicines history. Patients were signposted to more suitable sources of treatment where information was not available to ensure safe care and treatment.
- 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.
- 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.
- The service monitored the process for seeking consent appropriately.

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.
- Risk factors were identified, highlighted to patients and where appropriate highlighted to their normal care provider for additional support.
- Where patient's needs could not be met by the service, staff redirected them to the appropriate service for their needs.

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.
- Procedures were established and effective in obtaining parental consent for the circumcision service. Parental authority was required from both parents and this included evidence of identification and both were required to sign the consent form for the circumcision of their child before the procedure was undertaken.
- Staff supported patients to make decisions. Where appropriate, they assessed and recorded a patient's mental capacity to make a decision.

Good

Are services caring?

We rated caring as Good because the provider was committed to providing a caring service.

Kindness, respect and compassion

Staff treated patients with kindness, respect and compassion.

- The service did not routinely seek feedback on the quality of clinical care patients received or undertake a customer satisfaction survey. The provider's website allowed patients to post feedback regarding the service they received and this was displayed for public viewing. The reviews displayed were wholly positive, most appeared to refer in the main to the provision of driver medicals or services not within the scope of registration.
- We heard that feedback from patients was positive about the way staff treated patients, however this feedback was anecdotal and not recorded.
- 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. In addition multi-lingual staff were available and could offer support to patients.
- At the time of this inspection there were no patients at the service and the CQC had not received any information from patients or the public about this service.
- 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: The provider's website gave clear information regarding the injection treatment offered to treat hay fever. Patients who attended for this treatment received comprehensive information verbally from the clinician and with the consent form. Parents bringing their baby for the circumcision were offered advice leaflets to take away and read in their own time. The GP also spent time discussing the procedure with parents and this included a pictorial presentation to support the verbal explanation of the circumcision procedure.

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 the provider offered a service to meet patient demand.

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. Before the pandemic the provider was seeking to expand the services they offered to include a private GP service and a slimming clinic. The pandemic and the resultant restrictions on services nationally effectively prevented the growth of these services. Post pandemic the provider had recommenced a regular circumcision service and now offered a hay fever treatment. Other services such as a private GP service and services to treat and support patients with slimming were also offered but the provider confirmed there had been no uptake for this. At the time of this inspection no patients had attended the clinic for support and treatment for obesity. Following the inspection, the provider submitted an application to remove the regulated activity Services in slimming clinics from their registration.
- The service was looking to introduce a private travel vaccination clinic and was also seeking training for staff in phlebotomy.
- The facilities and premises were appropriate for the services delivered, although the main clinical room used for the circumcisions appeared untidy.
- Reasonable adjustments had been made so that people in vulnerable circumstances could access and use services on an equal basis to others.

Timely access to the service

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

- Patients were able to access care and treatment quickly. The services were offered on a private, fee-paying basis only, and as such was accessible to people who chose to use it.
- Circumcisions were usually undertaken on the first Monday of each month and waiting times were minimal. Appointments could be made via dedicated telephone booking line, or through the service's website.
- The clinic opened in response to patient requests for a medical service and an appointment. Patients could access the service by telephone or via the website seven days a week between 7am and 10pm.

Listening and learning from concerns and complaints

The service took complaints and concerns seriously and they confirmed they would respond to them appropriately to improve the quality of care.

- The service had a complaint policy and procedure in place. The registered manager told us that they had not received any complaints but would respond compassionately and quickly should a complaint be received. The manager told us they would look to improve service quality if a complaint highlighted an issue.

Requires Improvement

Are services well-led?

We rated well-led as Requires improvement because some systems to ensure a safe and effective service were not available or fully established.

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 the range of clinical services they offered. They understood the challenges and were addressing them.
- They explained the impact of the pandemic had restricted the development of their service.
- Leaders were visible and approachable and they worked closely with staff and others to make sure they prioritised compassionate and inclusive leadership.

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 developed its vision, values and strategy jointly with staff. The small team of staff met every two months to discuss issues and future plans to develop the service.
- 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 a culture of high-quality sustainable care.

- The staffing at the service included the registered manager, a GP, a HCA and two reception staff. One of the reception staff we spoke with confirmed they felt respected, supported and valued.
- The service focused on the needs of patients.
- Leaders and managers acted on behaviour and performance inconsistent with the vision and values.
- At the time of this inspection, we were told that the service had not received any complaints and there had not been any incidents. The provider demonstrated openness, honesty and transparency in supporting this inspection. The provider was aware of the requirements of the duty of candour.
- There were informal processes for providing all staff with the development they need. Staff spoken with told us of how they had been supported. However evidence that staff had received an annual appraisal was not available during the visit. The provider sent a copy of an appraisal for one staff member dated from 2020. One staff member we spoke with confirmed that the manager had discussed their progress and development and plans were in place to develop their skills further with training in phlebotomy.
- The staff member we spoke with was aware of equality and diversity issues and they confirmed they felt part of the team and was treated equally with others. Evidence to show staff had received equality and diversity training was not available. The manager confirmed after the inspection that all staff had read the policy on equality and diversity.
- There were positive relationships between staff and teams.

Governance arrangements

Requires Improvement

Are services well-led?

Responsibilities, roles and systems of accountability to support governance and management were established but were not always fully effective.

- Staff were clear on their roles and accountabilities, although job descriptions were not available.
- The service offered had operated intermittently throughout the pandemic in accordance with government guidance and this had impacted on the planned development and expansion of the services offered. In addition the clinic location did not open up daily as it provided a service responsive to demand.
- The service had a quality management statement in place and this identified the standards of service it provided. However a system of quality monitoring to review and monitor standards was not in place.
- This inspection identified some gaps in relation to the availability of policies and procedures. For example a recruitment policy, responding to a medical emergency, and a business continuity policy were not available within the service's policy file. These were emailed to us after the inspection with an amended safeguarding policy. The policies that were available contained reviews dates, most of which were for 2023.
- A system identifying mandatory staff training and to monitor when refresher or training up dates were required was not established. At the inspection there was no clear system or oversight of what training had been provided to staff. The manager sent us certificates of e-learning for subjects such as fire safety, safeguarding and infection prevention and control after the inspection and these showed the training was undertaken on the day of the inspection or the day after. In addition the manager advised that staff had read a range of policies that included equality and diversity, chaperoning and health and safety.

Managing risks, issues and performance

There were processes for managing some risks, issues and performance.

- There was a process to identify, understand, monitor and address current and future risks including risks to patient safety. For example the provider had systems established to respond to incidents, complaints and patient safety alerts.
- Training certificates were available for the clinicians and these showed appropriate training had been undertaken to deliver safe clinical care and treatment.
- The service submitted data or notifications to external organisations as required.
- Reception staff did on occasion work from home. The staff member we spoke with confirmed a work place laptop with additional security was provided for them to undertake this work.
- Recorded evidence that non clinical staff were trained appropriately and supported with annual appraisal was not readily available. The one appraisal record provided was almost two years old.
- One cycle of clinical audit was available reviewing post-operative circumcision outcomes that included reviewing for post-operative infection. Further audits were planned now the service was fully operational post pandemic

Appropriate and accurate information

The service acted on appropriate and accurate information.

- Full staff meetings were held every second month and minutes from these meeting were available. Quality and future service development were discussed and all staff had opportunities share and comment on proposed plans.

Engagement with patients, the public, staff and external partners

Systems to involve patients, the public, staff and external partners to support high-quality sustainable services were informal.

Requires Improvement

Are services well-led?

- A formal system requesting patient feedback for services offered within the scope of CQC registration was not established. This type of patient feedback would support the provider's quality monitoring processes.
- The service responded to feedback they received informally post treatment from patients., The provider's website provided opportunities for people to post their written feedback. Upon viewing this feedback many of the comments referred to services provided outside the scope of regulation and it was not clear what services had been provided at the clinic or provided at one of the host driver medicals services offered nationally by Just Health.
- The feedback available on the provider's website was complimentary .

Continuous improvement and innovation

There was evidence of systems and processes for learning and improvement.

- Systems were in place for the service to respond appropriately to incidents and complaints.
- The pandemic and associated restrictions in the last two years had prevented the planned development of the private medical services the provider wished to provide. The provider did diversify their services to meet changing demand for different services during pandemic time period. These services were not within the scope of CQC registration but included offering a range of health care medicals nationally by hosting a network of medics to support people throughout England. In addition one reception staff member was trained to become a COVID-19 swab taker so that PCR and antigen testing could be undertaken in accordance with the government requirements and those requirements for travelling abroad.

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 Services in slimming clinics Surgical procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance How the regulation was not being met The registered person had systems or processes in place that were operating ineffectively in that they failed to enable the registered person to assess, monitor and improve the quality and safety of the services being provided. In particular: An overarching system of continuous quality improvement was not yet established. This had led to gaps in governance arrangements for example: • Actions undertaken to ensure the standards identified in the service's quality management statement were met was not in place. • Evidence to demonstrate staff were fully trained in all areas of mandatory training, was not available and a system to allow management to monitor staff training status with dates was not established. Training in fire safety, infection control and safeguarding was undertaken in response to the inspection. • Staff had not received training in equality and diversity and chaperoning. • Staff had not received regular appraisal • There was no system to risk assess and record decision making in relation to issues identified within a staff members police check. • The service's Sharps policy was not adhered to in that the positioning of the sharps box on the floor in the clinical room posed a potential risk to people. • The Sharps box was also heavily stained and not signed or dated when first used. This was in breach of Regulation 17(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.