Hightree Clinic

Inspection report

High Tree House
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Uckfield
East Sussex
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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?	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 Hightree Clinic on 25 September 2019. This was the provider's first rated inspection, and to follow up on breaches of regulations

CQC inspected the service on 9 October 2018 under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This was the provider's first comprehensive inspection. We found the service was not providing safe, effective, responsive or well-led care in accordance with the relevant regulations. We issued two warning notices against Regulation 12 (Safe care and treatment) and Regulation 17 (Good governance), requiring the provider to achieve compliance with the regulations set out in those warning notices. We also issued two requirement notices for Regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 and Regulation 19 (Fees) of the CQC (Registration) Regulations 2009.

We then undertook a focussed inspection on 23 January 2019. At this inspection, we found the requirements of the two warning notices had not all been met. We issued two further warning notices against Regulation 12 (Safe care and treatment) and Regulation 17 (Good governance).

We then undertook a focussed inspection on 30 April 2019 to follow up on the actions taken in response to the warning notices. Although improvements had been made, not all issues were resolved and we issued two requirement notices for Regulation 12 (Safe care and treatment) and Regulation 17 (Good governance).

We followed up on the requirement notices issued following inspection on 9 October 2018 and 30 April 2019 at this inspection. We found the issues concerning Regulation 19 (Fees) of the CQC (Registration) Regulations 2009 had been resolved. We found that although significant improvement had been made, not all issues concerning Regulation 12 (Safe care and treatment) and Regulation 17 (Good governance) had been resolved.

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 and of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Hightree Clinic is an independent doctor service. They provide consultation, treatment and prescribing services for conventional and complementary medicine, with an aim to improve and/or sustain patients' overall quality of life. The clinic offers consultation and treatment only to patients over the age of 18.

Hightree Clinic provides a range of complementary therapies, for example medical acupuncture and osteopathy, which are not within CQC scope of registration. Therefore, we did not inspect or report on these services.

The lead GP 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.

We received 14 completed comment cards. Feedback from clients was consistently positive. We received comments that the staff were friendly, kind and knowledgeable. They commented that the service received from the lead GP was caring, professional and thorough.

Overall this service is rated as good.

We rated the service as requires improvement for providing safe services because:

- Systems and processes for infection prevention and control were not all effective, including processes to mitigate the risk of legionella and to maintain staff immunisation.
- Patient records we reviewed showed that information about care and treatment was not always available in an immediately accessible way.
- The clinic was not receiving all safety alerts.

Overall summary

Our key findings were :

- The clinic organised and delivered services to meet patients' needs. Patients could access care and treatment in a timely way.
- The provider was fully aware of the issues and challenges that affected the service. They had realistic action plans to make sure all necessary improvements were made.
- Feedback from clients who used the service was consistently positive.
- The service was proactive in seeking patient and staff feedback to identify and resolve concerns.
- There was a clear leadership structure and staff felt supported by management.
- The culture of the service encouraged candour, openness and honesty.
- Staff worked well together as a team. All staff demonstrated their determination and willingness to improve systems and processes at the clinic.

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

- Ensure care and treatment is provided in a safe way to patients.
- Establish effective systems and processes to ensure good governance in accordance with the fundamental standards of care.

We have told the provider to take action. You can see full details of the action and regulations not being met in the Requirement Notices section at the end of this report.

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

- Review and improve the organisation and structure of personnel files.
- Continue to review and strengthen training received relating to child and adult safeguarding, and basic life support.
- Strengthen and continue clinical quality improvement activity.
- Strengthen staff training by determining and implementing mandatory requirements for the clinic.

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 who was accompanied by a CQC GP Specialist Advisor and a practice manager Specialist Advisor.

Background to Hightree Clinic

Hightree Clinic is an independent doctor service. They provide consultation, treatment and prescribing services using conventional and complementary medicine. The clinic aims to address the physical, nutritional and well-being needs of patients in order to improve their health and aid recovery. The clinic offers health diagnostics and assessments, for example screening tests for a wide spectrum of infections, deficiencies and hormone imbalances. Services include intravenous treatments for nutritional deficiencies, oxygen therapy (such as medical ozone), local and whole-body hyperthermia. They also offer treatments for musculoskeletal disorders, including joint injections.

Services are provided from:

Hightree House,
Eastbourne Road,
Uckfield,
East Sussex,
TN22 5QL

The clinic is open between 9am to 5pm on a Monday, Tuesday and Thursday.

The service is provided by the lead GP, a nurse and a data management administrator. The provider also employed a consultancy agency to assist with improving and streamlining their governance arrangements. This agency also provided reception support.

Hightree Clinic is registered with CQC to provide the following regulated activities: Treatment of disease, disorder or injury; Diagnostic and Screening procedures.

How we inspected this service

Prior to this inspection we reviewed a range of information that we hold about the service, including information gathered by the provider from a pre-inspection information request. Whilst on the inspection we interviewed staff and reviewed key documents, policies and procedures in use by the service.

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 formed the framework for the areas we looked at during the inspection.

Requires improvement

Are services safe?

We rated safe as Requires improvement because:

- Systems and processes for infection prevention and control were not all effective; including processes to mitigate the risk of legionella and to maintain staff immunisation.
- The patient records we reviewed showed that information about care and treatment was not always available in an immediately accessible way.
- The clinic was not receiving all safety alerts.

Safety systems and processes

The service did not always have 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. They outlined clearly who to go to for further guidance. Staff received safety information from the service as part of their induction and refresher training.
- The service had some systems to safeguard children and vulnerable adults from abuse. Staff knew how to identify and report concerns. However, it was not clear whether all staff had received up-to-date safeguarding and safety training appropriate to their role. We were told the GP had completed level two training, although we were not shown evidence of this. The GP had plans to complete level three training by 2021. We saw that non-clinical staff had completed level one child safeguarding training and although adult safeguarding training had been completed, the competency level was not clear. New intercollegiate guidance for adult and child safeguarding sets out the requirements for levels of competency for all staff. For example, clinical staff (including nurses) should complete child safeguarding training to level three, and non-clinical staff to level two by 2021.
- The provider carried out recruitment checks prior to employment, although we found the organisation and structure of personnel files could be improved. The provider checked professional registration with the appropriate body on an ongoing basis and noted the expiry date in the staff file. Disclosure and Barring Service (DBS) checks were undertaken for all staff. (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.) Following our inspection, the provider sent us evidence to demonstrate they took immediate action and re-structured their personnel files to clearly record recruitment and training information.
- There were some systems to manage infection prevention and control. The nurse was now the infection, prevention and control (IPC) lead. However, additional training to support this role had not yet been completed. The nurse had been in post for two months. The service maintained appropriate standards of cleanliness and hygiene. We saw they kept records of cleaning completed, for both environmental and clinical equipment. The service conducted annual infection control audits and we saw evidence of the most recent audit completed on 20 August 2019, there were no actions required. A policy was in place, although this did not contain all of the information we would expect to see, for example the frequency of audits and expected training requirements for staff. The provider and staff were open and honest about the improvements needed for IPC, they were fully aware of the action required.
- A COSHH (control of substances hazardous to health) assessment had been completed and the service had data sheets for the products in use.
- The provider was unable to demonstrate staff vaccination was maintained in line with current Public Health England (PHE) guidance, if relevant to role. The personnel files that we looked at did not contain this information. Staff we spoke with told us they had not been asked to provide this information.
- A comprehensive health and safety assessment had been completed by an external body in December 2018, which included a risk assessment for Legionella (Legionella is a particular bacterium which can contaminate water systems in buildings). We saw the service had procedures regarding actions to minimise the risk of Legionella, which clearly described the recommended water temperature range and action to be taken if the temperature was outside of those ranges. We saw documentary evidence of water temperature testing. We noted the temperature recorded was consistently below the recommended minimum temperature. When asked, staff told us they had not taken appropriate action and recognised they had not followed their own procedure. Following our inspection, the provider took immediate action and contacted their health and safety facilities company. The provider told

us they had re-tested the water and it had reached the correct temperature. They also arranged for a review of the risk assessment to be undertaken on 3 December 2019.
- The provider ensured that facilities and equipment were safe, and that equipment was maintained according to manufacturers' instructions. There were systems for safely managing healthcare waste.

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.
- There was an induction system for agency staff tailored to their role.
- Staff understood their responsibilities to manage emergencies and to recognise those in need of urgent medical attention. However, we found that not all staff had received basic life support training. Whilst on inspection the provider took immediate action and booked training for all staff on 4 October 2019.
- There were emergency medicines readily available. These were easily accessible to staff in a secure area of the clinic and all staff knew of their location. All the medicines were checked monthly, were in date and stored securely. The clinic had a defibrillator and oxygen available on the premises. The defibrillator pads, battery and the oxygen were all in date and the oxygen cylinder was full. A first aid kit and accident book were available. The guidance for emergency equipment was in the Resuscitation Council UK guidelines.
- The provider evidenced that appropriate indemnity arrangements were in place.

Information to deliver safe care and treatment

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

- The service used a registration and risk assessment form that was completed by clients prior to their consultation. This included information such as contact details, next of kin, consent to share with the patient's own GP and details, medical conditions, regular medicines, and known allergies.
- The service used a checklist for each patient file to ensure all expected information was stored.
- Individual care records were written and managed in a way that kept patients safe. Throughout our inspection, the lead GP and all clinic staff consistently demonstrated their determination to improve record keeping. All consultation summaries were typed, printed and stored in the patient file, which were completed by the GP using new voice-to-text software. This was checked for accuracy. The care records we saw showed that information needed to deliver safe care and treatment was available to relevant staff, but not always in an immediately accessible way. We reviewed ten paper-based clinical files for patients seen since our last inspection. We saw significant improvement in the organisation and content of the files since our last inspection. Six of the ten files we reviewed had information we would expect to see. Three of the files did not contain all correspondence, including test results. When asked, the lead GP demonstrated the information regarding patient's care and treatment was available, however the records had not been stored in the patient paper file. The provider explained these were stored on a clinic computer and these could theoretically be accessed by staff if required. The service was also in the process of implementing a new computer operating system, where information (including patient records) was available to all staff within a shared folder. One of the patient files we reviewed did not contain evidence that the long-term risks of taking their prescribed medicine had been discussed with the patient. When asked, the GP told us the short-term risks had been discussed but not fully recorded. Follow up arrangements were in place and the GP told us they would fully explain the risks to the patient.
- Patient information was being recorded onto an electronic clinical system to improve record keeping, information sharing and future clinical audit opportunities. Staff told us they had reviewed the information held on the system and had implemented processes to include storage of clinical information, including test results, consultation summaries and treatment plans. We cross-checked three records on the clinical system and saw evidence of this. We found no gaps in recording.
- The service had systems for sharing information with staff and other agencies to enable them to deliver safe care and treatment. This included sharing treatment details with the patient's own GP.

Requires improvement

Are services safe?

- We saw the clinic had implemented new systems to ensure patients were followed up appropriately. This included a patient tracker to record information including required follow up arrangements. There was a blood test tracker to record when samples were sent and when results were expected or received.
- 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.
- We saw evidence that the lead GP 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 systems for appropriate and safe handling of medicines.

- The service had reviewed and improved their prescription recording form. This was used to ensure any prescribed and administered medicine was accurately recorded, including the patient details, the medication, batch number and dose, along with authorising signatures.
- The systems and arrangements for managing medicines, including vaccines, emergency medicines and equipment, minimised risks. The service kept prescription stationery securely and monitored its use.
- Medicines were purchased from a licensed pharmaceutical wholesaler and stored securely at the service. Medicines requiring refrigeration were stored and monitored appropriately.
- The service does not prescribe controlled drugs (medicines that have the highest level of control due to their risk of misuse and dependence). Neither did they prescribe schedule 4 or 5 controlled drugs.

Track record on safety and incidents

The service could not always demonstrate a good track record on safety.

- There were comprehensive risk assessments in relation to safety issues.
- 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 service acted on and learned from external safety events as well as patient and medicine safety alerts. All alerts had clinical oversight by the lead GP. There was a system to record the received alerts, any action required or if the alert was not relevant. The service had an effective mechanism in place to disseminate alerts to all members of the team including agency staff. However, we found that the provider was not aware of a recent medicine safety relating to a type of antibiotic. It was found that the provider was not signed up to this particular alert service; this was resolved during the inspection. The provider planned to check any missed alerts and take action if necessary.

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.
- There were adequate systems for reviewing and investigating when things went wrong. The service learned and shared lessons, identified themes and took action to improve safety in the service.
- For example, a needle stick injury during a clinical waste collection. The lead GP provided immediate support to the injured person. The service fully investigated the incident. They recorded a significant event, made an accident book entry and informed their health and safety provider. It was found that staff had not followed infection prevention and control procedures. The service took appropriate action. As a result of the incident, the service reviewed their sharps policy, completed a risk assessment for sharps disposal and discussed the event in a team meeting where national guidance was reviewed and shared.

Good

Are services effective?

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)

- Staff were aware of where to find best practice guidelines, including from the National Institute for Health and Care Excellence (NICE).
- The provider told us that any unconventional treatment offered would be fully discussed with patients, including the benefits, risks, potential side effects and if the medicine was not licensed in the UK. The provider used research and guidance appropriate to their service. We were shown medical literature that described groups of individual patient case studies, small scale clinical trials and narrative reviews of other published papers.
- Patients' immediate and ongoing needs were fully assessed. Where appropriate this included their clinical needs and their mental and physical wellbeing. We saw examples of the completed health risk assessment used by the clinic.
- 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. We saw the clinic had recently reviewed and improved their monitoring of patients with a thyroid condition. This included an annual health review, along with health monitoring tests. We saw evidence they had communicated this change by letter to their patients.
- Staff assessed and managed patients' pain where appropriate.
- The clinic had started to use a tablet computer to improve record keeping. For example, staff used this for stock taking.

Monitoring care and treatment

The service was involved in quality improvement activity.

- The clinic used information about care and treatment to make improvements. The service made improvements through the use of completed audits.
- The clinic had continued their monthly record keeping audit. This looked at data quality of the information held on the clinical system, and also a compliance check for completeness of the paper files. For example, that they all included the registration form, risk assessment, terms and conditions and consent to contact their GP. The service had extended the scope of the audit; the first phase was to ensure all new patient medical files were completed and updated. The second phase was to correct all historical patient information. We saw the file audits completed in August and September 2019. The audits identified that all paperwork was being completed, and typed consultation summaries had risen from 40% in July to 70% in August and 90% in September. Staff commented within the audit that this may have been a result of the new dictation software. The identified improvements were to minimise the delay of typed summaries and to increase information scanned on to the electronic system. We saw that scanned information had risen to 90% compliance in September. Clinic staff discussed the audits in team meetings and the lead GP was allocated protected time each week to ensure summaries were completed.
- The provider had not completed any clinical audits, but described those that were planned, to review the effectiveness and appropriateness of the care provided. For example, we saw evidence the provider had started to chart the reduction of cancer tumour markers for individual patients. This was to visually help patients to understand their results, show effectiveness of treatment and to gather data for future audit purposes.
- The provider described an audit that had been planned to review thyroid treatment and improve quality of prescribing. We saw evidence of the data collection and the provider told us the audit was in progress.

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.
- Relevant professionals (medical and nursing) were registered with the General Medical Council (GMC) or Nursing and Midwifery Council and were up to date with revalidation.

Good

Are services effective?

- Staff were provided with training and protected time to meet their learning needs, although we noted a lack of clarity for mandatory training requirements. 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 with other organisations, to deliver effective care and treatment.

- The service offered extended diagnostic services and worked with other providers where applicable. For example, samples were screened for a wide spectrum of infections, deficiencies and hormone imbalances. The analysis was conducted by various external laboratories around the world, including USA, Germany and Netherlands. The lead GP visited the laboratories personally to confirm safety and suitability. Patients were also referred effectively to other services for ultrasounds, ECGs (electrocardiography) and x-rays. The provider coordinated these results in order to provide holistic and person-centred care to their patients. All blood test results were checked by the lead GP.
- Staff referred to, and communicated effectively with, other services when appropriate. There were clear and effective arrangements for following up on people who had been referred to other services. We saw examples of patient referrals to other services and evidence that the provider had followed up to ensure treatment had been commenced.
- Before providing treatment, clinical staff 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 on each occasion they used the service. Where consent was not given, the lead GP had started to explore this with the patient.

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. Staff encouraged and supported patients to be involved in monitoring and managing their own health.
- The clinic told us they had many patients with complex treatment needs. They provided support to those who were concerned due to not understanding their diagnosis or who were particularly anxious. They told us they empowered patients to speak further with their own GP or specialist.
- Where patients' 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.
- Staff supported patients to make decisions. Where appropriate, they assessed and recorded a patient's mental capacity to make a decision.
- The service monitored the process for seeking consent appropriately.
- We were told that patients were provided with all the information, including costs, they required to make decisions about their treatment prior to treatment commencing. We saw the clinic now had a price list for consultations that was displayed at the reception desk. The clinic had revised their Terms and Conditions, which each patient was asked to read and sign. We saw evidence of completed Terms and Conditions in the patient files we reviewed.

Good

Are services caring?

Kindness, respect and compassion

Staff treated patients with kindness, respect and compassion.

- The service sought feedback on the quality of clinical care patients received. The clinic had a compliments and complaints book in the waiting room/communal area. Staff told us this had been recently introduced and we saw three entries since September 2019, which were positive about the care and attention provided. The provider also had employed a recognised UK survey company, that specialised in feedback for individuals and healthcare organisations. We saw ballot boxes and leaflets in the waiting room. The provider told us there was a patient feedback survey, colleague feedback survey and a self-assessment. This was in progress.
- Feedback from patients was consistently positive about the way staff treat people. We received 14 comment cards where patients had described the staff as caring, kind and knowledgeable. Many commented on the peaceful and relaxing environment at the clinic.
- 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 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. Patients commented that they received a unique service and felt the lead GP was genuinely supportive and interested in their care.

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.
- We did not see any patients during the inspection. However, staff gave assurances that doors were closed during consultations and conversations taking place in these rooms could not be overheard. Equipment used to treat patients was mostly in the clinical rooms to protect the privacy and dignity of patients, including for whole body hyperthermia and oxygen therapy. A communal area was used for patients receiving intravenous treatment, where that the patient had expressly consented to this. However, privacy screens were available to patients if required.

Good

Are services responsive to people's needs?

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. There was a consultation room, one treatment room, a waiting room/communal area and toilets that were available to patients.
- The facilities and premises were appropriate for the services delivered.
- Reasonable adjustments had been made so that patients could access and use services on an equal basis to others. The clinic had a ramp for wheelchair access to the clinic, if required.

Timely access to the service

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

- The clinic was open between 9am to 5pm on a Monday, Tuesday and Thursday. Walk in patients were also accepted. Appointments could be booked over the telephone or in person.
- 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.

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 a complaints policy and procedures in place. The service had received two verbal complaints within the last 12 months. The service learned lessons from individual concerns, complaints and would conduct analysis of trends. It acted as a result to improve the quality of care. For example, the clinic received a verbal complaint from a patient who felt they were not attended to in a timely manner. The clinic took this complaint seriously and as a result, employed additional staff.

Good

Are services well-led?

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. For example, they told us Britain withdrawing from the European Union may affect their medicine supply chain and so they were exploring options to address this.
- 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 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 strategy and supporting business plans to achieve priorities. The provider clearly described the improvements made since our last inspection. They were open and honest about those still to be made. They had also completed an overall action plan for all health and safety issues to be addressed at the clinic. We found that the provider was working towards completion of these actions. Each action had been given a realistic timescale for completion.
- The clinic mission statement was "The clinics commitment is to provide an individual prognosis and treatment plan to the individual's specific needs, with an outcome of arriving at a healthier person".
- Staff were aware of and understood the vision, values and strategy and their role in achieving them.

Culture

The service had a culture of high-quality sustainable care.

- Staff felt respected, supported and valued. They enjoyed working at the service and found the work to be varied and interesting.
- Staff were proud to work for the service. Throughout our inspection, the lead GP and all clinic staff consistently demonstrated their determination and willingness to improve systems and processes at the clinic.
- 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. 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 developmental support they needed. This included appraisal and career development conversations. All staff had received a regular annual appraisal 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 development and evaluation of their clinical work.
- There was a strong emphasis on the well-being of all staff. Staff we spoke with told us they felt very supported, with an additional monthly supervision session where any suggestions were welcome. They were also given the opportunity to talk through any upsetting cases.
- The service actively promoted equality and diversity. For example, as a result of treating transgender patients, they intended to amend their registration to ask patients for the gender they identify with. The service identified and addressed the causes of any workforce inequality. Staff felt they were treated equally.
- There were positive relationships within the staff team.

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.

Good

Are services well-led?

- Staff were clear on their roles and accountabilities. The provider had employed a new agency nurse since our last inspection who had been fully included in the team. All staff were positive about the future and felt it was a strong team.
- The clinic had continued to review and update their policies and procedures. We saw this process was now completed.
- The provider had signed up to an employee assistance programme to provide access to telephone support for any issues in the workplace. They had also extended their provision with their health and safety provider to include any employment queries. The company would be providing bespoke employee handbook.

Managing risks, issues and performance

There were 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. After our last inspection the provider sent us an action plan detailing how they planned to meet regulation. We saw the planned to have completed all improvement actions by December 2019. The provider and staff were fully aware of the need to continuously review and improve their methods to record patient details, consultations and treatment.
- The service had processes to manage current and future performance. Leaders had oversight of safety alerts, incidents, and complaints.
- The provider demonstrated quality improvement activity. We saw evidence that a clinical audit was in progress. The provider was confident it would have a positive impact on quality of care and outcomes for patients.
- The provider had plans in place and had trained staff to deal with major incidents.

Appropriate and accurate information

The service acted on appropriate and accurate information.

- 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 submitted data or notifications to external organisations as required.
- There were robust arrangements in line with data security standards for the 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 brought in a complaints and compliments book, that was regularly monitored and would be acted upon if there was any negative feedback.
- Staff could describe to us the systems in place to give feedback. The service held regular staff meetings, supervision and daily updates on the service. We saw evidence of this.
- We saw evidence of a recent staff survey that was conducted in September 2019. The findings were being processed.
- 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. For example, staff had developed a 20-point health and safety walk around that was conducted every day to identify and resolve any issues.
- The service reviewed 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

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment **How the regulation was not being met:** • The registered persons had not assessed the risks to the health and safety of service users of receiving care or treatment and done all that was reasonably practicable to mitigate any such risks. In particular, discussing the long-term risks of medication with patients. • The provider was unable to demonstrate effective systems or processes to assess the risk of, and prevent, detect and control the spread of, infections, including those that are health care associated. This included training for staff, actions to mitigate the risk of legionella and processes to maintain staff vaccination. **This was in breach of regulation 12(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.**

Regulated activity	Regulation
Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance **How the regulation was not being met:** • The practice was unable to demonstrate effective systems and processes to ensure that information to deliver safe care and treatment was available to relevant staff in an accessible way. • The provider was unable to demonstrate systems and processes were in place to ensure safety alerts were always thoroughly recorded, acted on, analysed and appropriately stored. **This was in breach of regulation 17(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014.**