Sk:n - Leicester Gallowtree Gate

Inspection report

29 Gallowtree Gate
Leicester
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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?	Requires Improvement
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? – Requires improvement

Are services caring? – Good

Are services responsive? – Good

Are services well-led? – Requires improvement

We carried out an announced inspection at SK:N Leicester Gallowtree Gate on 9 August 2022 as part of our inspection programme.

SK:N Leicester Gallowtree Gate is registered under the Health and Social Care Act 2008 to provide the following regulated activities:

• Diagnostic and screening procedures.

• Surgical procedures.

• Treatment of disease, disorder or injury

This service is registered with CQC in respect of some, but not all, of the services it provides. The service provides private dermatology services, offering some skin treatments and minor surgery which fall under the scope of CQC registration, as well as other non-regulated aesthetic treatments. There are some exemptions from regulation by CQC which relate to particular types of regulated activities and services and these are set out in Schedules 1 and 2 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We only inspected and reported on the services which are within the scope of registration with the CQC.

There was no registered manager on site on the day of the inspection. However, the provider's nominated individual was present throughout the day. 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. The Director of Clinical Services was the nominated individual at the time of the inspection and was responsible for supervising the management of the regulated activity provided. The only staff who were associated with the delivery of regulated activities were the two clinicians, a nurse and the management team. There were other staff on the premises who provided the non-regulated activities. The provider holds a contract to provide some NHS treatments at this location.

Due to the current pandemic we were unable to obtain comments from patients via our normal process of asking the provider to place comment cards within the service location. However, we saw from reviews on social media that patients had given mixed reviews about the service.

Overall summary

Patients also commented on the clinic being well-maintained and clean. We did not speak with patients on the day, as there were none attending for regulated activities.

Our key findings were:

- We found that the service was caring and compassionate towards patients and we observed many positive comments received from those who had used the service.
- On the day of the inspection we found at this location that clinical records reviewed did not always contain the required relevant information to ensure patient safety. No audits were available in regard to this location. However, we were assured after the inspection that they were aware of this issue across the whole organisation and had sent in June 2022 an email to all clinicians but audits to monitor this issue had only recently commenced.
- There had been insufficient action taken to address some legionella, fire safety and health and safety risks.
- There were some processes to assess the risk of, and prevent, detect and control the spread of infection. However, staff immunisations were not monitored in line with current guidance. We saw evidence at the inspection that this process had recently commenced.
- Most policies were in place and provided relevant and sufficient information, to provide effective guidance to staff. Some policies, for example, fire safety needed further information and there was no policy in place for legionella and patient safety alerts.
- There was a lack of evidence of clinical audit and regular auditing of clinical record keeping processes.
- The service involved patients in decisions about the care and treatment.
- Appointments were pre-bookable by phone or in person.

The areas where the provide **must** make improvements are:

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

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

- Demonstrate that actions from risk assessments and infection control audits are documented when completed.
- The infection control lead should undertake additional training to support this role.
- Seek feedback on the quality of clinical care received as well as customer satisfaction.

Dr Sean O'Kelly BSc MB ChB MSc DCH FRCA

Chief Inspector of Hospitals and Interim Chief Inspector of Primary Medical Services

Our inspection team

The inspection was led by a CQC inspector and a GP Specialist Advisor.

Background to Sk:n - Leicester Gallowtree Gate

SK:N Leicester Gallowtree Gate is operated by Lasercare Clinics (Harrogate) Limited, 34 Harborne Road, Edgbaston, Birmingham, B15 3AA and provides services from Gallowtree Gate, Leicester. LE1 5AD . The provider has over 54 clinics registered with the CQC in England. A link to the clinic's website is below:

https://www.sknclinics.co.uk/clinics/the-midlands/leicester-gallowtree-gate

The clinic has been registered with the CQC since 2011 and had an inspection in June 2013. The link to that report is:- https://www.cqc.org.uk/location/1-125650956

It is registered to treat patients aged 18 years and over. The services offered include those that fall under registration, such as mole removal, minor skin procedures involving a surgical procedure and medical acne treatment. Other procedures, that do not fall under scope of registration include lip fillers, skin peels, anti-ageing injectables, dermal fillers and laser hair removal.

The clinic is located in the centre of Leicester. There is no on-site parking due to its location.

The service opening times are Monday closed. Tuesday to Thursday 12midday to 8pm, Friday 9am to 6pm, Saturday 9am to 6pm and Sunday 9am to 4pm.

How we inspected this service

This inspection was carried out both remotely and by visiting the provider's location.

This included:

- A site visit
- Reviewing information provided to us electronically before our site visit.
- Reviewing patient feedback on an external social platform.

The provider is not required to offer an out-of-hours service. Patients who need urgent medical assistance out of the service opening hours are requested to seek assistance from alternative services such as their own GP, the NHS 111 telephone service or accident and emergency.

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:

- There were processes in place to ensure that risks to patients were assessed but not all were well-managed.
- Information needed to deliver safe care and treatment was not always available to staff in a timely manner.

Safety systems and processes

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

- The service had systems in place to safeguard vulnerable adults and children from abuse, which included safeguarding policies. There was an identified safeguarding lead within the service. There were policies in place which outlined who to go to for further guidance but they needed further information, for example, current issues such as female genital mutilation (FGM), human trafficking and modern day slavery and county line gangs. Since the inspection the management team told us that they had a separate policy for FGM. They sent us evidence of a FGM clinical advice pack to provide additional guidance to staff and advised that the safeguarding policy now had links to any separate policies held by the provider and relevant to safeguarding
- Most employed staff at the service had received up-to-date safeguarding training appropriate to their role. At the time of the inspection we found that there was no evidence of safeguarding training for one clinician who worked at the service.
- Disclosure and Barring Service (DBS) checks were undertaken where required (DBS checks identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable). On the day of the inspection we found that one DBS check was missing but since the inspection the management team had advised us that this new member of staff was still in the probation period, was supervised and the checks were still in progress.
- The provider carried out recruitment checks on new staff and maintained evidence of this. We reviewed one staff file for a person had joined the service in the last two months but we did not see any evidence of a disclosure and barring check or references requested from a previous employer.
- The provider had recently started collecting records of staff vaccination status. This had started in June 2022 and all new staff had to supply this information. They had a plan to contact all employees to gather this information so that the management team were assured that the staff who carried out regulated activities were up to date with vaccinations relevant to their role. A policy was had also been introduced.
- All staff who carried out the role of chaperone had received the appropriate training but we did not see any chaperone posters on the provider website, in reception, treatment rooms we looked at. Since the inspection the management team provided evidence that chaperone posters were available in reception and in the doctors room
- 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.
- There was a system in place to manage infection prevention and control. The building was visibly clean and free from dust in the rooms we reviewed on the day of the inspection. Cleaning schedules were in place and identified what cleaning had been undertaken and how. They employed an external cleaner for six hours a week who completed this work after regulated activities had been carried out. On other days the staff would clean the rooms in between clients but we did not see any cleaning schedules for staff in place. Since the inspection the management team have provided photographic evidence of cleaning schedules in place for employed staff to complete when carrying out general cleaning of the rooms.
- The provider had carried out an infection control audit on 14 April 2022. Actions for improvement had been completed and a re-audit had taken place on 26 July 2022. We were told that the lead for infection control had not undertaken specific lead infection control training to provide guidance and support to staff. However, they had completed online level one and two infection control training.
- The management of sharps was appropriate with sharps bins in place which were signed, dated and not over filled.

Requires Improvement

Are services safe?

- There was information available to staff to support them when using hazardous substances. This was in line with legislation.
- We saw a legionella risk assessment had been carried out on 15 July 2021. Actions had been identified, two medium and one low and on the day of the inspection these had not been completed. No monthly water temperature monitoring took place however, taps were flushed by the clinic manager each week. Since the inspection the management team had sent in evidence to demonstrate that the required actions from the risk assessment were completed on 15 August 2022. We were told that the management team would discuss further completing monthly water temperature testing going forward.
- The provider did not have a legionella policy in place to provide guidance to staff.
- We saw a fire risk assessment had been carried out on 13 October 2021. Five actions had been identified, three high and two medium along with a further two actions that had been carried forward from the last fire risk assessment. Only two out of the three high actions had been completed. Medium actions and those carried forward from the previous fire risk assessment were still outstanding. Since the inspection the management team had sent in evidence to demonstrate that the required actions from the risk assessment were completed on 12 August 2022.
- A fire evacuation drill had taken place on 20 May 2022 and we saw a detailed report about this drill.
- The provider carried out appropriate environmental risk assessments which took into account the profile of people using the service and those who may be accompanying them.

Risks to patients

There were systems in place 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 effective 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. They knew how to identify and manage patients with severe infections, for example sepsis.
- When there were changes to services or staff the service assessed and monitored the impact on safety.
- There were appropriate indemnity arrangements in place
- There were suitable medicines and equipment to deal with medical emergencies which were stored appropriately and checked regularly. If items recommended in national guidance were not kept, there was an appropriate risk assessment to inform this decision. We saw evidence that the equipment and medicines were checked and a checklist was in place.

Information to deliver safe care and treatment

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

- Individual care records we reviewed were not always written and managed in a way that kept patients safe. We looked at six care records for patients who had received care and treatment under the regulated activities since the beginning of 2022. For example, illegibility of information written, missing information about how the treatment was given, consent not fully completed, allergies not completed in some records, lack of comprehensive notes in regard to the treatments given, when local anaesthetic was used, no batch number, expiry dates in some records. Post operation forms were not always signed. After the inspection the management team told us they would audit six months of patient records to check that General Medical Council (GMC) guidance was being followed. Since the inspection the management team had sent in evidence to demonstrate that in June 2022 the provider had sent a written email to all clinicians in regard to the completion of medical records. A sample of patient records had been reviewed and they had

found a number of health care professionals to be in breach of the GMC guidelines for good record keeping. Further audits would be completed. They had recognised that there was an issue in regard to documentation and going forward the provider had plans in place to introduce more record keeping audits across all locations registered with the CQC'

- We reviewed the histology recording log. For one patient who had received treatment we identified that it had been recorded that they appeared to have been informed before the date the histology report was received. Since the inspection the management team had sent in evidence to demonstrate that the histology reports for those records looked at on the day of the inspection had been audited and for this one record the date had been amended.
- The service did not have systems for sharing information with staff and other agencies to enable them to deliver safe care and treatment. For example, a patient's GP practice.
- 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.

Safe and appropriate use of medicines

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

- The clinic had a system in place for managing medicines which included injectables, emergency medicines and equipment which minimised risks. The service kept prescription stationery securely and monitored its use.
- The service does not prescribe Schedule 2 and 3 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.
- 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 kept accurate records of medicines. Where there was a different approach taken from national guidance there was a clear rationale for this that protected patient safety.

Track record on safety and incidents

The service did not always have a good safety record.

- There were risk assessments in relation to safety issues. These included Fire, Legionella and Health and Safety. Some of the actions detailed in the 2021 risk assessments had not been completed by the day of the inspection.
- The electrical installation condition check of the premises had been carried out on 1 September 2021.
- We noted that the safety of electrical portable equipment was assessed at the premises on 20 August 2021 to ensure they were safe to use.

Lessons learned and improvements made

The service were not able to demonstrate that they learnt and made improvements when things went wrong.

- There were adequate systems for reviewing and investigating when things went wrong. We saw completed incident forms (most of which related to non-regulated activities).
- We reviewed one incident that related to the regulated activities and found that it lacked detail, investigation, learning and actions. A further incident had been completed in relation to fire safety, there was no description of the incident, however action had been taken within two days to replace the fire panel. We saw no evidence that these had been discussed and learning shared in minutes of meetings we reviewed.
- The provider was aware of the duty of candour.

Requires Improvement

Are services safe?

- At this inspection we found the systems in place for receiving and actioning external safety alerts as well as patient and medicine safety alerts needed further improvement. They were disseminated through the corporate structure via the Medical Standards Team (MST) to all the locations registered with CQC. We were not assured that they received all the relevant alerts to disseminate. For example, we saw a recent safety alert from the government in relation to monkeypox virus and although the clinical team told us they were aware of it and it had been included in a bulletin from the medicines safety team, it was not found on this alert system. Since the inspection the management team had sent us evidence that the alert for monkeypox had been added to the MST alert tracker. The provider demonstrated that they had an effective mechanism in place to disseminate alerts to members of the team. We saw examples of MST Bulletins which contained alerts and information to staff.

Requires Improvement

Are services effective?

We rated effective as Requires improvement because:

- Patient records did not always contain full details of the patients history, and include full details of treatment. However, we were assured after the inspection that they were aware of this issue across the organisation and had sent in June 2022 an email to all clinicians but audits to monitor this issue had only recently commenced.
- The provider could not demonstrate how it kept staff up to date with evidence-based practice.
- There was no evidence of quality improvement audits for patient care being completed.
- It was not always evidence from clinical records reviewed that consent was being obtained and documented in full for each procedure.

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 but did not always document the delivered care and treatment in line with current legislation, standards and guidance (relevant to their service)

- Almost all the patients who attended this clinic completed a self-referral.
- Clinicians with practicing privileges also worked at the service with specialities such as plastic surgery and dermatology. They had high levels of skills, knowledge and experience to deliver the care and treatments some of which came within scope of registration with CQC.
- We found from records we reviewed that whilst patients' immediate and ongoing needs were not fully assessed and they were not clearly documented. Clinical records were kept but treatment planning and information was not always fully documented. However, we were assured after the inspection that they were aware of this issue across the organisation and had sent in June 2022 an email to all clinicians but audits to monitor this issue had only recently commenced.
- 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 patients who required a follow-up appointment. This was initially by telephone or if they needed to be seen, they were given a further appointment.
- Staff advised patients of any side effects and risks, including pain, and understood how to assess patients' pain where appropriate.

Monitoring care and treatment

The service could not demonstrate that they had an effective system in place in regard to quality improvement activity.

- From the records we reviewed on the day of the inspection we saw that clinicians were working with clinical evidence based practice. However, it was not clear how they ensured that clinicians kept up to date with current evidence-based practice, for example, in the removal of moles and skin tags.
- There was a lack of focus on continuous improvement within the service. We asked for information regarding audits to improve patient care. The registered provider could not identify or produce any. The audits that we did see throughout the day did not relate to direct patient care. Audits were carried out on a regular basis, in relation to infection control, health and safety, patient feedback and clinical audits in relation to documentation in patient records. We reviewed a clinical audit carried out on 10 March 2022 and there were 12 areas identified as needing actions to be completed. At the end of the document there was no clear action plan or dates that these had been completed.

Effective staffing

Requires Improvement

Are services effective?

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

- All staff were appropriately qualified.
- The provider had an induction programme for all newly appointed staff.
- The Director of Clinical Services who was the nominated individual at the time of the inspection was appropriately qualified.
- Relevant professionals (medical and nursing) were registered with the General Medical Council (GMC) and Nursing and Midwifery Council (NMC). They were up to date with revalidation.
- The provider understood the learning needs of staff and provided protected time and training to meet them. Records were kept of skills, qualifications and training but they were not up to date as one clinician had not provided evidence of their training which included safeguarding. Staff were encouraged and given opportunities to develop.

Coordinating patient care and information sharing

Staff did not always work well with other organisations, to deliver effective care and treatment.

- We examined some patient clinical records (covered under the regulated activities) and we saw, it was not always clear if they had adequate knowledge of the patient's health, past medical history or allergy status had been reviewed. We were told that 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. However, we were assured after the inspection that they were aware of this issue across the organisation and had sent in June 2022 an email to all clinicians but audits to monitor this issue had only recently commenced.
- As the majority of patients self-referred it was not clear when the service would share details of patient care. We were told that if the patient had histology results which required further investigations the clinic would then write to their GP for onward care.
- Where patients' needs could not be met by the service, staff redirected them to the appropriate service for their needs. Where appropriate, staff gave people advice so they could self-care.
- There was evidence that the clinic monitored the process for seeking consent appropriately but we found in records we reviewed that this process was not effective. However, we were assured after the inspection that they were aware of this issue across the organisation and had sent in June 2022 an email to all clinicians but audits to monitor this issue had only recently commenced.

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.

Consent to care and treatment

The service did not always obtain and clearly document consent to care and treatment in line with legislation and guidance.

- Records we reviewed did not always show consent being obtained for every procedure the patient had received. The provider's consent form did not contain evidence of the risks and benefits of the care and treatment being provided. We did not see any evidence in the patient records that risk factors were identified and discussed with patients. However, we were assured after the inspection that they were aware of this issue across the organisation and had sent in June 2022 an email to all clinicians but audits to monitor this issue had only recently commenced.

Requires Improvement

Are services effective?

- From patient records, we cannot be assured that patients were supported to make decisions about care as discussions of risks and benefits of treatment was not clearly documented. In records we reviewed we did not see that the clinician had assessed and recorded a patient's mental capacity to make a decision. However, we were assured after the inspection that they were aware of this issue across the organisation and had sent in June 2022 an email to all clinicians but audits to monitor this issue had only recently commenced.

Good

Are services caring?

We rated caring as Good because:

Staff treated patients with kindness, respect and compassion.

- For reasons of safety and infection prevention and control related to the COVID-19 pandemic, we did not commission patient feedback with CQC comments cards. We did not speak to any patients during this inspection.
- The service told us that patients had sufficient time during their consultations to make an informed decision about the choice of treatment available to them. These would be treatments carried under the regulated activities of diagnostic and screening procedures, surgical procedures and treatment of disease, disorder and injury.
- From evidence we reviewed prior to the inspection we saw that the service only sought feedback on customer satisfaction and not the quality of clinical care patients received.
- Feedback from patients was mixed in response to the way staff treat people. Feedback from patients was available on the website and on google reviews. The service had a score of 3.5 out of five from 62 reviews. 79% who had completed a review had rated their experience as excellent or great whilst 16% of those who responded had rated them as bad. The location had responded to each negative comment and asked for the patient to contact them to discuss further. Positive comments were also responded to.
- Staff understood patients' personal, cultural, social and religious needs.

Involvement in decisions about care and treatment

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

- Interpretation services were not readily available for patients who did not have English as a first language but they had just introduced a service whereby they could contact an external company to provide interpretation services if they were required.
- Information leaflets were available and we were told that they could be provided in easy read formats or larger print if required, to help patients be involved in decisions about their care. We did not see any notices in the reception areas, including in languages other than English, informing patients this service was 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:

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

Complaints were listened and responded to but further work was needed to demonstrate that the information was used to improve the quality of care.

Responding to and meeting people's needs

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

- The provider understood the needs of their patients.
- The facilities and premises were appropriate for the services delivered.

Timely access to the service

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

- Patients had timely access to initial assessment and treatment.
- Waiting times, delays and cancellations were minimal and managed appropriately.
- Patients with the most urgent needs had their care and treatment prioritised such as patients who may have reacted to previous treatments and needed to be reviewed by the clinician.
- Opening times - Monday closed. Tuesday to Thursday 12 midday to 8pm, Friday 9am to 6pm, Saturday 9am to 6pm and Sunday 9am to 4pm.

Listening and learning from concerns and complaints

Complaints were listened and responded to but further work was needed to demonstrate that the information was used to improve the quality of care.

- The service had a complaints policy and procedures in place with timescales for responding to the complaint. The provider encouraged a culture of openness and honesty. The service would write to a patient, provide an apology, explain what had happened, and ensure that the patient was satisfied with the response.
- Information about how to make a complaint or raise concerns was not readily available on the service website and on the day of the inspection we did not see any information about how to complain. Since the inspection the management team had provided evidence that complaints information was readily available if required.
- There had been 19 complaints in the last 12 months. We asked to look at two of these complaints. The information was not readily available as we were told complaints were dealt with by a complaints team. Since the inspection we have been sent the information for one complaint and was advised that the other turned out not to be a complaint and should not have been on the spreadsheet. Information was not made available to inform patients of any further action that may be available to them should they not be satisfied with the response to their complaint. We saw limited evidence that these had been discussed and learning shared in minutes of meetings we reviewed.
- However, we did see on the practice website where patients complained that the staff had treated patients who made complaints compassionately.

Requires Improvement

Are services well-led?

We rated well-led as Requires improvement because:

- On the day of the inspection leaders were not always able to demonstrate that they were aware of issues within the service such as record keeping, management of risk and lack of policies for safety alerts and legionella
- The roles and responsibilities for governance and risk management were the overall responsibility for one person in the organisation. There was not contingency plans in place to cover for absences and annual leave.
- There was no evidence of quality improvement for clinical care covered within the regulated activities due to a lack of clinical audits being completed.

Leadership capacity and capability;

Leaders had some skills to deliver high-quality, sustainable care.

- A new clinic manager had started on 1 August 2022 but had worked at another location registered with CQC. Whilst they were new to this location they were knowledgeable about some of the issues and priorities relating to the quality and future of services. They already understood some of the challenges and were working on plans to address them. Those staff we spoke with told us leaders were visible and approachable.
- Leaders had some awareness and understanding of the issues and priorities relating to the quality and future of the service.
- Leaders expressed a clear desire to address issues raised on inspection and to make improvements to deliver high quality care.
- We found a lack of oversight of some areas and some governance arrangements were not always effective.

Vision and strategy

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

- The provider had a vision and desire to provide a high-quality service that put caring at its heart, and which promoted 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.
- Staff were aware of and understood the vision, values and strategy and their role in achieving them.

Culture

The service did not always have a culture of high-quality sustainable care.

- The service focussed on the needs of the patients. However, they did not always have safe systems and processes in place.
- The provider was aware of the duty of candour.
- Staff felt respected, supported and valued.
- There were processes for providing all staff with the development they need. This included appraisal and career development conversations. There had been a high turnover of staff in the last 12 months but annual appraisals were in place. Staff were supported to meet the requirements of professional revalidation where necessary.
- 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.

Requires Improvement

Are services well-led?

Governance arrangements

There were clear responsibilities, roles and systems of accountability to support good governance and management but these need to be strengthened further.

- We saw that structures, processes and systems to support good governance and management were in place but they needed to be further embedded to be effective. This included the system for record keeping, management of fire safety and legionella, incidents and complaints. However the management team had demonstrated their commitment to continuous improvement and acted immediately to respond to some of the initial findings of our inspection.
- Leaders had established most policies, procedures and activities to ensure safety but they were not assuring themselves that they were working as intended. Some of the policies we reviewed did not contain current and up to date information, for example, safeguarding adults and children, fire safety procedures. There was no policies in place for legionella and patient safety alerts to provide guidance to staff in order for them to carry out their role.
- Staff appeared clear on their roles and accountabilities.
- Staff meetings took place on a regular basis but the meeting minutes did not demonstrate that quality and safety were discussed. During the inspection the management team told us that going forward they would have a set agenda which would contain items such as patient safety alerts, incidents, complaints, infection control, and training.

Managing risks, issues and performance

There were processes for managing risks, issues and performance but these needed strengthening further.

- There were some arrangements for identifying, recording and managing risks, issues and implementing mitigating actions. However, monitoring of specific areas such as medical records, fire safety and legionella required improvement. However the management team had demonstrated their commitment to continuous improvement and acted immediately to respond to the initial findings of our inspection.
- There were three staff members at the service who carried out the regulated activities and at the time of the inspection and no quality monitoring was undertaken.
- Leaders had oversight of safety alerts, incidents and complaints but the systems in place needed further work.
- We did not see any evidence of systems to improve and impact on quality of care and outcomes for patients as there were no clinical audits completed.

Appropriate and accurate information

The service did not always have appropriate and accurate information.

- The service had some quality and operation information which was used to ensure and improve performance. Performance information was combined with the views of the patients. This was mainly in relation to the caring and responsiveness of the service. However, they did not always have the appropriate information available to monitor the safety of the service.
- Care and treatment records were kept securely but records reviewed on the day of the inspection were not always written and managed in a way that kept patients safe.
- There were 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 and the public to support high-quality sustainable services.

Requires Improvement

Are services well-led?

- The service encouraged feedback from patients to shape their services.
- Patients were encouraged to leave reviews on the service's website.
- The practice valued the feedback from patients so that they could make improvements to their services. They used a framework called 'You said, we did' to ensure that they delivered the best patient journey. We saw examples for July 2022 such as 'a patient saying that opening from 12 midday onwards was too late. The clinic took that on board and now have someone in the clinic from 10am onwards to deal with queries and patients that walk-on wanting treatments. Another patient said that there was long wait times at the call centre to make bookings. The clinic now conduct wellness calls to all patients to confirm appointments and answer any questions. They now also give out a contact email address for further bookings and queries.

Continuous improvement and innovation

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

- There was focus on continuous learning but the service were not able to demonstrate improvements in the quality of care.
- The management team demonstrated their commitment to continuous improvement and acted immediately to respond to the initial findings of our inspection.
- The service made use of internal and external reviews of incidents and complaints but we did not see much evidence that learning and actions was shared and used to make improvements.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

The table below shows the legal requirements that were not being met. The provider must send CQC a report that says what action they are going to take to meet these requirements.

Regulated activity	Regulation
Diagnostic and screening procedures Surgical procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance Regulation 17 HSCA (RA) Regulations 2014 Good Governance There was limited systems or processes in place that enabled the registered person to assess, monitor and improve the quality and safety of the services being provided. In particular:- • The oversight of the work undertaken by contracted clinicians was unclear and not formalised in order to provide assurances, for example, that contracted clinicians were up to date in terms of clinical and professional knowledge, received regular appraisals and recorded patient notes for the service to an acceptable standard in order to provide safe care and treatment. • Systems in place for obtaining consent from patients were not always effective. • There were no systems to show any quality improvement within the service as a scheduled programme of clinical audit for patient care was not in place. • The systems in place for significant events/incidents was not effective as the investigations were not detailed and evidence of learning and actions were limited. • The service did not have effective governance arrangements in place to ensure that policies and procedures being relevant to the service contained all the relevant information and were used at the location. There were limited systems and processes in place to assess, monitor and mitigate the risks relating to the health, safety and welfare of service users and others who may be at risk which arise from the carrying on of the regulated activity. In particular:-

This section is primarily information for the provider

Requirement notices

- Risk assessments relating to health and safety, in relation to fire safety and legionella had outstanding actions that had not been completed.

This was in breach of Regulation 17(1)(2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.