VSL Clinic

Inspection report

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

Ratings

Overall rating for this location	Good
Are services safe?	Good
Are services effective?	Good
Are services caring?	Good
Are services responsive?	Good
Are services well-led?	Good

Overall summary

This service is rated as Good **overall.**

The key questions are rated as:

Are services safe? – Good Are services effective? – Good Are services caring? – Good Are services responsive? – Good Are services well-led? – Good

We carried out an announced comprehensive inspection at VSL Clinic as part of our inspection programme.

VSL Clinic is an independent health services provider which operates from Wakefield in West Yorkshire. The provider is a limited company which offers a range of medical, and cosmetic and aesthetic services. 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. VSL Clinic offers a range of non-surgical cosmetic interventions, for example fillers for skin rejuvenation, which are not within CQC scope of registration. Therefore, we did not inspect or report on these services.

One of the officers of the company 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 of the Health and Social Care Act 2008 and associated Regulations about how the service is run.

On the day of inspection we spoke with two service users to gather their views of the service, in addition we received three CQC comment cards, and seven comments submitted either electronically or via telephone, from people who had used the services of the clinic. This feedback was universally positive.

Our key findings were:

- The service was offered on a private, fee-paying basis only and was accessible to people who chose to use it.
- Procedures had been safely managed and there were effective levels of service user support and aftercare.
- The service had systems in place to identify, investigate and learn from incidents relating to the safety of service users and the provider.
- There were systems, processes and practices in place to safeguard service users from abuse. However, safeguarding training for the organisation was not at the required level for all non-clinical members of staff. We found that clinical members of staff had been trained to the required level.
- Information for service users was comprehensive and accessible. The provider being clear with regard to the services on offer and the levels of payment.
- Service user outcomes were evaluated via reviews and feedback, and the service had undertaken some limited audits to support quality improvement processes.
- The provider had the relevant skills, knowledge and experience to deliver the care and treatment offered by the service.
- The service shared relevant information with others or referred on to other services when required and with appropriate consent.
- The service encouraged and valued feedback from service users.
- The service demonstrated that it valued staff welfare and had put measures in place to meet specific needs.
- Working with a local dementia organisation, volunteers from the clinic had delivered a number of dementia awareness plays for the local community.

We saw the following Outstanding practice:

- Staff from the clinic delivered free to attend training seminars to other local health professionals. Subjects included suspicious skin lesions and menopause management.

Overall summary

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

- Continue to increase quality improvement activity to ensure audits are repeated to make sure any identified improvements had been embedded, and to ensure that clinical outcomes are examined in a more structured way.
- Develop and embed a formal system for staff appraisals.

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, and two other CQC inspectors.

Background to VSL Clinic

We carried out an inspection of VSL Clinic on 9 January 2020.

VSL Clinic is an independent health care provider operated by VSL Clinic Limited. The service operates its services from Trident House, 106 Barnsley Road, Wakefield, West Yorkshire, WF1 5NX. The service has a web presence at www.vslclinic.com.

VSL Clinic is registered with the Care Quality Commission to deliver the following regulated activities:

- Diagnostic and screening procedures
- Treatment of disease, disorder or injury
- Family Planning (this activity is not being delivered by the service at this time)
- Surgical procedures

The service delivers a range of health and care services from modern facilities. Parking, including parking for those with mobility issues, is available on the site. There is a manual access lift in place and all treatment rooms are accessible to service users with mobility issues. The premises is accessed via a call button to enhance and aid security.

Services provided include:

- Ophthalmology - including cataract services and refractive lens exchange.
- Plastic surgery – including the removal of lipomas and skin tags.
- Neurology clinics.
- Gynaecology.
- Private GP services.
- Cosmetic and aesthetic services.
- Blood testing

At the VSL Clinic some of the aesthetic treatments that are provided are exempt by law from CQC regulation. Therefore, we carried out the inspection in relation to medically related treatment only.

These services were delivered to persons who were aged 18 years and above. No services were offered to those under this age.

Service users access the service via direct contact with the clinic.

In addition to consultation and treatment facilities the service has a minor surgery room.

The service operates from Monday to Friday from 10am to 7pm, Saturdays 10am to 2pm, and on Sundays by specific arrangement.

The service had begun operation in March 2019, and at the time of inspection is currently building its client base.

The service is operated by two company officers who oversee and manage the delivery of services. Other staff including consultants, doctors and nurses are employed on a sessional basis. Non-clinical staff including receptionists and a cleaner are employed directly by the service. All doctors who work for the service have been granted practising privileges after approval by the organisation's medical advisory committee.

During our inspection we:

- Looked at the systems in place relating to safety and governance of the service.
- Viewed a number of key policies and procedures.
- Explored clinical oversight and how decisions were made.
- Spoke with a range of staff.
- Reviewed CQC comment cards and other feedback received from service users where they shared their views and experiences.

To get to the heart of service users' experiences of care and treatment, we always ask the following five questions:

- Is it safe?
- Is it effective?
- Is it caring?
- Is it responsive to people's needs?
- Is it well-led?

These questions therefore formed the framework for the areas we looked at during the inspection.

Good

Are services safe?

We rated safe as Good

Safety systems and processes

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

- The provider conducted safety risk assessments. It had appropriate safety policies, which were regularly reviewed and communicated to staff including locums. They outlined clearly who to go to for further guidance. Staff received safety information from the service as part of their induction. The service had systems to safeguard children and vulnerable adults from abuse.
- The service had undertaken a fire risk assessment and had ensured that issues identified as part of this assessment had been actioned. This included the fitting of self-closers to fire doors. Fire evacuations had been held twice since the opening of the service. Tests of the fire alarm system were held. However, it was noted that occasionally weekly checks had lapsed. Since the inspection we have been informed that the fire alarm testing procedure has been updated and will be carried out on a set day in the week to prevent future lapses.
- The service had undertaken an assessment in respect of the Control of Substances Hazardous to Health Regulations 2002. However, when we examined this in detail it was found that certain items held and used by the service didn't reconcile with the items in the assessment, with some additional items being held. Since the inspection the service has sent us evidence to show that they had undertaken an updated assessment of chemicals, and that procedures were in place to manage their safe usage.
- The service worked with other agencies to support service users and protect them from neglect and abuse. Staff took steps to protect service users from abuse, neglect, harassment, discrimination and breaches of their dignity and respect.
- The provider carried out staff checks at the time of recruitment and on an ongoing basis where appropriate. Disclosure and Barring Service (DBS) checks were undertaken where required. (DBS checks identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable). In addition to their own checks, many of the clinicians employed by the service were also subject to similar checks by their substantive employers in the NHS.
- Although the service only delivered care and treatment to adults, (those 18 years of age or over) training to an appropriate level in child safeguarding was still required. It was noted during the inspection that not all non-clinical staff had received up-to-date child safeguarding training to the level appropriate to their role in the organisation. When we discussed this with the service they told us that this would be rectified, and staff would be trained to the required level. After the inspection we were sent information by the service which confirmed that this training had been completed and that all staff had now received safeguarding training appropriate to their role. At the time of inspection we saw that all clinical staff had received training to the appropriate level.
- All staff had received necessary training with regard to health and safety and emergency evacuation procedures.
- Staff knew how to identify and report concerns. Staff who acted as chaperones were trained for the role and had received a DBS check. The service was considering extending chaperone training to other staff to increase capacity should this be required.
- There was an effective system to manage infection prevention and control. We saw that equipment was kept clean.
- The service had in place a system and procedure for handling clinical specimens such as blood samples.
- 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.
- 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. For example, the service had undertaken a full legionella risk assessment in 2019, and we saw that records had been maintained to evidence that weekly system flushing had been carried out.

Risks to service users

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

Good

Are services safe?

- There were arrangements for planning and monitoring the number and mix of staff needed. The service told us that should demand continue to grow then they were aware of the need to ensure staff capacity kept pace, and subsequently had developed plans to meet this contingency.
- There was an effective induction system for any agency staff which was tailored to their role.
- Staff understood their responsibilities to manage emergencies. However, not all staff, were fully aware how to identify and manage service users with severe infections, for example sepsis. We discussed this issue with the service and they told us that this would be actioned. After the inspection we were sent evidence to show that this had been completed. Actions undertaken included raising staff awareness through the provision of information and materials, development of a specific policy, and the adoption of a screening tool.
- There were medicines and equipment to deal with medical emergencies which were stored appropriately and checked regularly. When we assessed the emergency medication held by the service it was noted that it had not stocked atropine (this can be used to help keep the heart beat normal during surgical procedures). We were informed by the service that this was brought in when required. Since the inspection we have been informed by the service that atropine was now held for emergency use.
- When there were changes to services or staff the service assessed and monitored the impact on safety.
- We checked staff records which showed that there were appropriate indemnity arrangements in place.

Information to deliver safe care and treatment

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

- Individual care records were written and managed in a way that kept service users 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.
- The provider had in place secure systems for the storage of service user information and records.
- 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 systems for appropriate and safe handling of medicines.

- The systems and arrangements for managing medicines, including vaccines and equipment which minimised risks.
- The service kept prescription stationery securely and monitored its use.
- Due to the limited time elapsed since opening (March 2019), and the current throughput of the service, the provider had not yet carried out a medicines audit to ensure prescribing was in line with best practice guidelines for safe prescribing. The service told us that this was an activity which was planned to be undertaken in the future. However, performance, which included that in relation to prescribing and any medicines related issues was overseen by the service's Medical Advisory Committee, the clinical director and the organisational Board.
- The service did 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. The service had once prescribed a controlled drug in error and this had been raised as a significant event. This event had been fully investigated and learning measures identified to prevent a recurrence.
- Staff prescribed, administered or supplied medicines to service users 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. If there were to be any difference in approach taken from national guidance, then the service would ensure that there was a clear rationale for this that protected service user safety. The

service told us that up to this point their approach followed national guidance. Any changes in this approach would be considered by the VSL Clinic Board and the VSL Clinic Medical Advisory Committee.

Track record on safety and incidents

The service had a good safety record.

- There were comprehensive risk assessments in relation to safety issues. These included specific welfare risk assessments for individual staff members identified as being at risk.
- 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.
- There were adequate systems for reviewing and investigating when things went wrong. The service learned, shared lessons, identified themes and took action to improve safety in the service. For example, the service had identified a prescribing error. This had been investigated and learning points identified for the clinician who had wrongly prescribed the medication.
- The provider was aware of, and complied with, the requirements of the Duty of Candour. The provider encouraged a culture of openness and honesty. The service had systems in place for knowing about notifiable safety incidents.

When there were unexpected or unintended safety incidents:

- The service gave affected people reasonable support, truthful information and a verbal and written apology.
- They kept written records of verbal interactions as well as written correspondence.
- The provider acted on and learned from external safety events as well as medicine safety alerts. The service had an effective mechanism in place to disseminate alerts to all members of the team including sessional staff.

Good

Are services effective?

We rated effective as Good

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 such as the National Institute for Health and Care Excellence (NICE) best practice guidelines. Updates to guidelines were discussed at the Medical Advisory Committee and cascaded to clinicians via a number of communication routes which included emails and meetings.
- Service users' immediate and ongoing needs were fully assessed. Where appropriate this included their clinical needs and their mental and physical wellbeing.
- Clinicians had enough information to make or confirm a diagnosis. This included gathering information through service user pre- treatment assessments.
- We saw no evidence of discrimination when making care and treatment decisions.
- Staff assessed and managed service users' pain where appropriate.

Monitoring care and treatment

The service was involved in quality improvement activity.

- A limited number of persons had accessed the service since it began operation in early 2019, despite this the service was able to evidence to us that some quality improvement activity had been undertaken, and the provider had used this information to identify possible areas for improvement. For example, the service had carried out audits which included infection prevention and control audits, and a clinical audit into cataract surgery outcomes. We were told by the service that as user numbers increase the scope of audits would be expanded, and would take place over more than one cycle. As an example of a completed audit, one carried out in relation to cataract surgery showed good overall performance with 100% of service users showing improved visual acuity.

When we discussed the currently limited amount of audit activity the service told us that they would seek to develop a future audit programme. This planned programme was subsequently sent to us and included audits planned to cover:

- Medical records
- Consent
- Infection control
- User satisfaction
- Surgical complications

- The provider examined feedback from users of the service and complaints or concerns and used this to identify areas for possible improvement. For example, they had identified the need to manage the expectations of service users, especially if they were to be referred on to other providers for follow-on treatment or other services.

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. Clinical staff employed by the provider were mostly experienced professionals who also worked for nearby NHS providers.
- Relevant professionals (medical and nursing) were registered with the General Medical Council (GMC)/ Nursing and Midwifery Council and were up to date with revalidation.
- The provider understood the learning needs of staff and supported these. Up to date records of skills, qualifications and training were maintained. Staff were encouraged and given opportunities to develop.
- The service organised and delivered free to attend educational events for local primary care colleagues. Subjects included suspicious skin lesions and menopause management. We saw excellent feedback from those who had attended these events.

Coordinating service user care and information sharing

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

Good

Are services effective?

- Service users received coordinated and person-centred care. Staff referred to, and communicated effectively with, other services when appropriate.
- Before providing treatment, doctors at the service ensured they had adequate knowledge of the person's health, any relevant test results and their medicines history. We heard of examples of potential service users being signposted to more suitable sources of treatment where this information was not available to ensure safe care and treatment.
- All persons who accessed the service 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.
- We were told that care and treatment for persons in vulnerable circumstances would be coordinated with other services if necessary.
- Service user information was shared appropriately (this included when they moved to other professional services), and the information needed to plan and deliver care and treatment was available to relevant staff in a timely and accessible way.

Supporting service users to live healthier lives

Staff were consistent and proactive in empowering service users, and supporting them to manage their own health and maximise their independence.

- Where appropriate, staff gave people advice so they could self-care.
- Any risk factors were identified and discussed with service users and where appropriate and with consent, highlighted to their normal care provider for additional support.
- Where users' needs could not be met by the service, staff redirected them to the appropriate service for their needs.
- The provider delivered free information evening events and open days for existing service users or potential service users where they could have one-to-one interaction with clinicians.

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 service users to make decisions. Where appropriate, they assessed a person's mental capacity to make a decision. We saw that staff had received appropriate training with regard to the Mental Capacity Act 2005.
- The service monitored the process for seeking consent appropriately.

Good

Are services caring?

We rated caring as Good

Kindness, respect and compassion

Staff treated service users with kindness, respect and compassion.

- The service sought feedback on the quality of clinical care received and for their overall satisfaction with the services they had received.
- We saw that feedback from service users was positive about the way staff treat people. For example, on the day of inspection we spoke with two service users to gather their views of the service, in addition we received three CQC comment cards, and seven comments submitted either electronically or via telephone, from people who had used the services of the clinic. All comments supported this view.
- Staff understood service users personal, cultural, social and religious needs. They displayed an understanding and non-judgmental attitude to all persons who accessed the service.
- The service gave service users timely support and information.

Involvement in decisions about care and treatment

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

- Information leaflets were available to help service users be involved in decisions about their care. In addition, a hearing loop was provided to support those who had a hearing impairment.
- The service did not have at the time of inspection support for interpretation or translation. This had however been identified as a development area for the service.
- Service users told us through their comments, 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.
- The service told us that for adults with learning disabilities or complex social needs family, carers or social workers would be appropriately involved if this was required.
- Staff communicated with people in a way that they could understand, for example, via face-to-face discussions.
- The provider was clear with service users regarding cost structures and payments.

Privacy and Dignity

The service respected clients' privacy and dignity.

- Staff recognised the importance of people's dignity and respect.
- All consulting rooms had keypad door locks fitted to maintain privacy.

Good

Are services responsive to people's needs?

We rated responsive as Good

Responding to and meeting people's needs

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

- The service was offered on a private, fee-paying basis, and was accessible to people who chose to use it and who were assessed as suitable to receive the procedure.
- The service offered a post-procedural support line, which service users could access 24 hours a day. It was possible to contact the clinic, and in certain circumstances individual consultants, in this way.
- The service had a contract with a virtual personal assistant service which ensured that incoming calls were not missed.
- The provider understood the needs of their users and altered services in response to those needs. For example, the service offered flexible appointment times.
- The facilities and premises were appropriate for the services delivered.
- Reasonable adjustments had been made so that people in vulnerable circumstances could access and use services on an equal basis to others. For example, the service had installed a manual lift which enabled persons with mobility issues to access the building. Once inside all consultation and treatment rooms could be accessed.
- The service had identified that it wanted to increase user feedback through additional means. At the time of inspection it was examining ways to achieve this.

Timely access to the service

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

- Service users had timely access to initial assessment, test results, diagnosis and treatment.
- Waiting times, delays and cancellations were minimal and managed appropriately.
- Service user feedback indicated that they could access services easily.
- Referrals and transfers to other services were undertaken in a timely way.

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 service users who made complaints compassionately.
- The provider informed service users of any further action that may be available to them should they not be satisfied with the response to their complaint.
- The service had complaint policy and procedures in place. The service learned lessons from individual concerns, complaints and from an analysis of trends. It acted as a result to improve the quality of care. We saw that concerns and complaints were discussed up to and including Board level, and that actions were identified to promote learning and prevent recurrence. For example, following a complaint regarding a referral on to an external organisation, they had identified the need to clearly manage service user expectations, especially when referring to other services outside their own immediate control.

Good

Are services well-led?

We rated well-led as Good

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, the management team understood that as the organisation grew, and demand increased that they would need to increase clinical capacity.
- 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, this included planning for the future development of the service.

Vision and strategy

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

- There was a clear vision and set of values. The service had a realistic strategy and supporting business plans to achieve priorities. We were told by the management team that they sought to provide a high quality, private healthcare service, which was to be delivered within a confidential and safe environment. They also sought to give individual care, and offered to the best standard throughout the service users' care journey.
- Staff we spoke with 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.

- Staff felt respected, supported and valued and enjoyed working at the clinic. They were proud to work for the service.
- The service focused on the needs of persons accessing the clinic.
- Leaders and managers told us that they would act 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 interviewed told us they could raise concerns and were encouraged to do so. They had confidence that these would be addressed.
- There were processes for supporting staff with the development they need. Due to the length of time the clinic had operated, appraisal and career development conversations had not been fully instituted. The service did however, monitor and support staff to meet the requirements of professional revalidation where necessary. Individual staff one-to-ones were also held which allowed discussions around performance and training needs. In addition, staff could approach Board members, who included a lay member, to raise concerns or issues.
- There was a strong emphasis on the safety and well-being of all staff. We saw for example how the service had supported a member of staff who had been diagnosed with a long-term condition. They had sought to meet the individual's specific needs, and had put in place measures such as a specific risk assessment, altered working practices, and issued the individual with a personal wrist alarm in case of difficulties.
- The service actively promoted equality and diversity. It identified and addressed the causes of any workforce inequality.
- There were positive relationships between the management team and staff.

Governance arrangements

There were clear responsibilities, roles and systems of accountability to support good governance and management.

- Structures, processes and systems to support good governance and management were clearly set out, understood and effective. The governance and management of partnerships, joint working arrangements and shared services promoted interactive and co-ordinated person-centred care. The service had developed a structure which included:

Good

Are services well-led?

- VSL Clinic Board – with the responsibility for the stewardship of the clinic, and to oversee the conduct of business. The Board met every two months and minutes were kept. Membership consisted of:
  - The medical director (also an officer of the limited company)
  - The chief executive officer (also an officer of the limited company). This person also acted as the CQC Registered Manager.
  - A non-executive director and lay representative.
- Operational team – supporting the operational running and organisation of the clinic. This met on a regular basis. Membership consisted of:
  - The medical director
  - The chief executive officer
  - The clinic office manager (vacant at the time of inspection).
- VSL Clinic Medical Advisory Committee – this committee advised the Board on clinical matters to promote standards and to assess applications from clinicians to recommend practice privileges. The committee discussed issues such as significant events and complaints. Committee meetings were minuted and meetings held on a quarterly basis. A nominated member of the committee acted as the clinical governance lead and another had been appointed as audit lead. The committee was composed:
  - Chair – medical director
  - Lead clinicians for services delivered by the clinic e.g. consultant ophthalmologist or consultant gynaecologist.

- Staff were clear on their roles and accountabilities
- The management team and supporting teams had established proper policies, procedures and activities to ensure safety and assured themselves that they were operating as intended.

Managing risks, issues and performance

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

- There was an effective process to identify, understand, monitor and address current and future risks including risks to service user safety.
- The service had processes to manage current and future performance. Performance of clinical staff could be demonstrated through the limited clinical audits currently in place. Leaders had oversight of safety alerts, incidents, and complaints.
- Clinical audit had a positive impact on quality of care and outcomes for service users. It was planned to increase the scope and depth of clinical audit with the increase in user numbers.
- The provider had plans in place and had trained staff for major incidents and had developed a business continuity plan.

Appropriate and accurate information

The service acted on appropriate and accurate information.

- Quality and operational information was used to ensure and improve performance.
- Quality and sustainability were discussed in relevant meetings where staff had sufficient access to information.
- The service used performance information which was reported and monitored, and management and staff were held to account
- The information used to monitor performance and the delivery of quality care was accurate and useful. There were plans to address any identified weaknesses or areas of challenge.
- The service was aware of the need to submit data or notifications to external organisations as required.
- There were robust arrangements in line with data security standards for the availability, integrity and confidentiality of service user identifiable data, records and data management systems.

Engagement with service users, the public, staff and external partners

The service involved service users, the public, staff and external partners to support high-quality sustainable services.

- The provider encouraged and heard views and concerns from the public, service users, staff and external partners and acted on them to shape services and culture.
- Staff had systems in place, both formal and informal, to give feedback and raise concerns.

Good

Are services well-led?

- The service was transparent, collaborative and open with stakeholders about performance.
- Working with a local dementia organisation volunteers from the clinic had delivered a number of dementia awareness plays for the local community. We saw feedback which showed that these performances were well regarded and felt to be informative. It was planned to extend these plays in 2020 to cover the subject of end of life.

Continuous improvement and innovation

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

- There was a focus on continuous learning and improvement.
- The service made use of internal and external reviews of incidents and complaints. Learning was shared and used to make improvements.
- Leaders and managers encouraged staff to take time out to review individual and team objectives, processes and performance.
- Staff from the clinic delivered free training seminars to other local health professionals. Subjects included suspicious skin lesions and menopause management.