Sk:n - Leeds Street Lane

Inspection report

52 Street Lane
Roundhay
Leeds
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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 to people's needs?	Good
Are services well-led?	Good

Overall summary

This service is rated as Good overall. The service had been previously inspected in February 2020 when it was rated as Good.

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

The full reports for previous inspections can be found by selecting the 'all reports' link for Sk:n -Leeds Street Lane on our website at www.cqc.org.uk

Sk:n - Leeds Street Lane is situated in the Roundhay area of Leeds, West Yorkshire. The provider operates as an independent doctor-led service which specialises in the combination of medical aesthetic treatments and anti-ageing medicine, as well as offering rejuvenation and dermatology services.

The service is registered with the Care Quality Commission (CQC) under the Health and Social Care Act 2008 in respect of some, but not all, of the services it provides. There are some exemptions from regulation by CQC which relate to particular types of regulated activities and services and these are set out in Schedule 1 and Schedule 2 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. For example, Sk:n – Leeds Street Lane provides a range of non-surgical cosmetic interventions, for example laser hair removal, lip fillers and facial peels which are not within CQC scope of registration. Therefore, we did not inspect or report on these services.

Sk:n – Leeds Street Lane shares the building it operates from with two other distinct services operated by the provider, The MOLE Clinic, and Harley Medical Group. These services did not form part of the inspection.

At the time of inspection, the location did not have a registered manager in post, and the provider was in the process of appointing someone into this role. 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 provider did have a person designated as a nominated individual for the service.

Why we carried out this inspection

We carried out an announced comprehensive inspection at Sk:n – Leeds Street Lane in response to concerns that had been raised with us.

How we carried out the inspection

This inspection was carried out in a way which enabled us to spend a minimum amount of time on site.

Overall summary

This included:

- Conducting staff interviews, some using telephone conferencing.
- Reviewing patient records to identify issues and clarify actions taken by the provider.
- Requesting evidence from the provider.
- Undertaking a site visit to the location.
- Speaking with patients and reviewing their feedback.

To get to the heart of patients' experiences of care and treatment, we asked the following questions:

- Is it safe?
- Is it effective?
- Is it caring?
- Is it responsive?
- Is it well-led?

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

Our key findings were:

- The service provided care in a way that kept patients safe and protected them from avoidable harm.
- Patients received effective care and treatment that met their needs.
- Staff dealt with patients with kindness and respect and involved them in decisions about their care.
- Patients could access care and treatment in a timely way.
- The way the practice was led and managed promoted the delivery of high-quality, person-centred care.
- Leaders and staff from the organisation were open, transparent and honest regarding issues and challenges they had identified. Once identified, issues such as delays in handling complaints had been tackled and processes put in place to prevent recurrence.
- The service had developed a detailed quality assurance and audit programme. This was regularly reviewed and reported to organisational board level.
- The service routinely sought feedback from patients and used this to improve services.

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

- Continue with the application process to appoint a suitable registered manager.
- Improve the consistency of care record completions.
- Improve the accuracy of pathology sample records, and the timeliness of handling and reporting results.
- Continue to promote staff engagement and hold performance management meetings.

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

Our inspection team was led by a CQC lead inspector and included a GP specialist advisor, and a second CQC inspector.

Background to Sk:n - Leeds Street Lane

Sk:n – Leeds Street Lane is an independent health clinic which is part of a group of services under the provider Lasercare Clinics (Harrogate) Limited. The provider is located at 2 Bromwich Court, 1st Floor, Gorsey Lane, Coleshill, Birmingham, B46 1JU. Lasercare Clinics (Harrogate) Limited has 49 regional locations registered with CQC.

For this inspection we visited the clinic in Leeds at:

Sk:n – Leeds Street Lane

52 Street Lane

Roundhay

Leeds

West Yorkshire

LS8 2ET

The service is located on the first floor, above a commercial unit. Accommodation includes a reception and waiting area, and treatment and consultation rooms. There is no passenger lift or stairlift in the building. Patients with mobility issues are redirected to other clinics which are more accessible. There is parking onsite for service users, additional street parking is available if required. Sk:n shares the building with two other distinct services operated by the provider, The MOLE Clinic, and the Harley Medical Group.

The provider operates as a doctor-led service which specialises in the combination of medical aesthetic treatments and anti-ageing medicine, as well as offering rejuvenation and dermatology treatments.

Services are available to adults aged 18 years and over. This service is registered with CQC under the Health and Social Care Act 2008 in respect of the provision of advice or treatment by, or under the supervision of, a medical practitioner, including the prescribing of medicines for the support of cosmetic or medical treatments. Regulated activities include:

- Diagnostic and screening procedures.
- Treatment of disease, disorder or injury.
- Surgical procedures.

The clinic is staffed by a doctor, 2 nurse prescribers, 2 nurses, 4 aesthetic practitioners (non-medical), and a member of administrative staff. At the time of inspection, the service was in the process of appointing a new manager for the location. Until the manager is in post interim management cover is provided by managers from other clinics and from the regional management hub.

The service operates:

- Tuesday – Thursday 10am-8pm (the service is closed on a Monday)
- Friday 9am-7pm
- Saturday 9am-6pm
- Sunday 10am-5pm

Good

Are services safe?

We rated safe as Good because:

The provider had developed and implemented processes and procedures to manage safety within the clinic. Staff had the training and information they needed to deliver safe care and treatment. However, the provider needed to improve the consistency of information recorded in patient notes, and in their accurate and timely handling and reporting of pathology results.

Safety systems and processes

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

- The provider conducted health, safety and welfare risk assessments. Safety policies and procedures were in place, regularly reviewed and communicated to staff. These outlined clearly who to go to for further guidance if this was required. Staff received safety information from the service as part of their induction and refresher training. We saw that mandatory assessments had been undertaken. These included those in relation to fire safety and Legionella. Necessary control measures or actions had been undertaken to reduce risks.
- The service had systems to safeguard vulnerable children and adults from abuse. Services were not provided to persons under 18 years old, and therefore children had limited access to the premises. Children could wait in the reception area, but only under the supervision of another accompanying adult. It was the service policy that no child under the age of 16 years be left unattended inside or outside the clinic at any time.
- The service had the ability to work with other agencies to support patients and protect them from neglect and abuse.
- 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). All staff had either received a DBS check, or had undertaken a risk assessment which covered them whilst they awaited a DBS check to be completed.
- At the time of the inspection, staff recruitment and personnel records failed to demonstrate that necessary checks had been undertaken. For example, there was no evidence in all cases that references had been obtained for newly appointed staff. The service quickly responded to these findings, and in the time following the inspection sent evidence to us which gave assurance that checks had been undertaken. In addition, it was noted that the service was still in the process of undertaking checks to assess the vaccination status of a new staff member.
- All staff received up-to-date safeguarding and safety training appropriate to their role. They knew how to identify and report concerns. We were informed that the clinic had a dedicated safeguarding lead who had been trained to level 4 in safeguarding. In addition, the service had developed internal safeguarding guidance procedures for staff which was detailed and comprehensive.
- The service only provided services for persons aged 18 years or above. We were told by the service that where there was doubt regarding the age of a patient that staff asked for evidence to confirm proof of age.
- Staff who acted as chaperones were trained for the role and had received a DBS check.
- There was an effective system to manage infection prevention and control (IPC). The service undertook regular IPC audits. The last audit had been undertaken in November 2022. The audit showed general overall compliance with requirements and the clinic had achieved an attainment score of 97%. We saw that areas identified for improvement had been actioned. For example, additional non-latex gloves had been ordered. In addition to formal IPC audits the service also undertook regular hand hygiene assessments.
- The provider ensured that facilities and equipment were safe, and that equipment had been maintained according to manufacturers' instructions. We reviewed records to confirm that equipment had been calibrated, and that portable electrical appliances had undergone testing at the required intervals.

Good

Are services safe?

- There were sufficient stocks of personal protective equipment, including aprons and gloves. The service performed minor surgical procedures for which they used single-use equipment.
- There were systems for safely managing healthcare waste. We saw that clinical waste bins were available in clinical rooms, and that the clinic had a contract with a company for the approved disposal of clinical 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.

Risks to patients

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

- There were arrangements for planning and monitoring the number and mix of staff needed. We were informed that rotas were in place for staffing. If the clinic experienced any staff shortages due to illness or other unforeseen events, we were told patients could be referred to other clinics operated by the provider, or additional staff could be sent to the Leeds clinic from other locations.
- There was an effective induction system for newly appointed staff tailored to their specific roles. Staff told us that they felt that the induction process supported them to integrate into the service quickly and effectively.
- If a patient experienced issues outside operating hours they were able to contact the provider's national contact centre which operated from 9am until 8pm Monday to Friday and 9am to 5.30pm on Saturdays. Outside of these hours patients were advised to seek emergency assistance.
- 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. Staff had undergone sepsis awareness training and posters displayed awareness information on the subject.
- When there were changes to services or staff the provider assessed and monitored the impact on safety.
- There were appropriate indemnity arrangements in place.
- The provider had public and employer's liability insurance policies in place for the clinic.
- 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. In addition, staff received mandatory annual basic life support training.

Information to deliver safe care and treatment

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

- Individual care records were generally written and managed in a way that kept patients safe. The care records we saw showed that information needed to deliver safe care and treatment was available to relevant staff in an accessible way. However, there was evidence that some record keeping was inconsistent. For example, one record we checked had not had the mental health assessment section completed,
- The service had systems for sharing information with staff and other agencies to enable them to deliver safe care and treatment. For example, with the consent of patients the service communicated with the patient's own NHS GP or private GP.
- 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. Both electronic and hard copy records were kept securely.
- Clinicians made appropriate and timely referrals in line with protocols and up to date evidence-based guidance.
- The service had developed and adopted procedures for the management of incoming pathology results. However, when we examined clinical records there was evidence of some errors and delays in handling and communicating results. None of these cases involved adverse results. We saw a clinical record of an adverse result which had been handled appropriately and in a timely manner.

Good

Are services safe?

Safe and appropriate use of medicines

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

- The systems and arrangements for managing medicines, including emergency medicines and equipment minimised risks. We saw that regular checks had been made on emergency medicines and equipment held within the clinic.
- Staff prescribed and administered medicines to patients and gave advice on medicines in line with legal requirements and current national guidance. We were informed that there were on occasion delays in prescriptions if pharmacists needed further clarification prior to issue, or if prescriptions were not collected by patients within one week and needed reissue.

Track record on safety and incidents

The service had a good safety record.

- There were comprehensive risk assessments in relation to safety issues. Health and safety concerns were managed and reviewed on a regular basis.
- Managers monitored and reviewed activity. This helped them to understand risks and gave a clear, accurate and current picture that led to safety improvements. The provider had a Medical Standards Team which had oversight of local, regional and national performance.
- The provider had an internal audit team who undertook audits on a six-monthly basis. Subjects covered by their audit programme included health and safety, and assessments of compliance with operating procedures. When managers started or left the clinic, we saw that audits had been undertaken to identify any issues or concerns. We saw that recent internal audits had identified issues and areas of non-compliance in the clinic. These included no evidence that one-to-one staff meetings had been held, and that required internal quarterly checks had been undertaken. We saw that the provider had taken steps to ensure these had been actioned.

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. We saw in the previous 12 months that no significant events had been recorded for regulated activities provided at the clinic. However, the provider had identified some issues in relation to the operation of the clinic via their internal audit procedures, and had put measures in place to address these.
- There were 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. We heard from staff, and saw evidence to support this, that following complaints and incidents relating to non-regulated activities that staff involved had opportunities to reflect on these concerns, and had received additional support and training to prevent recurrence.
- The provider was aware of and complied with the requirements of the Duty of Candour and encouraged a culture of openness and honesty.
- There were systems in place for identifying and actioning notifiable safety incidents.
- Managers told us that when there were unexpected or unintended safety incidents, they gave affected people reasonable support, truthful information and a verbal and written apology.
- The service acted on, and learned from, external safety events as well as patient and medicine safety alerts. There was an effective mechanism in place to disseminate alerts to all members of the clinic team.

Good

Are services effective?

We rated effective as Good because:

The provider assessed needs and delivered care in line with evidence-based guidelines. There was a programme of internal quality monitoring and improvement, which was reported on within their management structure. Staff were appropriately qualified, and had been trained to deliver services within their competencies.

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.

- 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), the British Association of Dermatologists (BAD), and the *British Association* of Aesthetic *Plastic Surgeons* (BAAPS) best practice guidelines.
- Patients' immediate and ongoing needs were fully assessed.
- Staff told us they worked with patients to understand their care and treatment, and to manage expectations of outcomes.
- We found clinicians had enough information to make or confirm a diagnosis
- We saw no evidence of discrimination when making care and treatment decisions.
- Staff assessed and managed patients' pain and discomfort where appropriate.
- The service was aware of patient issues such as body dysmorphia disorder, and had processes in place to support such patients (body dysmorphia disorder - a mental health condition where a person spends a lot of time worrying about flaws in their appearance).

Monitoring care and treatment

The service was actively involved in quality improvement activity.

- Information about care and treatment was used to make improvements.
- The service made improvements through the use of completed audits. An audit programme was in place. We saw that a clinical audit had been undertaken for the quarter July to September 2022. This showed that of 16 minor surgery procedures undertaken, that there had been no cases of post-operative infection.
- We saw that regular internal audits were undertaken by the provider, such as a detailed service and management audit. Recently this had identified some areas of non-compliance and was linked to the previous management of the clinic. We saw that these concerns had been reported within the oversight and governance structure of the provider, and that actions had been implemented to mitigate any associated risks. For example, we saw that staff engagement had been reinstated. The internal audit process for service locations used a rating system to indicate compliance based on that used by CQC.

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. A newly appointed member of staff told us that they felt well supported by the clinic during their induction period.
- Relevant professionals (medical and nursing) were registered with the General Medical Council (GMC) and the Nursing and Midwifery Council (NMC).

Good

Are services effective?

- The provider understood the learning needs of staff and provided protected time and training to meet them. Up to date records of skills, qualifications and training were maintained. Staff were encouraged and given opportunities to develop.
- We saw that the service had recognised the needs of specific vulnerable, or high-risk groups. For example, they had developed awareness raising training for staff regarding interaction with people who were autistic, or who had a learning disability.

Coordinating patient care and information sharing

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

- Patients received coordinated and person-centred care. Staff referred to other services when appropriate.
- Before providing treatment, doctors at the service ensured they had adequate knowledge of the patient's health and medicines history.
- Patients when required were asked for consent to share details of their consultation and any medicines prescribed with their registered GP.
- Patient information was shared appropriately, and the information needed to plan and deliver care and treatment was available to relevant staff in an accessible way.

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. This included information on wound care.
- Risk factors were highlighted to patients, and where appropriate, and with consent, communicated to their normal care provider for additional support.
- Post-procedural feedback allowed the service to identify potential issues being experienced by patients.
- 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. Patients confirmed with us that they had been asked for their consent when they signed up for treatment.
- Staff supported patients to make decisions. Where appropriate, they assessed and recorded a patient's mental capacity to make a decision. Clinical staff had received mental capacity training.

Good

Are services caring?

We rated caring as Good because:

Staff at the clinic treated patients with kindness and understanding and involved them in decisions about their care and treatment. The service had established patient satisfaction feedback systems, and we saw that this feedback was used to drive quality improvement.

Kindness, respect and compassion

Staff treated patients with kindness, respect and compassion.

- The service sought feedback on the quality of clinical care patients received. Patients were regularly contacted by the service for their feedback. Comments were shared with staff to support their development, and when necessary either prompt improvement or recognise good service. Data from 1 May 2022 to 31 October 2022 showed that the clinic had received an overall rating of 4.1 out of 5, with 74% of 170 patients being positive about the service, 7% neither positive nor negative, and 19% negative.
- Feedback from patients we spoke with on the day of inspection about the way staff treated them was positive.
- Staff understood patients' personal, cultural, social and religious needs. They displayed an understanding and non-judgmental attitude to all patients. Staff had received equality and diversity training.

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. These services were charged to the patient within the overall cost of their treatment. The service told us that patients were advised on booking that they could not bring a relative or friend into the clinic to help translate for them.
- Information about services offered and prices of treatments were available on the clinic's website, and also material was available within the clinic.
- Patients told us during interviews, that they felt listened to and supported by staff and had enough time during consultations to make an informed decision about the choice of treatment available to them.
- Patients with a sensory impairment were able to be supported. For example, information was available in larger font sizes and in braille, For those with a hearing impairment the clinic had installed a hearing loop.

Privacy and Dignity

The service respected patients' privacy and dignity.

- Staff recognised the importance of people's dignity and respect.
- Treatments and consultations were undertaken with the privacy of patients in mind. Staff informed us that rooms could be locked to prevent interruptions, and that whenever possible patients only had to take off the minimum amount of clothing as required by the procedure.
- Staff knew that if patients wanted to discuss sensitive issues or appeared distressed, they could offer them a private area to discuss their needs.
- Chaperones were available to patients on request. All chaperones had received training, Disclosure and Barring Service checks, and had signed confidentiality agreements.
- Staff were aware of information security, and we saw that patient records were stored securely.

Good

Are services responsive to people's needs?

We rated responsive as Good because:

The service organised and delivered treatment and care to meet the needs of patients.

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 delivered services in response to those needs.
- The facilities and premises were appropriate for the services delivered. However, access to the building was limited for those patients with limited mobility as the service was located on the first floor, and the building did not have a passenger lift installed. If patients with mobility issues contacted the service, they were referred to other clinics in the region with better access.
- Reasonable adjustments had been made so that people in vulnerable circumstances could access and use services on an equal basis to others. For example, for patients with a hearing impairment, a hearing loop had been fitted, and if necessary British Sign Language support could be offered free of charge to the patient.
- Feedback from the services own patient survey for the period 1 May 2022 to 30 October 2022 showed that from 170 responses 74% of patients were positive about their experiences at the clinic, 7% were neutral, and that 19% were negative.

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 assessments, test results, diagnosis and treatment.
- Waiting times, delays and cancellations were minimal and managed appropriately.
- The service operated six days a week and offered appointments into the early evening. In addition, the provider had a national contact centre which operated from 9am until 8pm Monday to Friday and 9am until 5.30pm on Saturday to offer help and support to patients.
- Referrals to other services were undertaken in a timely way.
- Information to patients regarding treatments was available on the clinic's website.

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.

- The provider had a complaints policy and supporting procedures in place.
- Information about how to make a complaint or raise concerns was available. Staff treated patients who made complaints compassionately. Patients we spoke with on the day of inspection told us that they had been informed of the service's complaints procedures. In addition, staff we spoke with were aware of how to deal with complaints, and how these should be reported.
- In the previous 12 months the provider reported that they had received 20 complaints, none of these complaints were related to regulated activities delivered by the clinic.

Good

Are services responsive to people's needs?

- The service learned lessons from individual concerns, complaints and from analysis of trends, and acted as a result to improve the quality of care. For example, we were told of a complaint which, whilst out of the scope of our inspection, showed that it had been fully investigated and that remedial actions had been taken to prevent a recurrence. Actions taken included self-reflection by the staff member involved, and additional training and a period of observed practice for the staff member.
- The provider had identified that there had been past issues with the timely management and follow-up of complaints, and had put in measures to improve this aspect of their complaints handling process.
- The provider informed patients of further options that may be available to them should they not be satisfied with the provider's response to their complaint. For example, they had subscribed to the Independent Complaints Adjudication Service (ISCAS operates as a recognised independent adjudication services for complaints for the private healthcare sector).

Good

Are services well-led?

We rated well-led as Good because:

The provider had established clear structures, systems and processes to support effective leadership and governance.

However, the provider should seek to appoint a suitable person to the role of registered manager to meet the conditions of their CQC registration.

Leadership capacity and capability

Leaders had the capacity and skills to deliver high-quality, sustainable care.

- At the time of inspection, the clinic had no registered manager in place for over 6 months. This was a requirement of their registration. We saw that in the past the previous clinic manager had been in the process of applying to become a registered manager, but had left the organisation prior to being appointed. A new manager was due to take post in the Leeds clinic in December 2022, and it was planned that they would make an application to take over the role of registered manager.
- After the loss of the previous manager the provider had made interim arrangements with other managers in the region to support the clinic.
- Leaders within the organisation were knowledgeable about issues and priorities relating to the quality and future of the Leeds clinic. For example, via internal audit and staff feedback they had recognised several areas of non-compliance with standards at the Leeds clinic, and had put into place measures to address these.
- Leaders and managers at all levels were visible and approachable. They worked closely with staff and others to make sure they prioritised compassionate and inclusive leadership.
- The clinic was able to call on support from the wider organisation when required for specific advice.
- The provider had effective processes to develop leadership capacity and skills, including planning for the future leadership of the service.

Vision and strategy

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

- There was a clear vision and set of values. The service had a realistic strategy and supporting business plans to achieve priorities.
- Staff were aware of and understood the vision, values and strategy and their role in achieving them.
- The provider had developed a clear brand identity that was based on achieving the best outcomes for patients. They stated that it was their mission "*to deliver confidence through better skin*".
- The provider monitored progress against delivery of the strategy and reported this progress to board level.

Culture

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

- Staff told us that they felt respected, supported and valued by their employer.
- The service focused on the needs of patients.
- Leaders and managers acted on behaviour and performance inconsistent with the vision and values.

Good

Are services well-led?

- 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. We were informed that there had been some previous delays in responding to complainants. However, this had been recognised and measures put in place to prevent recurrence.
- Staff told us they could raise concerns and were encouraged to do so. They had confidence that these would be addressed.
- There were processes for providing all staff with the development they needed. This included appraisal and one-to-one discussions. The service reported that in recent months these activities had lapsed. However, this had been recognised and measures had been put in place to reinstate these. Staff had reported previously feeling isolated due to these lapses in management contact. However, they now reported feeling more supported in their roles.
- 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 safety and well-being of all staff.
- The service actively promoted equality and diversity. It identified and addressed the causes of any workforce inequality. Staff had received equality and diversity training. Staff felt they were treated equally.

Governance arrangements

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

- Structures, processes and systems to support good governance and management were clearly set out and understood by staff.
- The provider had established national and regional governance structures and clear lines of accountability.
- Staff were clear on their roles and accountabilities. Staff had the support of dedicated leads for key activities such as safeguarding.
- Leaders had established proper policies, procedures and activities to ensure safety and assure 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 patient safety. The provider had established governance and risk management structures and supporting processes in place. These included an operational risk register.
- The provider had processes to manage current and future performance.
- Leaders had an oversight of safety alerts, incidents, and complaints.
- Clinical audit had a positive impact on quality of care and outcomes for patients. There was clear evidence of action to change services to improve quality.
- The provider had plans in place and had trained staff for major incidents.
- Staff told us that changes were communicated to them by a variety of methods. These included an organisational bulletin, direct emails, and via meetings. Staff told us that they felt well informed.

Appropriate and accurate information

The service acted on appropriate and accurate information.

Good

Are services well-led?

- The information used to monitor performance and the delivery of quality care was accurate and useful. There were plans to address any identified weaknesses. For example, we saw that issues identified by internal audits such as lapsed staff engagement and management processes had been discussed at senior level, plans to rectify issues were made and had been implemented.
- The provider was aware of the need to submit data or notifications to external organisations when required.
- 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, staff and external stakeholders to support high-quality sustainable services.

- The service encouraged and heard views and concerns from the public, patients, staff and external stakeholders. They used this feedback to shape their services and culture, and to improve performance. For example, we saw how complaints feedback had been used to identify the need to improve individual staff performance.
- Patients were asked to give feedback on the care they had received after each treatment had been completed. Patients were contacted via text or email.
- There were systems in place for staff to give feedback. We saw evidence of feedback opportunities for staff, and how the subsequent actions were shared with staff. It had been recognised by the service that for a short period of time opportunities for staff to feedback views had been limited, and that one-to-one meetings, and staff meetings had lapsed. We saw that the provider had taken action to rectify these issues.
- The provider had put in place measures to ensure the additional wellbeing of staff. This included an employee discount scheme, offering a helpline for support, and the development of a wellness charter.

Continuous improvement and innovation

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

- There was a focus on continuous learning and improvement.
- The provider made use of internal and external reviews of incidents and complaints. We saw evidence that learning was shared and used to make improvements.
- Structures were in place within the organisation to review performance, and to plan and deliver service improvements.
- Leaders and managers encouraged staff to take time out to review individual and team objectives, processes and performance.
- There were systems to support improvement and innovation work. This included a programme of regular audits.