CLNQ Ltd

Inspection report

49-51
King Street
Knutsford
WA16 6DX
Tel:

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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 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 CLNQ Ltd on 2 August 2022. The inspection was carried out as part of our inspection programme. This was the first inspection of the service since it was registered with CQC.

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 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. CLNQ Ltd provides a range of services which are not within CQC scope of registration. Therefore, we did not inspect or report on these services.

CLNQ provides consultation, examination and treatments in general medicine for primary care,

aesthetic treatments, minor surgery procedures carried out under local anaesthetic, treatment of skin disorders and treatment/ management of hormone replacement therpay (using bio-identical hormones).

The registered manager for the service is also the person registered as the responsible person for the provider. A registered manager is a person who is registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

Our key findings were:

- The 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.
- The service organised and delivered services to meet patients' needs. Patients could access care and treatment in a timely way.
- Staff reported a good culture and effective systems were in place for quality control and governance.

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

- Review the arrangements for sharing information with patient's GPs.
- Maintain a record of the batch numbers for local anaesthetic.

Overall summary

- Ensure patients who are prescribed unlicensed medicines are formally informed of any potential risks associated with this.
- Formalise the staff induction process.

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**.** The team included a GP specialist adviser.

Background to CLNQ Ltd

CLNQ Ltd is a location registered by CLNQ Limited. The address of the service is: 49-51 Kings Road, Knutsford, Cheshire, WA16 6DX.

The provider is registered with CQC to deliver the Regulated Activities; diagnostic and screening procedures, surgical procedures and treatment of disease, disorder or injury.

Services to patients include consultation, investigation and treatment. The service provides a range of minor surgical procedures that are carried out using local anaesthetic. These procedures may be for health and or aesthetic purposes. Services may include; skin surgery to remove lesions minor eyelid surgery, minor aesthetic surgery. The service also provides consultation, pre-operative assessment and post-operative care for breast augmentation surgery. The surgery for breast augmentation is carried out at a local privately funded hospital. The clinical team consists of a consultant plastic surgeon and a GP. The service is provided to adults aged 18 and over. The range of services provided are listed on the provider's website. The service also offers a range of other aesthetic procedures that fall outside the scope of CQC registration.

The service operates Monday to Friday from 9am to 5pm. All appointments are pre-bookable.

The service is based in an end of terrace property on one of the main streets in Knutsford Village. Consultation rooms are available on the first floor of the building and there is no lift available to enable people to access this floor. The provider told us that those patients with access requirements can be seen at an alternative location which is within a hospital environment and provides fully accessible facilities.

How we inspected this service

Before visiting we reviewed a range of information we hold about the service and asked the provider to send us information. This included the complaints they had received in the last 12 months, details of significant events and the details of their staff members. We carried out a visit to the location and toured the premises and facilities throughout.

Our inspection also included:

- Speaking with the registered provider
- Speaking with members of the staff team
- Reviewing records
- Requesting supporting information and evidence from the provider

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.

Good

Are services safe?

We rated safe as Good because:

Safety systems and processes

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

- The provider had a range of safety related policies and procedures which had been communicated to staff.
- Staff were provided with safety related information as part of their training.
- Policies and procedures were in place to safeguard children and vulnerable adults from abuse. These included details as to the types of abuse, procedures in place to prevent abuse and details of the local agencies to refer to in case of suspected abuse.
- There was a lead for safeguarding and staff knew what action to take if they had any concerns or suspected potential abuse.
- Staff had received up-to-date safeguarding training appropriate to their role.
- Staff recruitment processes included ensuring appropriate pre-employment checks had been carried out prior to appointment. These included Disclosure and Barring Service (DBS) checks. (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).
- Procedures were in place to ensure appropriate standards of hygiene were maintained and to prevent the spread of infection.
- The premises were equipped to meet infection prevention and control requirements.
- Infection and prevention checks and audits were carried out on a regular basis.
- Cleaning schedules were in place and cleaning checks and audits were carried out on a regular basis. The provider was in the process of sourcing an alternative cleaning company at the time of our visit.
- There were systems for the management of healthcare waste.
- The premises and equipment were appropriately maintained and health and safety risk assessments and checks were carried out. However, a door on the ground floor entrance area could have presented a risk as a result of it leading directly onto a staircase to the basement. Following the inspection the provider confirmed that they had carried out a risk assessment of this and had taken action to mitigate the risk.

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.
- Staff had been provided with training in managing emergencies.
- There was a business continuity plan in place in case of major disruption to the service.
- There were suitable medicines and equipment to deal with medical emergencies including a defibrillator and oxygen. These were stored appropriately and checked regularly
- The provider assessed, monitored and reviewed risks and took action to mitigate risks to the safety of patients and staff. Risk assessments were reviewed on a regular basis.
- Health and safety checks and audits were carried out on a regular basis.
- A fire risk assessment and prevention plan was in place and measures were taken to mitigate the risk of fire. Staff were trained in fire safety.

Information to deliver safe care and treatment

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

Good

Are services safe?

- Individual care records were written and managed in a way that kept patients safe and protected their confidentiality.
- Information needed to deliver safe care and treatment was available to staff. The patient record system only allowed access to staff dependent upon on their role.
- Staff were required to sign confidentiality agreements and to undergo training in information governance.
- Patients were asked to agree if information could be shared with their GP. However, we saw little evidence that the service contacted a patient's GP regardless of the nature of the care and treatment provided.
- Referrals to other services were made promptly. At the time of the inspection this was largely to a private hospital.
- Clinicians required patients to provide their medical history and sought confirmation of this if this was required.
- Confidentiality and information governance policies were in place.

Safe and appropriate use of medicines

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

- The service had systems for the prescribing and handling of medicines. Processes were in place for the safe prescribing of medicines and staff kept appropriate records of medicines. We did note however, that batch numbers were not routinely recorded for local anaesthetic used.
- Prescriptions were stored securely and there was a system to ensure accountability for prescriptions.
- There were few medicines stored at the service. The medicines stored were those required for anaesthetic purposes, antibiotics and those required in case of a medical emergency.
- Checks were carried out on emergency medicines on a regular basis.

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. Staff told us they felt confident to raise issues and felt that they would be supported if they did so.
- We saw an example of action taken in response to an event. This included an investigation, and action taken to remedy the issue and to share the learning across the staff team.
- The provider was aware of the requirements of the duty of candour. Staff told us they felt the provider encouraged a culture of openness and honesty.
- The service acted on and learned from external safety events as well as patient and medicine safety alerts. The service had a system in place respond to patient safety alerts and these were shared with the staff team as appropriate.

Good

Are services effective?

We rated effective as Good because:

Effective needs assessment, care and treatment

Clinicians assessed needs and delivered care and treatment in line with current legislation, standards and guidance (relevant to their service).

- Patients' immediate and ongoing needs were assessed.
- We looked at the care and treatment provided to a sample of patients. This indicated that clinicians 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. However, we found that patients who were prescribed bio-identical hormones had not been required to sign a statement to the effect that they were agreeing to take an unlicensed drug and the potential benefits and risks associated with this. The provider told us these patients were verbally informed of this.
- The registered manager was part of a local aesthetics multi-disciplinary group. This consisted of local plastic surgeons convening bi-monthly to discuss issues, best practice and share learning.
- Patients were provided with two consultations with a clinician and a cooling off period prior to undergoing surgical procedures.
- The service worked with patients to develop personalised treatment plans. These included information about the procedures, associated risks and recovery. These were shared with patients in the form of letters.
- We saw no evidence of discrimination when making care and treatment decisions.
- Audits and performance data was monitored to improve outcomes for patients.
- The provider had risk assessed the services they offered. These were appropriate to the qualifications, skills and experience of the staff team and nature of the service provision.

Monitoring care and treatment

The provider carried out quality improvement activity.

- Quality improvement activity was undertaken to review the effectiveness and appropriateness of the care provided.
- A number of audits had been carried out. These included: an antibiotic prescribing audit and a clinical consultation and notes audit.
- Patients who had undergone breast augmentation were asked to complete a questionnaire to measure their satisfaction and check reported outcomes. This was a validated questionnaire that reviewed the psychological impact of the procedure on their wellbeing. This questionnaire was given to patients before and after their procedures.

Effective staffing

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

- Staff told us they had undergone an induction when they started, and they were required to undertake mandatory training within set timescales. However, the induction process was not documented/formalised.
- Relevant professionals (medical) were registered with the General Medical Council (GMC).
- The provider had assessed and understood the learning needs of staff and provided protected time and training to meet them.
- Staff told us they were encouraged and given opportunities to develop.
- Up to date records of staff qualifications and training were maintained.
- Staff had been provided with training in topics relevant to their roles and responsibilities.

Good

Are services effective?

- Staff were required to undertake regular mandatory training in topics such as; information governance, fire safety, equality and diversity, infection prevention and control, basic life support and safeguarding.
- Staff were provided with on-going support including supervision, annual appraisal and support for revalidation.

Coordinating patient care and information sharing

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

- The information needed to plan and deliver care and treatment was available to relevant staff in a timely and accessible way through the patient record system.
- Before providing treatment clinicians asked patients to share the details of their medical history to ensure care and treatment was provided appropriately.
- Staff worked together to deliver effective care and treatment.

Supporting patients to live healthier lives

Staff supported patients to manage their health.

- Where patients need 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.

- Clinicians understood the requirements of legislation and guidance when considering consent and decision making.
- Clinicians supported patients to make decisions. Patients were provided with two consultations prior to deciding to proceed with a procedure.
- Clinical staff had been provided with training in the Mental Capacity Act.
- Consent audits were carried out. We saw evidence of consent for the records we looked at with the exception of one. The provider told us this was because the consent had not been obtained on the electronic patient record and that they would include reference to this in records kept.

Good

Are services caring?

We rated caring as Good because:

Kindness, respect and compassion

Patients received care and treatment in a caring manner from staff who treated them with kindness and respect.

- The service sought feedback on the quality of care patients received. This was shared with us and was very positive. Patients were asked to provide feedback on the service following their appointment via e mail. Patients were also invited to complete a written questionnaire anonymously.
- The provider was committed to provide a positive patient journey. They described a patient centred service where patients were provided with a high standard of care and attention.
- Staff had been provided with training to understood patients' diverse needs. Those we spoke with displayed an understanding and non-judgmental attitude.
- Chaperones were provided for all surgical procedures or those involving examination by a clinician.
- Staff had undergone training in conflict resolution and handling complaints.

Involvement in decisions about care and treatment

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

- Patients were provided with a face to face consultations to discuss their individual needs and wishes and discuss their treatment options.
- The service manager told us that information could be made available in different formats to help patients be involved in decisions about their care if this was required. They told us the service would try to accommodate patients' diverse needs in whatever way they could, and this sometimes involved seeing patients in an alternative location.
- Staff had been provided with training in equality and diversity.

Privacy and Dignity

The service respected patients' privacy and dignity.

- Staff told us they recognised the importance of treating people with dignity and respect.
- All patient consultations and interactions were chaperoned.
- Staff who provided chaperoning had been trained in this and had undergone a Disclosure and Barring Service (DBS) check.
- Treatment room doors were closed, and nobody could access treatment rooms without permission.
- Privacy screens were provided in consultation and treatment rooms.
- Feedback from patients about how staff treated them was very positive.

Good

Are services responsive to people's needs?

We rated responsive as Good because:

Responding to and meeting people's needs

The provider organised and delivered services to meet patients' needs.

- The provider understood the needs of patients and planned services in response to those needs.
- Patients individual needs were discussed, assessed and services were delivered in line with their wishes and choices. Where the service was not able to meet a patients needs they were advised of alternative sources.

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, test results, diagnosis and treatment.
- Referrals to other services were made in a timely way. The majority of these were to a private hospital.
- Waiting times, delays and cancellations were minimal.

Listening and learning from concerns and complaints

The service had procedures in place for handling complaints and improve the quality of care.

- The service had a complaints policy and procedure and a system was in place for receiving, investigating and acting on complaints.
- The service had not been subject to a complaint so we could not review the effectiveness of the complaints procedure working in practice.
- Information about how to make a complaint was made readily available to patients. This was available in the waiting area.
- Staff had undergone dispute resolution training.
- The duty of candour had been applied in the management of incidents and the service manager informed us that this would be applied in the management of complaints.
- The provider would have oversite of complaints and how these were managed through the governance processes.
- Complaints was a standing agenda item on governance meetings.

Good

Are services well-led?

We rated well-led as Good because:

Leadership capacity and capability

Leaders had the capacity and skills to deliver good quality care.

- Staff told us that leaders were visible and approachable. They worked closely with staff and provided regular opportunities for meetings, discussion and development.
- Leaders were knowledgeable about issues relating to the range of services provided.
- A business development strategy was in place with a vision for expansion of the services provided.

Vision and strategy

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

- The provider had a clear vision for the service.
- Staff felt included in discussing and shaping the vision and strategy and understood their role in achieving this.

Culture

The service had a culture of providing good quality sustainable care.

- Staff told us they felt well supported and valued and that they were happy to work in the service.
- Staff told us they could raise concerns and were encouraged to do so. They had confidence that these would be addressed.
- Openness, honesty and transparency were demonstrated when responding to incidents.
- The provider was aware of and had systems to ensure compliance with the requirements of the duty of candour.
- Leaders and staff demonstrated a patient centred focus to their work during our discussions with them.

Governance arrangements

There were clear responsibilities, roles and systems of accountability.

- Structures, processes and systems to support governance and management were set out.
- Leaders had established policies, procedures and activities to ensure safety and assure themselves that they were operating as intended.
- There was a schedule of quality assurance checks and audits.
- There were clear roles and responsibilities and lines of accountability.
- Clinical staff used evidence based guidance in the treatment of patients.
- The provider carried out a range of risk assessments and put in plans to mitigate or control identified risks. Risk assessments were reviewed on a regular basis.

Managing risks, issues and performance

There were processes for managing risks, issues and performance.

- There were effective processes to identify, understand, monitor and address current and future risks including risks to patient safety.
- The provider had oversight of safety alerts, incidents, and complaints.

Good

Are services well-led?

- A business continuity plan was in place.

Appropriate and accurate information

The service acted on appropriate and accurate information.

- Staff were aware of requirements to submit data or notifications to external organisations as required.
- There were arrangements in line with data security standards for the availability, integrity and confidentiality of patient records.
- The service used performance information and feedback to monitor the quality of the service provided and to make improvements.

Engagement with patients, the public, staff and external partners

The service involved patients and staff views to develop and improve the service.

- The service encouraged feedback from patients and staff and acted on this.
- Staff attended regular governance meetings.
- A system of annual appraisal was in place where staff could discuss their learning and development needs.
- Staff had access to policies, procedures and information to support them in their role through a shared drive.

Continuous improvement and innovation

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

- There was a focus on learning and improvement.
- The service made use of internal and external reviews of incidents, complaints and safety alerts. Learning from these was shared and used to make improvements.
- Staff were involved in discussions about how to develop the service and encouraged to provide feedback about the service through regular staff meetings.