Rostra Healthcare Ltd

The Rostra Clinic

Inspection report

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Date of inspection visit: 19 May 2023
Date of publication: 03/10/2023

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

Ratings

Overall rating for this location	Requires Improvement
Are services safe?	Requires Improvement
Are services effective?	Good
Are services caring?	Good
Are services responsive to people's needs?	Good
Are services well-led?	Requires Improvement

Summary of findings

Overall summary

We rated this location requires improvement because:

- Staff completed and updated risk assessments for each service user. However, baseline observations were not routinely monitored to identify potential deterioration.
- The service level agreement (SLA) with the referring National Health Service (NHS) Trust had not been reviewed to demonstrate robust governance agreement and oversight of the service.
- The service did not operate effective governance processes. For example, audit practice was not always undertaken to review potential trends and create improvement opportunities.
- Policies had not consistently been revised to reflect guidance changes and polices were not always version controlled.
- The service did not instigate regular clinical governance meetings with the referring NHS trust to evidence robust oversight of both parties.
- Local rules for the safe use of the diode laser had not been reviewed and updated.

However:

- The service had enough staff to care for service users and keep them safe. Staff had training in key skills, understood how to protect service users from abuse, and managed safety well. The service-controlled infection risk well. Staff kept good care records. They managed medicines well. The service managed safety incidents well and learned lessons from them.
- Staff provided good care and treatment and gave service users pain relief when they needed it. Managers monitored the effectiveness of the service and made sure staff were competent. Staff worked well together for the benefit of service users, advised them on how to lead healthier lives, supported them to make decisions about their care, and had access to good information.
- Staff treated service users with compassion and kindness, respected their privacy and dignity, took account of their individual needs, and helped them understand their conditions. They provided emotional support to service users, families and carers.
- The service planned care to meet the needs of local people, took account of service users individual needs, and made it easy for people to give feedback. People could access the service when they needed it and did not have to wait too long for treatment.

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Surgery	Requires Improvement 	We rated this location requires improvement because: • Staff completed and updated risk assessments for each service user. However, baseline observations were not routinely monitored to identify potential deterioration. • The service level agreement (SLA) with the referring National Health Service (NHS) Trust had not been reviewed to demonstrate robust governance agreement and oversight of the service. • The service did not operate effective governance processes. For example, audit practice was not always undertaken to review potential trends and create improvement opportunities. • Policies had not consistently been revised to reflect guidance changes and polices were not always version controlled. • The service did not instigate regular clinical governance meetings with the referring NHS trust to evidence robust oversight of both parties. • Local rules for the safe use of the diode laser had not been reviewed and updated. However: • The service had enough staff to care for service users and keep them safe. Staff had training in key skills, understood how to protect service users from abuse, and managed safety well. The service-controlled infection risk well. Staff kept good care records. They managed medicines well. The service managed safety incidents well and learned lessons from them. • Staff provided good care and treatment and gave service users pain relief when they needed it. Managers monitored the effectiveness of the service and made sure staff were competent. Staff worked well together for the benefit of

Summary of findings

service users, advised them on how to lead healthier lives, supported them to make decisions about their care, and had access to good information.

- Staff treated service users with compassion and kindness, respected their privacy and dignity, took account of their individual needs, and helped them understand their conditions. They provided emotional support to service users, families and carers.
- The service planned care to meet the needs of local people, took account of service users individual needs, and made it easy for people to give feedback. People could access the service when they needed it and did not have to wait too long for treatment.

Summary of findings

Contents

Summary of this inspection

Background to The Rostra Clinic

The Rostra clinic is a subsidiary of Rostra Healthcare Limited, a healthcare company focussed on the provision of the highest quality of care within different areas of health and beauty.

Rostra Healthcare Limited has been established to provide an efficient and effective solution to National Health Service patients for the treatment of symptomatic varicose veins.

The clinic is part of the Laserveins national network of varicose vein clinics working with the specialist company Rostra Healthcare Ltd. The service we inspected was based in Sunderland providing specialist advice, diagnosis, treatment and aftercare to enable service users to make an informed choice about the best way to treat varicose veins.

The provider has a service level agreement with the local National Health Service (NHS) Trust. Service users are referred to the clinic following consultation with consultant vascular surgeons for venous surgery under local anaesthetic. Private service users can self-refer; however, these would not be treated at the Sunderland clinic.

Rostra Healthcare Ltd and the national network of surgeons in laserveins.org are experienced in all aspects of varicose vein assessment and treatments.

The Rostra clinic (Sunderland) is an independent provider registered to provide the following regulated activities:

• Treatment of disease, disorder or injury,

• Surgical procedures,

• Diagnostic and screening procedures,

Procedures are day case only undertaken under local anaesthetic.

For the period April 2022 to March 2023 (NHS service users)

Diagnostic ultrasound scan: 345

Endovenous laser ablation (EVLA): 394

Ultrasound guided foam sclerotherapy (UGFS): 132

Follow up (including scan): 84

We have not previously inspected The Rostra Clinic

Summary of this inspection

How we carried out this inspection

The team that inspected the service comprised of a CQC lead inspector, an assistant inspector and an offsite CQC inspection manager. This inspection was overseen by Sarah Dronsfield, Deputy Director of Operations.

This inspection was a short notice announced inspection, staff knew we were coming to observe routine activity.

We spoke with the registered manager who was trained to undertake the differing procedures at the clinic. The service also employed a team of healthcare assistants.

They all participated in the service delivery of the regulated activity and are referenced as staff throughout the report.

We spoke with 8 service users who had used the service and reviewed feedback they had provided on the day of inspection.

We observed the team undertaking an endovenous laser ablation procedure and ultrasound scans.

We reviewed a range of policies, procedures and other documents relating to the running of the service including consent and scan reports.

You can find information about how we carry out our inspections on our website: https://www.cqc.org.uk/what-we-do/how-we-do-our-job/what-we-do-inspection.

Areas for improvement

Action the service MUST take is necessary to comply with its legal obligations. Action a service SHOULD take is because it was not doing something required by a regulation, but it would be disproportionate to find a breach of the regulation overall, to prevent it failing to comply with legal requirements in future, or to improve services.

Action the service MUST take to improve:

- The service must ensure care and treatment is provided in a safe way for service users, including assessing the risks to the health and safety of service users receiving the care or treatment including but not limited to ensuring baseline observations are monitored. (Regulation 12 (1)(a)(b)).
- The service must assess, monitor and improve the quality and safety of the services provided in the carrying on of the regulated activities. Including but not limited to ensuring the service instigate a robust audit process. (Regulation 17(2)(a).
- The service must ensure systems and processes are established and operated effectively to ensure compliance. Including but not limited to ensuring robust governance processes are in place with the referring NHS trust, all policies are updated, version controlled, and the services service level agreement (SLA) is updated and signed by both parties. (Regulation 17(2)(a).

Action the service SHOULD take to improve:

- The service should ensure the local rules for the safe use of the diode laser are reviewed and updated.

Our findings

Overview of ratings

Our ratings for this location are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Surgery	Requires Improvement	Good	Good	Good	Requires Improvement	Requires Improvement
Overall	Requires Improvement	Good	Good	Good	Requires Improvement	Requires Improvement

Requires Improvement

Surgery

Safe	Requires Improvement
Effective	Good
Caring	Good
Responsive	Good
Well-led	Requires Improvement

Is the service safe?

Requires Improvement

Our rating of safe. We rated it as requires improvement.

Mandatory training

The service provided mandatory training in key skills to all staff and made sure everyone completed it.

Nursing staff received and kept up to date with their mandatory training. Staff were 100% compliant with all mandatory courses and reviewed certificates to evidence this.

The mandatory training was comprehensive and met the needs of service users and staff. Staff attend mandatory training modules provided by an external company. Staff told us they had recently attended a course on sepsis and manual handling.

Clinical staff completed training on recognising and responding to service users with mental health needs, learning disabilities, autism and dementia.

Managers monitored mandatory training and alerted staff when they needed to update their training. The service monitored staff compliance by accessing individual staff certificates of attendance on line.

Safeguarding

Staff understood how to protect service users from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it.

Staff received training specific for their role on how to recognise and report abuse. Mandatory safeguarding training requirements for staff groups were described in the safeguarding policy. The registered manager had recently completed level 3 safeguarding training via an on-line course in line with intercollegiate guidance for adult safeguarding (2018). Safeguard training was 100% compliant.

There was an adult and children safeguarding policy; however, this was dated October 2013 with a review date of July 2020. The policy included a referral form with information on how to escalate locally with the local safeguarding authority.

Requires Improvement

Surgery

Staff could give examples of how to protect service users from harassment and discrimination, including those with protected characteristics under the Equality Act.

Staff knew how to identify adults and children at risk of, or suffering, significant harm and worked with other agencies to protect them.

All staff knew how to make a safeguarding referral and who to inform if they had concerns. The service had a safeguarding folder with local safeguarding authority contacts for escalation.

Cleanliness, infection control and hygiene

Staff used equipment and control measures to protect service users, themselves and others from infection.

The service had recently commenced hand hygiene audits to identify trends and themes surrounding non-compliance. Compliance was 100% and we evidenced good hand hygiene during the inspection visit.

Clinical areas were clean and had suitable furnishings which were clean and well-maintained.

Staff used records to identify how well the service prevented infections. Staff completed a daily task cleaning record and a monthly infection control cleaning checklist which we saw evidence of during inspection. The checklist included checks of general environment, toilet areas, sharps bins, clinical treatment rooms and management of laundry. However, this was not audited to identify themes or trends surrounding compliance.

Staff followed infection control principles including the use of personal protective equipment (PPE).

Staff cleaned equipment after service user contact and labelled equipment to show when it was last cleaned.

Staff worked to prevent, identify and treat surgical site infections. The provider had reported 1 infection following treatment of 22,000 service users. Staff told us infections would be reviewed by the referring vascular surgeon and the infection treated and managed by the NHS trust in line with process. Staff told us the procedure was minimally invasive, with strict adherence to infection control procedures.

Environment and equipment

The design, maintenance and use of facilities, premises and equipment kept people safe. Staff were trained to use them. Staff managed clinical waste well.

Service users could reach call bells and staff responded quickly when called. We observed staff assisting service users during inspection and feedback was positive.

The design of the environment followed national guidance.

Staff carried out daily safety checks of specialist equipment. The service used an external agency to complete portable appliance testing. All equipment had been reviewed and was managed annually. We saw evidence of the most recent inspection report which had been undertaken February 2023.

The service used a class 4 diode laser, there was appropriate health and safety signage on the treatment door. The clinic had a local safety laser rules policy (May 2023 v3) for all staff to adhere to. Protective eye wear was used by all staff and staff explained the importance of wearing these during the procedure to service users.

Requires Improvement

Surgery

We observed an annual test report dated March 2023 to evidence service of the biolitec laser used by the service.

The service had suitable facilities to meet the needs of service user and their families. The clinic was situated on the ground floor with wheelchair access.

The service had enough suitable equipment to help them to safely care for service users.

Staff disposed of clinical waste safely. Staff informed us clinical waste was collected by an external provider. Clinical waste was stored in yellow waste bins and transferred to a locked compound outside the facility which was collected by an external provider.

Assessing and responding to service user risk

Staff completed and updated risk assessments for each service user. However, service user baseline observations were not routinely monitored to identify potential deterioration. The service made sure service users knew who to contact to discuss complications or concerns.

Vital baseline observations such as blood pressure, pulse and oxygen saturation rates were not recorded before, during or after the procedure. However, staff were aware of signs to observe surrounding potential deterioration for example: nausea, fainting and blood loss. Staff told us these types of complications would be quickly reviewed and actioned. The service had equipment available to monitor service user baseline observations; however, this was not routinely used. Whilst the service had a deteriorating patient and resuscitation policy (May 2023 V4); this did not include the need to routinely assess and monitor service users baseline observations.

This meant there was limited assurance that all risks to the health and safety of service users were suitably and sufficiently assessed to reduce the risk of possible deterioration.

Staff completed risk assessments for each service user on admission / arrival and reviewed this regularly, including after any incident. All service users seen by The Rostra clinic are existing service users of the partner National health Service (NHS) Trust, initially referred to the relevant consultant from primary care services. All general practitioner (GP) referrals are seen by a trust consultant prior to any input from the service. The primary and on-going requirements regarding the service user pathway were managed wholly by the consultant to whom the referral was made. Staff told us service users were risk assessed during their pathway and needed to be low risk to be suitable for treatment at the clinic. Service users deemed as high risk were listed with the referring NHS trust.

Staff knew about and dealt with any specific risk issues.

Safe surgery checks were completed prior to commencing surgery, by checking service user name, skin marking, date of birth, consent to treatment, allergies and surgical procedure to be undertaken.

Venous thromboembolism stockings were measured and fitted post procedure. Service users received a post operative booklet explaining potential risks and aftercare. Service users were encouraged to walk prior to returning home. The booklet included out of hours emergency contact numbers.

Staff shared key information to keep service users safe when handing over their care to others.

Requires Improvement

Surgery

Staffing

The service had enough support staff with the right qualifications, skills, training and experience to keep service users safe from avoidable harm and to provide the right care and treatment.

The service had enough support staff to keep service users safe. The clinic employed 3 healthcare assistants who covered all onsite clinics. The registered manager was a registered nurse, who was competent to undertake the differing procedures on offer at the service.

We reviewed staff recruitment files which evidenced references and training certificates. We saw evidence of disclosure and barring service (DBS) applications.

Procedure lists were managed by the registered manager. Some clinics were undertaken by consultant vascular surgeons from the referring trust.

Records

Staff kept detailed records of service user's care and treatment. Records were clear, up to date, stored securely and easily available to all staff providing care.

The service had an up-to-date data protection policy which described management, privacy, retention period and storage in line with national guidance.

Service user notes were comprehensive, and all staff could access them easily.

Records were stored securely. The service used the referring NHS trusts electronic system to access individual service user medical case notes. Surgical treatment consent forms post operatively were stored in a locked cabinet onsite and collected weekly by the referring trust. The trust would then scan the consent record onto the electronic system for audit purposes. Procedures were documented in real time on the electronic system by healthcare staff. All staff had access to the electronic record system.

We reviewed 5 sets of records and saw record completion on the day of inspection by clinic staff.

Record keeping audits were not undertaken. There was no planned audit schedule in place. Staff were aware of processes and systems; however, audit review of record keeping was not undertaken to review potential trends and create improvement opportunities.

Medicines

The service used systems and processes to safely store, administer and record medicines. However, medicine stock levels were not routinely recorded or audited.

Staff followed systems and processes to administer medicines safely. Service users were pre assessed by a consultant vascular surgeon at the referring NHS trust. Service users requiring deep vein thrombosis (DVT) prophylaxis pre surgical intervention were referred to their local general practitioner for prophylaxis treatment. This information was recorded and sent to the clinic for awareness. Pre surgical treatment service user pre assessments and clinic letters were routinely checked to clarify referring consultant assessment and potential risk.

During inspection we observed staff document in service user records details of medicines used for their treatment.

Requires Improvement

Surgery

Staff did not complete periodic medicine audits. There was no planned audit schedule in place. Staff were aware of processes and systems; however, audit review of medicine management was not undertaken to review potential trends and create improvement opportunities.

Staff reviewed each service user's medicines and provided advice to service users and carers about their medicines.

Staff stored and managed all medicines safely. Medicines stored onsite were limited to local anaesthesia and saline solutions. These were stored securely, and stocks checked weekly. The provider replenished stock according to planned procedures.

Incidents

The service managed service user safety incidents well. Staff recognised and reported incidents and near misses. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave service users honest information and suitable support.

Staff knew what incidents to report and how to report them.

Staff raised concerns and reported incidents and near misses in line with the service's policy. The service had an incident reporting policy; however, this had not been reviewed since 2019.

Staff recorded incident details in an accident book, we noted there had been no recent incidents recorded. Staff told us all incidents were reported to the referring consultant surgeon at the NHS trust where trust policy was followed.

The service had reported no never events.

Staff understood the duty of candour. They were open and transparent and gave service users and families a full explanation if and when things went wrong.

Is the service effective?

Good

Our rating of effective. We rated it as good.

Evidence-based care and treatment

The service provided care and treatment based on national guidance and evidence-based practice. However, not all policies had been reviewed, some policies were out of date and were not version controlled.

Staff did not always follow up-to-date policies to plan and deliver high quality care. Most policies we reviewed were out of date and were not version controlled.

This meant we had concerns staff may not always be aware of significant changes in legislation, guidance and evidence-based practice. At the time of writing this report the provider gave assurance that clinic policies accurately reflected national guidelines for the treatments provided.

The registered manager was aware that policies required review and work was ongoing to address this.

However, the registered manager told us staff had access to the trusts intranet allowing access to trust local policies and procedures. All staff had access to the trusts intranet site and knew how to access this. Any query with regards to trust policy could be directed to the appropriate individual within the trust. For example, a service user may request a delay in treatment. This could be checked and verified to ensure adherence to trust policy. A service user had recently required VTE prophylaxis, and a request had been made to the consultant regards current local policy regards choice of method/ medication.

Pain relief

Staff assessed and monitored service users regularly to see if they were in pain.

Service users we talked to told us pain relief options were discussed before, during and after the procedure.

Staff prescribed, administered and recorded pain relief accurately.

Service user outcomes

Staff monitored the effectiveness of care and treatment. They used the findings to make improvements and achieve good outcomes for service users. However, audit practice was limited and not embedded.

We saw evidence to support review of service user outcomes. Staff told us routine follow up and audit of service user outcomes was no longer considered a necessity for this type of procedure. A paper was presented at the vascular society annual general meeting several years ago clearly demonstrating that outcomes following venous intervention was so predictable that routine follow up was unnecessary.

The service provided evidence of completed audits to demonstrate service user outcomes. A telephone follow up of service users treated beyond 5 years had been undertaken and was awaiting review & analysis. Additionally, data had been collected to investigate the outcomes of different service users body mass index (BMI) measurements. The referring NHS trust had agreed to review both pieces of work; however, due to the current lack of junior medics available to complete this review and analysis results were unavailable.

The service had adopted a model of service user initiative based follow up in excess of 90% of service users. Service users were routinely followed up by their local general practitioner within 3 to 6 months following the procedure. Complications at that stage were routinely referred back to the referring trust.

The service reported clinical outcomes to individual referring consultant vascular surgeons and the clinical management team. This evidenced procedure undertaken, discharge and follow up if required. The service could refer individual service users for comprehensive consultant follow up if and when required.

The service had taken part in an audit to review adjuvant therapy following EVLA for varicose veins with two local NHS trusts. The study supported the contention that EVLA is a robust and effective way of treating varicose veins with over 90% of treated service users requiring no further treatment.

Audits on medicines, environmental cleaning and record keeping were not routinely undertaken.

Requires Improvement

Surgery

There was no planned audit schedule in place. The service had recently commenced hand hygiene audits to identify trends and themes surrounding non-compliance. Compliance was 100% and we evidenced good hand hygiene during the inspection visit.

Staff were aware of processes and systems however, assessment was not always undertaken to review potential trends and create improvement opportunities.

This meant we had concern's that practice was not continuously assessed and monitored to, improve governance surrounding safe effective care.

The registered manager was aware that audit practice was not in line with clinic policy and work was ongoing to address this.

Competent staff

The service made sure staff were competent for their roles. Managers appraised staff's work performance continuously to provide support and development.

Staff were experienced, qualified and had the right skills and knowledge to meet the needs of service users.

The services clinical governance strategy (version 2019, version 1) policy stated the line manager should complete a comprehensive performance appraisal and development plan for all responsible staff as an integral part of the appraisal system. Staff should also have individual performance reviewed through appraisal systems and one to one meetings with their line manager.

The registered manager told us that staff received continuous 360-degree appraisal of their performance. The clinical team consisted of 4 healthcare staff including the registered manager. Staff appraisals were not routinely completed annually. If staff required additional support or training, then this would be planned and actioned.

Following inspection, the registered manager drafted an appraisal schedule and recording log. The appraisal process currently in place would continue but would be augmented by a formal, documented annual discussion using the staff appraisal form.

Multidisciplinary working

Staff worked together as a team to benefit service users. They supported each other to provide good care.

Staff spoke positively of team working, effective communication and peer support.

Seven-day services

Services were available to support timely and flexible care.

The service operated 2 days a week on Thursdays and Fridays. Service users were offered differing appointment choices on both days to suit their needs.

Health promotion

Staff gave service users practical support and advice to lead healthier lives.

Requires Improvement

Surgery

We observed health information displayed in the waiting area. For example, posters that promoted hand hygiene awareness.

In addition, we saw staff give advice on the benefits of exercise post operatively.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

Staff supported service users to make informed decisions about their care and treatment. They followed national guidance and ensured that service users gave consent in a two-stage process with a cooling off period of at least 14 days between stages. They understood how to support service users.

Staff understood how and when to assess whether a service user had the capacity to make decisions about their care.

Staff gained consent from service users for their care and treatment in line with legislation and guidance. Staff made sure service users consented to treatment based on all the information available.

The consent process commenced when service users were seen and assessed by the trust consultant and then re-affirmed when reviewed following a diagnostic ultrasound scan at the service. Consent is documented by the consultant in the letter to the GP and service user.

Staff were able to verbally describe how they would obtain consent from service users. First stage consent was discussed with the service user at the initial consultation with the vascular consultant. Second stage consent was discussed and signed at the clinic.

The service had an informed consent policy which was in date and version controlled (March 2023, V3). On the day of treatment, second stage consent is undertaken and consent to proceed is signed and dated.

Staff clearly recorded consent in service user records.

Is the service caring?

Good

Compassionate care

People were truly respected and valued as individuals. Feedback from people who had used the service and those who were close to them was continually positive about the way staff treat people. People thought that staff went the extra mile and the care they received exceeded their expectations. Staff were highly motivated and inspired to offer care that was kind and promoted people's dignity.

Staff were discreet and responsive when caring for service users. Staff took time to interact with service **users** and those close to them in a respectful and considerate way.

Staff showed an awareness of the importance of maintaining service user privacy and dignity. For example, staff told us they ensured that service users were covered with privacy sheets wherever possible during procedures. The clinic has two private changing areas where service users are asked to change into and out of gowns pre and post procedure. Both rooms led directly into the treatment room meaning service users privacy & dignity was maintained.

Requires Improvement

Surgery

Service users said staff treated them well and with kindness. We observed a surgical procedure and scans during the inspection where we saw staff interact with service users. Staff were professional and demonstrated compassion at all times.

Staff emphasised the need for talking with service users and relatives politely and using jargon free language.

Staff followed policy to keep service user care and treatment confidential.

Staff understood and respected the individual needs of each service user and showed understanding and a non-judgmental attitude.

Emotional support

Peoples emotional and social needs were highly valued by staff and were embedded in their care and treatment. Staff provided emotional support to service users, families, and carers to minimise their distress.

Staff gave service users and those close to them help, emotional support and advice when they needed it. We observed staff offering support and advice which included information regarding driving and recommended exercises post procedure.

Staff supported service users who became distressed in an open environment and helped them maintain their privacy and dignity. During inspection we observed staff offering support to service users who were anxious. Staff and service user interaction was consistent throughout the service user journey. Service users who expressed anxiety at pre assessment were offered earlier appointments on the day of treatment. We saw staff engage with service users offering support and advice.

Staff understood the emotional and social impact that a person's care, treatment or condition had on their wellbeing and on those close to them. Feedback from service users was extremely positive, feedback indicated that staff responded in a compassionate and supportive manner.

Understanding and involvement of service users and those close to them

People who use services were active partners in their care. Staff were fully committed to working in partnership with people. Staff always empowered people who use the service to have a voice and to realise their potential.

Staff made sure service users and those close to them understood their care and treatment.

Staff talked with service users, families and carers in a way they could understand, using communication aids where necessary. Staff told us the provider offered a translation service and information in differing languages.

Service users and their families could give feedback on the service and their treatment and staff supported them to do this. The service used a standard, voluntary, service user feedback questionnaire which was made available to all service users who attended the clinic. This feedback was regularly logged and monitored.

During inspection we asked service users using the service to complete a brief questionnaire regarding care they received. We received 8 responses, all of which were positive. Service users said, "questions were answered professionally by staff", "staff were professional and explained everything in detail".

Requires Improvement

Surgery

The provider website was informative offering service user's information regarding the service and useful links to external sites such as the vascular society and best practice guidance enabling service users to make informed treatment choices.

Is the service responsive?

Good

Our rating of responsive. We rated it as good.

Meeting people's individual needs

The service planned and provided care in a way that met the needs of local people and the communities served.

Facilities and premises were appropriate for the services being delivered.

The service was located near the A19 on a bus route and there was a public car parking available.

The opening times were as flexible as possible to meet the needs of service users.

Staff ensured that service users who did not attend appointments were contacted to understand why they didn't come and offered the opportunity to rebook.

Managers and staff made sure service users, loved ones and carers could get help from interpreters or signers when needed. On the day of inspection, a service user was assisted by an interpreter. This had been organised by the service following pre assessment at the NHS trust.

Service users were provided with post-discharge care information, which included clinic contact details for post-operative advice and specific instructions about their care.

Access and flow

People could access the service when they needed it and received the right care.

Managers monitored waiting times and made sure service users could access services when needed and received treatment within agreed timeframes and national targets. When a treatment decision was made by a trust consultant the service users was added to the appropriate waiting list by the medical secretary. The waiting list specific to the Rostra clinic for referred service users was monitored by the clinic. Clinical sessions are allocated to trust consultants, service users on the waiting list are then scheduled onto an available session.

Once a session was appointed from the waiting list, this schedule was communicated to the trust medical secretary and waiting list team to generate and forward the invite letters to the service users.

On the day of treatment, the service user episode was recorded on the trusts electronic system and email communication to confirm procedure and outcomes is made to all relevant and necessary individuals.

The outcome was then actioned by the responsible individual. For example, if further treatment was required, follow up by the clinic, follow up by trust consultant team or discharge to the service users initiated follow up.

Any follow up requirement was then scheduled, and an invite letter sent to the service user at a suitable time. On the day of follow up the service user episode was recorded on the trusts electronic system and email communication to confirm outcomes were made to all relevant and necessary individuals.

Service users told us it was easy to schedule their appointment and that staff offered differing appointment times and options.

The clinic was open two days a week for assessment scans and surgical intervention.

Learning from complaints and concerns

It was easy for people to give feedback and raise concerns about care received. The service treated concerns and complaints seriously, investigated them and shared lessons learned with all staff. The service included service users in the investigation of their complaint.

Service users, relatives and carers knew how to complain or raise concerns.

The service clearly displayed information about how to raise a concern in waiting areas.

Staff understood the policy on complaints and knew how to handle them.

Managers investigated complaints and identified themes.

Staff knew how to acknowledge complaints and service users received feedback from managers after the investigation into their complaint. There was a complaint management policy in place. Staff stated they would aim to resolve any service user complaints and concerns immediately. Staff were aware of the complaints procedure and who had overall responsibility for managing the complaints process.

Managers shared feedback from complaints with staff and learning was used to improve the service.

Staff could give examples of how they used service user feedback to improve daily practice.

Service user experience response rates were generally low although questionnaires were available for service users to feedback. The provider records and reviews these to assess improvement actions required. The provider gave an example of changes made to service user information as a response to feedback. For example, the service revised the clinic directions. The service also made available local bus service schedules for service user using public transport and had amended signage with highly visible markings.

Is the service well-led?

Requires Improvement

Our rating of well-led. We rated it as requires improvement

Leadership

Requires Improvement

Surgery

Leaders had the skills and abilities to run the service, however, they did not fully understand and manage the priorities and issues the service faced. They were visible and approachable in the service for staff.

The registered manager held overall responsibility for the leadership of the service at site level with support from the operations director and a medical director. However, they had not identified, prioritised and managed all the risks associated with the lack of effective governance processes throughout the service.

The provider met the Fit and Proper Persons Requirement (FPPR) (Regulation 5 of the Health and Social Care Act (Regulated Activities) Regulations 2014). This regulation ensures that directors are fit and proper to carry out this important role.

Staff we spoke with told us they felt confident to discuss any concerns with their manager.

Vision and Strategy

The service had a mission statement and strategy to turn what they wanted to achieve into action.

The service displayed the Rostra Healthcare franchise values on the website of being effective, efficient, caring and accountable. We reviewed the mission statement which outlined the different ways the service cared for service users and visitors and their related policies.

Culture

Staff felt respected, supported and valued. They were focused on the needs of service users receiving care. The service promoted equality and diversity in daily work. The service had an open culture where service users, their families and staff could raise concerns without fear.

Staff told us they felt supported by the organisation and specifically the registered manager. Staff told us that the manager promoted an open culture and they felt able to speak up and raise incidents and be able to encourage service users and their families to do the same.

Staff told us that the organisation promoted equality and diversity. Staff equality and diversity training was 100% compliant. All staff told us it was a good place to work and were enthusiastic about the service they provided to service users.

Governance

The service did not fully operate effective governance processes, throughout the service and with partner organisations. However, staff were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service.

The registered manager told us the SLA with the referring NHS trust had not been revised since February 2022. We requested to see a copy of the SLA; this was provided; however, the copy was not signed or dated.

The service did not instigate clinical governance meetings with the referring NHS trust. This was clarified by the registered manager following inspection.

This meant we were not assured of the oversight of both parties of monitoring of incidents, complications, risk management, etc.

Requires Improvement

Surgery

The service did not always operate effective governance processes. The clinical governance strategy (2019, version 1) stated that the services minimum audit standards should include: staff appraisal, clinical outcome, adverse incidents, complaints and service user satisfaction. The service did not adhere to the governance strategy in terms of audit practice.

For example, audit activities were not always routinely undertaken. Audit activity was not fully embedded. Audits on medicines, monthly cleaning, staff appraisal and record keeping were not undertaken. Staff were aware of processes and systems; however, assessment was not always undertaken to review potential trends and create improvement opportunities.

The service had recently commenced hand hygiene audits. We requested to see a copy of the audit actions to evidence assessment and improvement actions; however, this was not provided at the time of writing this report. The service did not have a planned audit schedule in place.

This meant we had concern's that practice was not continuously assessed and monitored to improve governance surrounding safe effective care.

Staff did not always follow up-to-date policies to plan and deliver high quality care according to best practice and national guidance. The provider had not revised all clinic policies to reflect guidance changes, policy review and not all policies were version controlled. Whilst the service had a deteriorating patient and resuscitation policy; this did not include the need to routinely assess and monitor service users baseline observations.

This meant we had concerns staff may not always be aware of significant changes in legislation, guidance, evidence-based practice and potential service user deterioration during procedures.

The service used a diode laser (class 4). The laser was purchased when the service opened and serviced annually. The laser was last serviced March 2023; we saw evidence to support this. The service provided evidence to support the use of a pre laser activation check list protocol. The document accompanied the local laser usage rules. The check list included a seven-point check that staff were expected to complete whilst the diode laser was in standby mode.

The clinic had a local laser safety policy (May 2023 v3) for all staff to adhere to. The last formal review of the local laser rules by a laser protection advisor (LPA) was undertaken in 2015. Review and update of this was requested by the service in March 2023. We did not see evidence of this review at the time of writing this report.

We saw evidence of consultant practising privileges provided to us following inspection.

We reviewed the most recent board papers dated April 2023. Clinical governance, clinic activity, complications, complaints, audit and risk management were discussed and minuted.

Management of risk, issues and performance

Leaders and teams identified and escalated most relevant risks and issues and identified actions to reduce their impact. They had plans to cope with unexpected events.

The service had insurance covering both public and employer liability. The insurance certificate was in date up to March 2024.

The service had a business continuity policy which outlined procedures for staff to follow in the event of equipment failure, building closure or short notice staff absence.

Requires Improvement

Surgery

Following inspection, the service provided a copy of an up-to-date risk register. This included hazards, existing controls, action required and review date.

Information Management

The service collected reliable data and analysed it. Staff could find the data they needed, in easily accessible formats, to understand performance, make decisions and improvements. The information systems were integrated and secure. Data or notifications were consistently submitted to external organisations as required.

Information management was a mandatory training module for all staff and compliance was 100% at the time of our visit. We observed electronic computer systems were password protected. Service user information was transferred via secure electronic systems. Staff informed us about how and who would submit data, alerts or notifications and could demonstrate secure access to these systems. Staff demonstrated they could locate, and access relevant information and service users records easily, which enabled them to carry out their day-to-day roles. The service stored data safely.

The service had a privacy policy. Service user information was managed in line with data protection guidelines and legislation (GDPR).

The service had a data protection policy, which referred to requirements under General Data Protection Regulation (GDPR) 2018.

Staff reported they had sufficient numbers of computers, printers, and laptop devices.

Information on the website was clear about the services provided. Information included advice and assessment about surgery or laser treatments, this enabled service users to have information to help them make the right decisions about the treatment options available.

Engagement

The registered manager actively and openly engaged with staff and service users to plan and manage services.

The service engaged well with service users and staff, to plan and manage services.

The service's website provided a wide range of information about the services offered.

The registered manager was accessible which provided service users and visitors with the opportunity to express their views and opinions face to face.

Staff we spoke with told us their manager engaged with them. They felt their manager was supportive and encouraged them to voice their opinions and speak up if they had any concerns. They told us they felt appreciated by their colleagues.

The provider monitored feedback from service users via feedback forms.

Learning, continuous improvement and innovation

All staff were committed to continually learning. The service had clear plans for learning, continuous improvement and innovation.

Requires Improvement

Surgery

The service had a significant focus on recovering from the negative impact of the COVID-19 pandemic which impacted on innovative practice. The service has recently been informed by the trust that they are to be a local training facility for the trust to enhance the experience of junior medical staff.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Surgical procedures	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment The service did not ensure care and treatment is provided in a safe way for service users, including assessing the risks to the health and safety of service users receiving the care or treatment including but not limited to ensuring baseline observations are monitored.

Regulated activity	Regulation
Surgical procedures	Regulation 17 HSCA (RA) Regulations 2014 Good governance The service did not assess, monitor and improve the quality and safety of the services provided in the carrying on of the regulated activities. Including but not limited to ensuring the service instigate a robust audit process. The service did not ensure systems and processes are established and operated effectively to ensure compliance. Including but not limited to ensuring robust governance processes are in place with the referring NHS trust, all policies are updated, version controlled, and the services service level agreement (SLA) is updated and signed by both parties.