The Highgrove Clinic

Inspection report

Hambrook Court West
Bristol
BS16 1RY
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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. This is the locations first inspection since registering with CQC in October 2020

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 The Highgrove Clinic as part of our planned inspection programme.

The Highgrove Clinic is the registered location and the registered provider is The Highgrove Clinic Limited. The clinic provides services for privately funded patients who self-refer to the service.

This service is registered with CQC under the Health and Social Care Act 2008 in respect of some, but not all, of the services it provides. There are some exemptions from regulation by CQC which relate to particular types of regulated activities and services and these are set out in Schedule 1 and Schedule 2 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The Highgrove Clinic provides a range of non-surgical cosmetic interventions, for example wrinkle reduction injections by botulinum toxin injections (botox) and dermal filler treatments which are not within CQC scope of registration. Therefore, we did not inspect or report on these services. We only inspected elements of the service which fell under our scope of regulated activities, for example minor skin surgeries, hyperhidrosis and bruxism with botox, thread lifts and vasectomies.

The provider has one location at the address above in Bristol. The Highgrove Clinic has two company directors. Care and treatment at The Highgrove Clinic is managed by one of the directors who is the registered manager. We will refer to this person as the registered manager throughout this report. 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.

Vasectomies carried out under this registration and location were also advertised under a separate website known as Bristol Vasectomy Clinic.

The provider and registered manager is a Doctor registered with the General Medical Council and a member of Association of Surgeons in primary care and contributes towards worldwide learning. The other director is a registered dentist and member of the Royal College of Surgeons who works at the service to provide some of the regulated activities. The service also had an administrative member of staff.

Overall summary

The Highgrove Clinic is in the city of Bristol. There is parking made available at the location through gates which is accessible to those with disabilities also. Consultations were provided via an initial telephone call followed by a face to face consultation where required.

We reviewed feedback which had been collated by the service and that was submitted to us during a monitoring call in November 2022. We received 18 “Give feedback on care” forms in the last 12 months.

Our key findings were:

- Staff involved and treated patients with compassion, kindness, dignity and respect.
- The service organised and delivered services to meet patient’s needs. Patients were well informed about aspects of the service provided. The service welcomed feedback.
- There were clear responsibilities, roles and systems of accountability to support governance and management. There were systems for managing risk and issues, however further work was required to review, monitor and embed revised policies to meet the service’s needs.
- Clinical staff held appropriate qualifications and knowledge to provide quality patient care.

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

- Review and embed health and safety policies to meet the service’s needs and document appropriately.
- Consider the threshold for documentation of incidents including near misses in line with the service policy.

Dr Sean O’Kelly BSc MB ChB MSc DCH FRCA

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

Our inspection team

The inspection was led by a CQC inspector who had access to advice from a specialist advisor.

Background to The Highgrove Clinic

- The Highgrove Clinic is operated by The Highgrove Clinic Limited and is registered with CQC to provide the regulated activities: Diagnostic and screening procedures, Surgical procedures and Treatment of disease, disorder or injury from the registered location, The Highgrove Clinic, Hambrook Court West, Bristol, BS16 1RY.
- The Highgrove Clinic was first registered with CQC on 3 October 2020 and is registered to provide services to patients over the age of 18. Children are not treated at this service.
- This service run by 3 members of staff from a family building which has one clinic room which was adapted for these purposes. Patients enter through a hallway and appointments are booked in a way where patients would not need to wait.
- The opening hours are between 9am and 8pm and patients can contact the service via telephone. Patients are given a contact number for out of hours advice and support related to their treatment, which is available 24 hours a day, 7 days a week.
- The Highgrove Clinic provides some services at other locations, however the treatments offered are not in the scope of CQC registration, therefore they were not inspected or reported on during the inspection.
- The Highgrove Clinic provides services that are in scope for CQC regulated activities to approximately 240 patients per year.

How we inspected this service

Before the inspection, we asked the provider to send us information about the service. This information was reviewed and an interview was carried out with the registered manager prior to the site visit. We also reviewed information held by CQC on our internal systems.

During the inspection we spoke with the provider, reviewed documentation and records including clinical records. We also made observations of the premises and facilities where the service was provided.

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:

- Although we found some areas where improvement could be made, the service had responded and were able to provide evidence that reduced the risk to patients. To remain proportionate to the size of the service we have rated the Safe domain as good and advised the provider should make steps to continue to improve the service. These are outlined under our key findings in the section above.

Safety systems and processes

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

- The provider conducted safety risk assessments. On the fire risk assessment there had been 1 remedial action identified which was to review if fixed installations required further testing. It was not clear whether this action had been completed. Leaders told us this was an example provided on the template used and was not appropriate to this service. This had not been made clear on the documentation. All other items on the risk assessment had been reviewed and had existing control measures in place.
- On the day of inspection, the service had a set of health and safety policies which had been reviewed annually. However, these policies were not always adapted for the service or the premises in which it was delivered from. For example, the service had a Fire safety policy which stated they were going to complete fire drills 4 times a year and fire alarm tests every week. The service operates out of one room in a residential property. The building had smoke detectors instead of fire alarms and had not recorded the testing of the smoke detectors or fire drill evacuations. We were therefore unable to be fully assured that oversight and monitoring of fire safety had been considered in order to keep staff and patients safe. We discussed this with the provider who subsequently post inspection provided an updated version of the Fire policy. This stated they will carry out fire evacuations annually, however we were not provided with evidence one had yet been carried out. The policy did not include testing of smoke detectors. The fire risk assessment completed by the registered manager identified the use of smoke detectors rather than fire alarms and had not actioned due to low occupancy levels.
- The service had systems to safeguard children and vulnerable adults from abuse. All staff had been trained to the appropriate level in line with the intercollegiate guidance. The registered manager was the safeguarding lead, who was trained to level 3. The service held a safeguarding policy which advised staff of where to escalate concerns and with other agencies to support patients and protect them from neglect and abuse.
- The service was run by two individual clinicians and a support staff member who were family members and as such did not hold recruitment folders. There was no risk assessment in place to evidence why they were not holding this information. However, we were provided details of membership to relevant professional bodies and that a Disclosure and Barring Service (DBS) check had been undertaken for all staff members. (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).
- The provider did not routinely hold vaccination history of staff in a system. On the day of the inspection, we were provided with evidence that one clinician had vaccination history in line with The Green Book guidance. Following the inspection, we were provided with evidence that staff had received immunity in line with guidance.
- There was an effective system to manage infection prevention and control. The service had a cleaning schedule and completed an audit in September 2022. This identified the service needed to actively record the monitoring of the cold chain. During the inspection, we saw staff has been completing fridge temperature logs daily. The clinic room appeared visibly clean.
- The service told us they had completed annual Legionella testing and were awaiting the results from the February 2022 sample. Post inspection, they provided evidence of the results showing the service continued to be negative for Legionella.

Good

Are services safe?

- The premises were clinically suitable for the assessment and treatment of patients. The provider ensured that facilities and equipment were safe and that equipment was maintained according to manufacturers' instructions. There were systems for safely managing healthcare waste.
- Both clinicians had annual appraisals with third parties where they could discuss their work for this service. The registered manager had also completed a 360-degree feedback which included self-reflection, patient feedback and colleague feedback. The non-clinical staff member had not received an appraisal. Following our inspection, we were sent evidence that this had been completed. They were also in regular communication with leaders and were able to raise concerns or learning needs in the absence of an appraisal.

Risks to patients

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

- The clinicians who worked at this service were company directors. The third member of staff had responsibility for greeting patients, answering the telephone and providing some informal counselling. The service did not employ any other staff members and did not intend on opening up recruitment.
- Staff understood their responsibilities to manage emergencies and to recognise those in need of urgent medical attention. The service told us they would only treat patients considered to be low risk for complications. Staff could recognise complications and be able to refer appropriately if needed.
- The service held emergency medicines and equipment. The service had reviewed the medicines held and risk assessed where they did not hold all the recommended medicines. The service had a defibrillator and some emergency medicines but did not have oxygen on site. The service had written on their risk assessment that they do not intend to see unwell or high-risk patients and that they felt holding oxygen on site increased the risk of fire. The service had also considered how they would seek support in the event oxygen was required.
- There were appropriate indemnity arrangements in place for both clinicians.
- The service had a service level agreement with a third-party organisation to ensure reusable instruments were sterilised as required.

Information to deliver safe care and treatment

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

- The clinicians managed individual care records separately depending on the treatment they were receiving. There were some paper patients records and some which were held on an online documentation system. Both systems were managed safely and were written to reflect the care and treatment received. Records were accessible to staff that required them.
- There were systems for sending and receiving test results provided by an external company, for example Semen analysis post vasectomy and pathology results from lump removal. The provider held appropriate documentation in agreement with this service and the results were returned to the provider in a secure way.
- The service did not contact the patient's General practitioner (GP), however patients who received a vasectomy were provided with a letter they could share with their GP if they wish.
- Staff had a process for receiving and responding to medical alerts.
- 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.
- Clinicians' decisions were in line with evidence-based guidance and had maintained knowledge by:
  - Attending and contributing to learning sessions and conferences for example. The World Vasectomy Day Summit where the use of a specific technique was shared.

Good

Are services safe?

- Members of the Royal college of Surgeons and Association of Surgeons in Primary Care.
- Maintenance of clinical knowledge through other clinical roles and professional responsibilities.

Safe and appropriate use of medicines

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

- The systems and arrangements for managing medicines, emergency medicines and equipment minimised risks. The service kept an active record of emergency medicines expiry date which was reviewed on a regular basis.
- The service does not prescribe Schedule 2 and 3 controlled drugs (medicines that have the highest level of control due to their risk of misuse and dependence). Neither did they prescribe schedule 4 or 5 controlled drugs.
- Staff prescribed, administered or supplied medicines to patients and gave advice on medicines in line with legal requirements and current national guidance. Processes were in place for checking medicines and staff kept accurate records of medicines.
- The service held medicines which required refrigeration and to be monitored. The service monitored the fridge temperatures daily and were able to tell us the processes they would follow should the fridge go out of range. Where there had been a concern over a medicines delivery, they had responded to this appropriately however, they had not documented this as an incident in line with their policy.

Track record on safety and incidents

The service had a good safety record.

- There were comprehensive risk assessments in relation to safety issues.
- The service monitored and reviewed activity. This helped it to understand risks and gave a clear, accurate and current picture that led to safety improvements.

Lessons learned and improvements made

The service learned and made improvements when things went wrong.

- There was a system for recording and responding to significant events and incidents. We found there was 1 example of a near miss incident which had been appropriately actioned in line with the service policy but not recorded. For example; a medicine that required to be refrigerated arrived at the premises outside of the delivery window and policy of the medicines provider. Due to concern over integrity, they contacted the medicines provider to seek assurances. They were then able to use the medicine without concern over its efficacy. We discussed this with the provider who told us they did not believe it met the threshold for reporting as it hadn't been considered for patient use until they were satisfied. All staff members were aware of the actions and response taken.
- We were told if there were concerns regarding clinical practice, these could be raised with external colleagues they had arrangements with.
- The service had completed clinical audits into vasectomy outcomes and the outcomes for patient receiving treatment for Bruxism (excessive grinding of the teeth). Both audits compared outcomes to other guidance or studies and had reflected on the outcome of the results. In comparison to guidance or studies, the results found at this service were reasonable or positive. Where the audit had reflected improvements could be made, this had been reflected on and considered to be due to low numbers of patients being treated at the clinic in comparison to the study. The clinician planned to re audit once further patients had attended.

Good

Are services safe?

- The service understood the requirement of duty of candour and had a process to inform patients and relevant bodies should an incident occur.
- Significant events were on the agenda to be discussed at the services governance meetings on a monthly basis. The service provided evidence that Governance meetings minutes are reviewed by clinical third party.

Good

Are services effective?

We rated effective as Good because:

- The provider maintained knowledge of their specialist field. They reviewed and monitored the care provided.
- Clinicians assessed and delivered care and treatment in line with current legislation, standards and guidance.

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

- Clinicians maintained their knowledge and received updates via attending and contributing to relevant medical conferences.
- Patients' immediate and ongoing needs were fully assessed. Where appropriate this included their clinical needs and their mental and physical wellbeing. Where patients enquired about a procedure, that clinicians did not believe would provide the desired outcome, they would be advised of alternative options or be advised to seek advice elsewhere.
- Clinicians had enough information to make or confirm a diagnosis. We were told, if pathology results returned were abnormal, patients would be signposted to the relevant service.
- We saw no evidence of discrimination when making care and treatment decisions. Patients were assessed and treated on an individual basis and advised on treatment options based on this information.
- Arrangements were in place to deal with repeat patients. Due to the small scale of the service, patients were advised to contact the service when they were ready for further treatment. Records from previous attendances could be used to inform decisions.
- Staff assessed and managed patients' pain where appropriate.
- Where having an additional member of staff would improve patient outcome this was utlised. For example; we were told that when performing a thread-lift they increased the appointment time and the clinician performing the procedure would have support from the other clinician to reduce the risk of infection.

Monitoring care and treatment

The service monitored activity for quality improvement.

- Due to the small scale of the service and in line with the registered managers vision for the service, the service did not actively seek quality improvement projects or pilots. However, the clinical staff did use patient feedback and clinical audits to check for areas they could improve on. Outcomes of audits and patient feedback were positive in nature and therefore the service had continued the work that had resulted in this.

Effective staffing

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

- The 2 clinical staff were appropriately qualified and registered with the General Medical Council (GMC) and the General Dental Council (GDC) and were up to date with revalidation. There was a third member of staff providing a support role.
- The Registered manager was required to have an annual appraisal under their GMC registration. The other director maintained registration with the General Dental Council (GDC) and held other roles, where they received an appraisal and could discuss their work at this service through peer critical support.

Good

Are services effective?

- The registered manager and joint director took responsibility for their own learning needs, however neither were accountable to one another. Post inspection we were sent evidence that the registered manager was monitoring all mandatory training needs.

- The service offered chaperones for procedures. This was carried out by a clinical or non-clinical member of staff. When we requested sight of training records, there was no evidence of chaperone training. However, since the day of inspection, we have been sent evidence that staff are appropriately trained.

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. Where staff felt at consultation the proposed treatment was inappropriate, patients would be told this and signposted to other services.
- Patients were required to sign a consent form prior to treatment.
- The service did not routinely contact the patients GP for information about a patient's history. However, the service ensured they had knowledge of the patient's health and medicine history before providing treatment.
- The provider had risk assessed the treatments they offered. The provider did not provide or prescribe high risk medicines.
- Patients were assessed clinically each time they attended the service. The provider told us they had not encountered any vulnerable patients but had a policy for escalated concerns with appropriate agencies.
- Patients' self-referred to the service. There was not a system to accept or refer patients onto other services, however staff would advise patients what treatment to seek elsewhere when appropriate. For example;
  - Staff told us where they felt a thread-lift would not give the desired outcome, they may advise the patient seek a plastic surgeon consultation.
  - Staff told us they would advise of other treatments that may further support their conditions and how to seek this.
- The service monitored the process for seeking consent appropriately.
- Due to the nature of service and appointment scheduling, there was an appropriate cooling off period between enquiry and initial consultation and treatment where appropriate.
- Patients that were booked for a vasectomy received counselling. The staff member responsible for this had not completed formal counselling training. We were told they had attended a training session but were unable to provide evidence of this. The doctor providing the service would review all elements discussed during this session before completing the procedure.
- The service had access to translation service where required and would take the time to read documents to visually impaired patients.

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.

- Staff gave people advice so they could self-care post treatment. This was recorded in patient records and for patients receiving a vasectomy, they would received a letter which included some self care advice.
- Risk factors were identified, highlighted to patients and where appropriate highlighted to their normal care provider for additional support. For example, patients receiving a vasectomy were provided with an aftercare letter. Advice was given and documented for patients receiving care for other procedures.
- Where patients needs could not be met by the service, staff redirected them to the appropriate service for their needs.

Good

Are services effective?

- Patients could recontact the service post procedure including out of hours for advice and support if they were concerned or experienced a complication.

Consent to care and treatment

The service obtained consent to care and treatment in line with legislation and guidance.

- Staff understood the requirements of legislation and guidance when considering consent and decision making.
- Staff supported patients to make decisions. Where appropriate, they assessed and recorded a patient's mental capacity to make a decision.

Good

Are services caring?

We rated caring as Good because:

- Staff treated patients respectfully and involved them in decisions about their treatment. Patients reported positively on their experience with the service.

Kindness, respect and compassion

Staff treated patients with kindness, respect and compassion.

- The service sought feedback on the quality of clinical care patients received.
- Positive feedback from patients included; patients felt at ease, were provided with easy aftercare advice and provided a clean, private and relaxing service.
- Staff understood patients' personal, cultural, social and religious needs. They displayed an understanding and non-judgmental attitude to all patients.
- The service told us they allowed extended time for all appointments. The appointment system worked so that there were gaps between patients so there would not be a delay upon arrival.

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. Information leaflets could be provided in easy read formats, to help patients be involved in decisions about their care. The service did not have access to a hearing loop.
- Patients told us through comment cards, that they felt listened to and supported by staff and had sufficient time during consultations to make an informed decision about the choice of treatment available to them.
- For patients with learning disabilities or complex social needs family, carers or social workers were appropriately involved.
- Staff communicated with people in a way that they could understand, for example, communication aids and easy read materials were available.

Privacy and Dignity

The service respected respect patients' privacy and dignity.

- Staff recognised the importance of people's dignity and respect. Consultations were carried out in the clinic room. The service did not allow more than 1 patient to be present at any time.
- Staff organised appointments to allow 1 patient to visit the service at any time. This allowed patients to discuss sensitive issues. Feedback from patients included that the service felt private and relaxing.

Good

Are services responsive to people's needs?

We rated responsive as Good because:

- The service organised and delivered services to meet patient's needs.
- In the absence of complaints, the service actively sought feedback.

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 improved services in response to those needs. The service did not provide any urgent services and offered appointments to suit their patients' needs.
- The service would schedule appointments between the times of 9am and 8pm to suit patient needs.
- The facilities and premises were appropriate for the services delivered.
- Reasonable adjustments had been made so that people in vulnerable circumstances could access and use services on an equal basis to others. The clinic room was on the ground floor and the building could be easily accessed from the carpark.

Timely access to the service

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

- The service was set up to provide services to small patient numbers. They took pride in providing quality of work over quantity.
- Where patients did require test results, these were provided in a timely way and signposting advice would be given where needed. Patients could receive consultations in a timely way.
- The service provided care to non-urgent patients only and would advise patients if they were unable to meet timely expectation.
- Waiting times, delays and cancellations were minimal and managed appropriately.
- Patients reported that the appointment system was easy to use.

Listening and learning from concerns and complaints

The service took complaints and concerns seriously and would respond to them appropriately to improve the quality of care.

- The service had complaint policy and procedures in place. Although staff told us they had not received any complaints, they had actively sought feedback from patients, which reflected the positive experience of the clinic.

Good

Are services well-led?

We rated well-led as Good because:

- On the whole we found evidence that the service was well led and providing high quality care.
- The service was small and run as a family business with three staff. As such there was a lack of documented evidence that all health and safety risks had been fully reviewed and monitored.
- Leaders demonstrated a learning and improvement culture in that they were responsive to feedback. Following feedback about the lack of documented evidence around policies we were promptly provided post inspection with revised copies of processes to enhance safety.
- Leaders had the knowledge and capacity to deliver quality sustainable care.
- Staff had a positive culture, where concerns and information was shared routinely.

Leadership capacity and capability;

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

- The service provided regulated activities to a small amount of patients, for example; per year the service treats approximately 2 thread-lifts, 144 vasectomies, 95 minor surgery procedures, 35 treatments for Bruxism and 12 treatments for Hyperhidrosis.
- Staff were visible and approachable to each other at all levels including leaders. Although, conversations were had surrounding and issues or concerns with the service, these were not documented to reflect or monitor.
- All staff strived for inclusivity and compassion.
- The provider had processes to develop leadership capacity and skills, for example, including increasing governance responsibly for the second director. However, there continued to be open discussions about the service leadership and retirement planning.
- Leaders were knowledgeable about issues and priorities relating to the quality and future of services. They continued to attend and participate in conferences to maintain this.

Vision and strategy

The service had clear vision to deliver high quality care and promote good outcomes for patients, however had not documented a strategy to monitor this.

- Due to the small nature of the business and run by family members, there was no documented vision and strategy in place. However, the service was able to tell us about their aims and purpose towards delivering high quality, person centred care.

Culture

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

- Staff felt respected and valued. They felt able to request support from one another where appropriate and were proud to work for the service.
- The service focused on the needs of patients.
- Openness, honesty and transparency were part of the service values when responding to incidents and complaints. All staff were aware of the near miss incident and had responded appropriately.
- The provider was aware of and had systems to ensure compliance with the requirements of the duty of candour.

Good

Are services well-led?

- Staff told us they could raise concerns with each other. Due to relationship of staff members, they told us if they had concerns about each other, they could raise this with external appraisers and colleagues.
- Staff welcomed external advice where appropriate and sought review of service meeting minutes.
- Processes for providing clinical staff with the development they needed involved self reflection and annual external appraisals. Each director was responsible for their own learning and in some cases used training for other roles to support this service. There was no process within the service to monitor training needs. The non-clinical member of staff had not had training needs assessed and had not received an appraisal on the day of inspection. This staff member was also a family member who felt they could seek support or training if they wished, but training needs had not always been reviewed as a result.
- All staff were considered valued members of the team and there was an 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.

- During the inspection we found policies and procedures were in place, however some of which were of a generic nature and had not been adapted to fit the suitability of the premises or business. For example, in applying the policy to their home in which the clinic operated out of. We raised this at inspection and post inspection, we received details that this had been reviewed by the registered manager and an action was in place to review these policies to check if they meet the needs of the service.
- Leaders were responsive to our feedback and quick to action. Where risk assessments or processes were not in place they were able to verbalise that they had considered the risk and rationale and put some mechanisms in place. However, due to the small size of the service, this was not always documented.
- Staff were clear on their roles and accountabilities, however the service was lacking systems to keep oversight of staff training and responsibilities.

Managing risks, issues and performance

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

- Leaders held appropriate clinical risk assessments for treatments carried out at the service and audited themselves to assure themselves the service is performing as expected.
- In the absence of complaints, the service sought feedback to assure themselves they were receiving information to drive the service.
- The service would submit data or notifications to external organisations as required.
- There were robust arrangements in line with data security standards for the availability, integrity and confidentiality of patient identifiable data, records and data management systems.
- There was process to identify, understand, monitor and address current and future risks including risks to patient safety. However, in some areas, documentation could be improved to reflect the actions that had been completed to keep patients safe.
- The service had processes to manage current and future performance. Performance of clinical staff could be demonstrated through audit of their clinical outcomes. Leaders had oversight of safety alerts and complaints.

Good

Are services well-led?

- 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 held a business continuity plan. Whilst all efforts would be made to maintain the planned service, leaders told us they did not treat any urgent patients and would signpost elsewhere if they could not meet patient expectations.

Appropriate and accurate information

The service acted on appropriate and accurate information.

- Quality and operational information was used to ensure and improve performance. Performance information was combined with the views of patients.
- Quality and sustainability were discussed in relevant meetings where all staff had sufficient access to information.

Engagement with patients, the public, staff and external partners

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

- The service encouraged and heard views and concerns including feedback from the public, patients, staff and external partners and acted on them to shape services and culture. For example,
  - Leaders encouraged patients to give feedback on third party websites, to CQC and reviewed feedback for their own knowledge.
  - Team meeting minutes were reviewed by a third party clinician for transparency.
- The service was transparent, collaborative and open with stakeholders about performance.

Continuous improvement and innovation

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

- Leaders were responsible for their own learning, maintenance of professional registrations. Post inspection, they reviewed needs of the non-clinical staff member and sent evidence they were monitoring all staff mandatory training.
- The service had a process to utilise internal and external reviews of incidents and complaints. Learning was shared and used to make improvements, however we found 1 example where it was not documented.
- Due to the culture and relationship of staff members, service objectives and performances was under regular review. Leaders had open discussions about succession planning which remained up for review. These conversations were not documented.

Whilst the service wasn't actively involved in innovative work or quality improvement, they sought feedback from patients and continued to engage with peers to keep their knowledge relevant for their specialisms. For example, attending and providing training for clinical conferences.