Manchester Aesthetics

Inspection report

453 Lightbowne Road
Manchester
M40 0HW
Tel: 01612223890

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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	Requires Improvement
Are services safe?	Requires Improvement
Are services effective?	Requires Improvement
Are services caring?	Good
Are services responsive to people's needs?	Good
Are services well-led?	Inadequate

Overall summary

This service is rated as Requires improvement overall. This provider was registered on 22 December 2021 and had not yet been inspected.

The key questions are rated as:

Are services safe? – Requires improvement

Are services effective? – Requires improvement

Are services caring? – Good

Are services responsive? – Good

Are services well-led? – Inadequate

We carried out an announced comprehensive inspection at Manchester Aesthetics as part of our inspection programme.

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. Manchester Aesthetics provides a range of non-surgical cosmetic interventions, for example, laser hair removal treatments and Botox for cosmetic reasons, as well as beauty treatments such as waxing, and lashes which are not within CQC scope of registration. Therefore, we did not inspect, or report on these services.

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

Our key findings were:

- We found safety concerns, such as lack of appropriate systems to oversee and mitigate risks, ineffective systems concerning recruitment, clinical and general oversight, and audit.
- The provider was unable to demonstrate that clinical records were used effectively for the monitoring of patients where appropriate, coordination and collaboration with relevant professionals was effective, or that quality improvement activity was consistent or effective.
- Client feedback we saw demonstrated that clients were satisfied with the way they were treated and access to the services and the treatment they received. We were unable to determine if any concerns or complaints had been raised.
- The provider was unable to demonstrate that all governance arrangements in place were working as intended, were adhered to or were effective when implemented.

The areas where the provider **must** make improvements as they are in breach of regulations are:

- Establish effective systems and processes to ensure good governance in accordance with the fundamental standards of care.

You can see full details of the regulations not being met at the end of this report.

Overall summary

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

- Establish a succession plan to ensure provider viability going forward.
- Complete staff appraisals with an appropriate frequency.
- Only supply unlicensed medicines against valid special clinical needs of an individual patient where there is no suitable licensed medicine available.
- Establish a system to record verbal complaints.

We issued the provider with a warning notice following our inspection, highlighting where improvements must be made.

Dr Sean O'Kelly BSc MB ChB MSc DCH FRCA

Chief Inspector of Health Care

Our inspection team

Our inspection team was led by a CQC lead inspector**.** The team included a second CQC Inspector and a nursing specialist adviser.

Background to Manchester Aesthetics

- The name of the registered provider is Manchester Aesthetics Clinic Ltd., their registered location is called Manchester Aesthetics.
- The registered location is situated 453 Lightbowne Rd, Manchester, M40 0HW.
- Services offered by the provider that are in scope of registration include, Botox treatments for excess sweating, sexual health services, soft tissue infections treated with antibiotics and medical condition consultations and associated treatments. They are registered for the 'diagnostic and screening procedures', surgical procedures' and 'treatment of disease, disorder and injury' regulated activities. The provider treats patients that are over 18 only and offers services to the whole population where appropriate. Treatments are subject to consultation and are delivered on site.
- Services are offered from 10am until 5pm 7 days a week.

How we inspected this service

This inspection was carried out by way of a site visit to the registered location.

This included:

- Interviewing available staff
- Requesting evidence from the provider.
- A single day site visit.

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

Requires Improvement

Are services safe?

We rated safe as Requires improvement because:

We found safety concerns, such as lack of appropriate systems to oversee and mitigate risks, ineffective systems concerning recruitment, clinical and general oversight, and audit.

Safety systems and processes

The service had systems to keep people safe and safeguarded from abuse but there were gaps identified.

- The provider conducted safety risk assessments, but these were not always fully effective. For example, we found that in the health and safety audit provided, dated May 2023, was not completed in relation to ventilation, heating, water monitoring, electrical equipment and COSHH, amongst other missing areas. Similarly, we found that the fire risk assessment, dated December 2022, was missing considerations for relevant risks and areas where some risk was identified but not actioned.
- In relation to infection prevention and control (IPC), we found that areas of risk were not considered in the audit tool provided to us, dated May 2023, in relation to single use equipment. We received a second IPC audit tool that had been completed by the provider in June 2023, which provided a more comprehensive assessment of the risks, but did not always contain plans to action missing areas they had identified, such as elbow taps or mounted liquid soap dispensers.
- Equipment used by the provider that required maintenance was for services offered that were out of scope of registration, so were not reviewed as part of this inspection. There were systems for safely managing any healthcare waste.
- The service had safety policies, which were regularly reviewed. There was no evidence available when asked, that these had been directly communicated to staff. We saw that the provider had the systems in place to share information through team meetings. The policies outlined clearly who to go to for further guidance.
- When asked, the provider was unable to demonstrate that employed staff received safety information from the service at recruitment because inductions had not been completed. However, due to the small number of staff employed, this presented a lower risk than in a larger service. The provider sent us an action plan document, which committed to providing in depth inductions for all new staff going forward. The lead nurse had an extensive background of both training and experience in the field, but the provider could not always demonstrate training for all staff. The service had systems to safeguard children and vulnerable adults from abuse and the lead nurse we spoke with was able to articulate an appropriate course of action should they suspect abuse or modern slavery.
- We saw that the registered nurse in charge had completed safeguarding training but was unable to demonstrate that all staff had safeguarding training completed. We were unable to speak with any staff during our visit as they were not working that day.
- The service worked with some other agencies to support patients and protect them from neglect and abuse. The provider took steps to protect patients from abuse, neglect, harassment, discrimination and breaches of their dignity and respect in relation to safeguarding. The provider told us they were in contact with patients' GPs with consent but were unable to show us any evidence of this when asked.
- The provider was unable to demonstrate that they carried out staff checks at the time of recruitment or on an ongoing basis where appropriate. They were also unable to demonstrate that appropriate director 'fit and proper person' checks had been completed. Disclosure and Barring Service (DBS) checks were not undertaken where required. (DBS checks identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable). The service was unable to demonstrate that they had fully considered the risk of not having DBS checks for staff that were interacting with clients, or consideration of the risk of these clients bringing children with them into the premises. The service offered chaperoning services but could not demonstrate that those staff who might be asked to chaperone, had a DBS check.

Requires Improvement

Are services safe?

During the inspection the provider informed us a clinical member of staff was not directly employed. However, following the inspection we saw evidence this member of staff had been employed since 2020. Similarly, following the inspection, the provider supplied us with a risk assessment outlining that staff without DBS and other recruitment checks were not seeing clinical clients, but this did not provide assurances that all clients were effectively safeguarded.

Risks to patients

There were systems in place to assess, monitor and manage risks to patient safety in relation to staffing mix and medical emergencies.

- There was limited need for arrangements of planning and monitoring the number and mix of staff needed as the service told us they had one employed member of staff and relied on the experience and presence of the registered nurse in charge. As a smaller service, the provider was confident that there was enough staff with appropriate experience to provide the services offered. Following the inspection, the provider supplied us with a contract of employment for a doctor that provided clinical oversight of the lead nurse as part of their role. This doctor was not seeing Manchester Aesthetic clients but was operating under a different legal entity within the same building. We saw that this person had been employed in their role as clinical auditor with Manchester Aesthetics since 2020.
- The provider understood their responsibilities to manage emergencies and to recognise those in need of urgent medical attention. They knew how to identify and manage patients with severe infections, for example sepsis.
- There were suitable medicines and equipment to deal with medical emergencies relevant to the service type, which were stored appropriately and checked regularly.
- There were appropriate indemnity arrangements in place.

Information to deliver safe care and treatment.

The provider could not demonstrate that staff had the information they needed to deliver safe care and treatment to patients.

- The provider was unable to demonstrate that individual care records were written and managed in a way that kept patients safe. We asked the provider to supply us with information from their records for patients receiving treatments that were in scope of registration but were not supplied with them. The provider told us that their system was not set up to be searchable for these individual treatments but would speak to their system developers to try and resolve this. The provider did supply us with an action plan which outlined that patient notes will be audited for “accuracy and thoroughness” on a monthly basis but did not supply any information about what these meant in practical terms. Following the inspection, the provider supplied us with an audit of 2 patient records, indicating that in their assessment, all relevant documents were present, but supplied us with no details or evidence of the records themselves.
- The service had limited systems for sharing information with staff and other agencies to enable them to deliver safe care and treatment. We were able to see that meetings had been held and attended by staff and stakeholders but did not demonstrate that staff had meaningfully contributed to the running of the service and no standard agenda items were recorded. We asked the provider to supply us with evidence that communication had occurred with other professionals, such as the clients’ GP in line with what we had been told. They were unable to provide these details.
- The provider told us that appropriate and timely referrals were made in line with protocols and up to date evidence-based guidance. We saw that the registered nurse in charge was working from “Better to know” guidance in relation to the sexual health services they offered, we found that this guidance was out of date and had not been replaced. In addition, the provider could not demonstrate that these had been followed, because they were unable to provide any clinical records for us to review.

Requires Improvement

Are services safe?

- The service had a policy in place concerning the retention of medical records in line with Department of Health and Social Care (DHSC) guidance in the event that they cease trading, records were kept electronically, accessible through a personal tablet computer and a desktop computer.

Safe and appropriate use of medicines

The service did not always have reliable systems for appropriate and safe handling of medicines.

- The systems and arrangements for managing medicines were not always effective, we saw that systems to manage vaccines, controlled drugs, emergency medicines and equipment minimised risks but systems in relation to prescribing and evidence-based guidance were not effective.
- The service kept prescription stationery securely but were unable to demonstrate that they monitored its use. We saw that prescription stationary was generic and was not serialised with numbers for tracking or auditing purposes. The provider supplied us with a risk assessment and action plan for this to be changed but this did not include retrospective consideration of prescriptions already issued. There was no system in place to ensure prescription stationary had not gone missing or been used inappropriately and systems to follow-up with fulfilling pharmacies were not in place. Going forward, the provider explained that all prescriptions would be completed electronically and kept on the clinical system for review.
- The service could not demonstrate that it had carried out regular medicines audits to ensure prescribing was in line with best practice guidelines for safe prescribing. The provider supplied us with an action plan detailing that this would be carried out once the medical director returned to the business following a period of absence. Following the inspection, the provider supplied us with a peer review of prescribing that was dated prior to our inspection, this was a single example and contained no details of what records had been used to evidence the findings.
- We saw that up-to-date local microbial guidance was in place in relation to dispensing antibiotics, however, the provider was unable to demonstrate that prescribing had always been completed appropriately as systems in place for providing prescriptions were ineffective.
- Appropriate staff prescribed, administered, and supplied medicines to patients but were not able to demonstrate that they always gave advice on medicines in line with legal requirements and current national guidance. Following the inspection, the provider supplied us with a consultation document for a patient, which outlined the side effects of botulinum toxin (which is used for some aesthetics and medical treatments). There was no consideration documented of contraindications with other medicines taken by the client.
- The provider told us that they had not prescribed the high-dose steroid medicine used to treat hay fever up to the inspection date, although this was an option on their website for clients, we found they did not have the appropriate protocols in place when we asked, but the risk had been mitigated as they had not yet administered any. During our review of evidence following the inspection, the provider supplied us with a protocol that contained some inaccurate information and did not contain any information on the need for the prescriber to issue a steroid card to the patient. We found that this medicine had been prescribed and administered to a client shortly after our inspection. We asked the provider for further information about this and found that the provider had prescribed and administered this to a patient based on the inaccurate protocol. They had not informed the patient that the medicine was not licenced in the UK (independent prescribers are still able to prescribe this but must inform patients of its non-licenced status), and they had not issued a steroid card in line with guidance.
- There were no protocols in place for verifying the identity of patients.
- The service did not prescribe Schedule 2 and 3 controlled drugs (medicines that have the highest level of control due to their risk of misuse and dependence). Neither did they prescribe schedule 4 or 5 controlled drugs.
- Processes were in place for checking medicines on site and the provider kept accurate records of these medicines.

Track record on safety and incidents

Requires Improvement

Are services safe?

The service could not demonstrate a good safety record.

- There were risk assessments in place in relation to some safety issues but those in place were not always effective.
- The service could not demonstrate that it monitored and reviewed activity, which, if in place, would enable the provider to understand risks and give a clear, accurate and current picture that could then lead to safety improvements where necessary.

Lessons learned and improvements made.

The service had systems in place to learn and make improvements when things went wrong but could not demonstrate that it was effective or fully embedded.

- There was a system in place for recording and acting on significant events, but the provider told us that they had never had any to report. The provider understood their duty to raise concerns and report incidents and near misses.
- There were systems in place for reviewing and investigating when things went wrong but the service was unable to demonstrate that these were effective as there had been no recorded concerns. This limited the providers ability to learn, share lessons, identify themes, and take action to improve safety in the service.
- If there were unexpected or unintended safety incidents, the provider told us they would give affected people reasonable support, truthful information, and a verbal and written apology, but none of these had occurred to be recorded.
- When asked, the provider was unable to demonstrate that they kept written records of verbal interactions as well as written correspondence with patients or professionals, with the exception of their patient feedback, which was positive.
- The service had an informal system in place for acting on and learning from external patient and medicine safety alerts. As a speciality service, we were told that they had not had any alerts that were relevant to them but could not demonstrate that this review process was formal or had been documented. The service had limited mechanisms in place to disseminate alerts to all members of the team: staff meeting minutes we reviewed had no standard agenda items including safety alerts. We were told that relevant staff would be emailed should the need arise.

Requires Improvement

Are services effective?

We rated effective as Requires improvement because:

The provider was unable to demonstrate that clinical records were used effectively for the monitoring of patients where appropriate, coordination and collaboration with relevant professionals was effective, or that quality improvement activity was consistent or effective.

Effective needs assessment, care, and treatment

The provider had systems and protocols to keep clinicians up to date with current evidence-based practice. Evidence that clinicians assessed or did not assess needs and delivered care and treatment in line with current legislation, standards, and guidance relevant to their service could not be confirmed by the provider when asked.

- Patients' immediate and ongoing needs were assessed in relation to the services provided but there was no evidence provided that this had been verified by the patient's GP where appropriate.
- The provider was unable to demonstrate that arrangements were in place to deal with patients returning for similar treatment. They were unable to identify individual treatments patients had had on their clinical system. They told us this is something they are working to achieve following our visit.
- We saw no evidence of discrimination when making care and treatment decisions.
- The provider told us that relevant staff informally assessed and managed patients' pain where appropriate and in line with their competencies.

Monitoring care and treatment

The service was not actively involved in quality improvement activity.

- The service had a limited capacity to use information about care and treatment to make improvements. We asked to see evidence of quality improvement activity, perhaps in the form of completed audits. Although we saw some environmental audits, they were ineffective. The provider was unable to demonstrate that any clinical audits had been completed or any learning gleaned from this area of the business, nor any positive outcomes for clients. They told us, this is something they planned as an aspiration. Following the inspection, the provider supplied us with audits of 2 patient records and an audit of consultations, treatment and prescribing decisions, but there was no supplementary evidence provided to demonstrate their effectiveness.
- The providers' clinical system was not searchable, nor did it enable them to view or take advantage of opportunities to improve or learn. There was limited evidence of action to resolve concerns and improve quality, this was partly due to a lack of complaints and significant events, but when asked the lead nurse in charge told us that verbal complaints would be dealt with but not recorded.

Effective staffing

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

- All staff, whose files we reviewed were appropriately qualified when relevant to treatments in scope of registration, but the provider did not have an induction programme in place for all newly appointed staff. The service was not planning

on recruiting more staff at this stage and provided us with an action plan to demonstrate that going forward they would have an induction process in place. Following the inspection, the provider informed us that the doctor working at the service had been employed since 2020, although we did not review this person personnel file as we were told they were not employed. We saw that they were registered with the GMC.

- Relevant professionals were registered with the Nursing and Midwifery Council (NMC) and told us they were up to date with revalidation. We asked to see the nurse revalidation summary, but the provider was unable to provide this.
- For the single non-clinical employee, who conducted dual roles, the provider told us they understood their learning needs and provided protected time and training to meet them, we saw some evidence of this. However, training records were not always complete, and the provider did not have a system of oversight in place.

Coordinating patient care and information sharing

The provider could not demonstrate that they worked well with other organisations, to deliver effective care and treatment.

- We were told that patients received coordinated and person-centred care. We were unable to verify what we were told in this area due to the inability of the provider to supply us with evidence concerning their clinical records, or evidence that information was shared with other relevant professionals such as a patient's registered GP.
- Before providing treatment, clinical staff at the service ensured they had knowledge of the patient's health from a comprehensive medical history collection proforma, but this was not coordinated or confirmed with the relevant professionals. For example, when removing lesions or moles or if clients were taking prescribed medicines from other professionals. The provider told us that these patients could be treated the same day, which ran the risk of not having enough time to complete these checks.
- We were told that clients would be signposted to more suitable sources of treatment should the service determine that they were unsuitable for treatment or were underage. We were unable to verify this as the provider was unable to grant us access to relevant patient records.
- We saw documentation that patients were asked for consent to share details of their consultation and any medicines prescribed with their registered GP on each occasion they used the service. This consent was not a prerequisite for providing treatment and the provider was unable to demonstrate that this always occurred when necessary.
- The provider offered antibiotic prescriptions and dispensing of these medicines. They offered treatments on their website that they told us they were not yet providing, such as high-dose steroids for the treatment of hay-fever. Shortly after our inspection, we found that the provider had begun delivering this unlicensed medicine, but systems in place to support its prescribing were not effective.
- The provider had identified medicines that were not suitable for prescribing if the patient did not give their consent to share information with their GP, or they were not registered with a GP. For example, medicines liable to abuse or misuse, and those for the treatment of long-term conditions such as asthma. The provider told us that they did not prescribe any of these types of medicines.
- Where any patient had agreed to share their information, we saw no evidence of correspondence sent to their registered GP in line with GMC guidance.

Supporting patients to live healthier lives.

The service empowering patients by providing them with relevant information about treatments.

- Where appropriate, the provider gave people advice so they could self-care.

Requires Improvement

Are services effective?

- There was limited evidence that risk factors were identified and highlighted to patients. For example, we saw that no contraindications for medicines already taken had been formally explored or documented, we also saw that unlicenced medicines were prescribed without informing patients of the medicine's status, but we did see that manufacturer patient information was provided. The provider was unable to provide any evidence that patients' normal care provider was always involved to provide additional support.

Consent to care and treatment

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

- The provider understood the requirements of legislation and guidance when considering consent and decision making but could not always demonstrate that they monitored the process for seeking consent appropriately. For example, not all relevant information was provided or sought before treatments commenced.

Good

Are services caring?

We rated caring as Good because:

Client feedback we saw demonstrated that clients were overwhelmingly satisfied with the services and the treatment they received. We were unable to determine if any concerns had been raised.

Kindness, respect, and compassion

We saw staff treated client with kindness, respect, and compassion.

- The service sought feedback on the clinical care clients received in the form of satisfaction comments and an unused complaints system; we were unable to see how complaints were processed as the service told us they had received none. Verbal complaints were not documented but we were told these were dealt with once raised. Feedback supplied to us by the provider was undated but indicated that clients were satisfied with the services. Feedback about the quality of the treatments provided was not specifically sought by the service, particularly in relation to the sexual health services delivered. Feedback provided showed that clients were satisfied with aesthetic services. We asked the provider to supply the dates of this feedback, but they were unable to do so in all but one case.
- Feedback from clients was positive about the way staff treat people.
- The provider told us they understood clients' personal, cultural, social, and religious needs. They displayed an understanding and non-judgmental attitude to all clients who attended during the inspection.
- The service had a system for giving clients timely support and information, but this was not always effective.

Involvement in decisions about care and treatment

Staff helped clients to be involved in decisions about treatments.

- Interpretation services were available for clients who did not have English as a first language. The service told us information leaflets were available in easy read formats should they be requested, to help clients be involved in decisions about their care.
- We saw that staff communicated with people in a way that they could understand, for example, communication aids were available. The provider did not have a hearing loop but had no clients who had any hearing impairments. When asked what actions they would take should they encounter clients with impairments, the provider told us they would take all reasonable steps to make the services delivered as accessible as possible.

Privacy and Dignity

The service respected clients' privacy and dignity.

- The provider recognised the importance of people's dignity and respect.
- They knew that if clients wanted to discuss sensitive issues or appeared distressed, they could offer them a private room to discuss their needs.

Good

Are services responsive to people's needs?

We rated responsive as Good because:

Client feedback we saw demonstrated that clients were satisfied with access to the services and the treatment they received.

Responding to and meeting people's needs

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

- The provider understood the needs of their clients through conversations, relationships and through the gathering of information prior to treatments.
- 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 provider told us that clients who used a wheelchair were given access to treatment rooms closest to the entrance to facilitate their treatment.

Timely access to the service

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

- Clients had timely access to initial consultation and treatment, we were told that some were treated on the day of their consultation.
- Waiting times, delays and cancellations were minimal and managed appropriately.
- The provider told us that the appointment system was easy to use, we saw no evidence of any complaints, verbal or written which would have contradicted this. Feedback we received was not specific about access.
- The provider told us they signposted clients to other services, should their treatments be unsuitable for them.

Listening and learning from concerns and complaints

- Information about how to make a complaint or raise concerns was available. The provider had a policy and a procedure, including an escalation process. At the time of inspection, the provider confirmed that they had not received any written complaints to the service. They did acknowledge that they did not routinely record any verbal complaints, which were infrequent and had been resolved at the time.

Inadequate

Are services well-led?

We rated well-led as Inadequate because:

The provider was unable to demonstrate that all governance arrangements in place were working as intended, were adhered to or were effective when implemented.

Leadership capacity and capability;

Leaders had the capacity and skills to deliver high-quality, sustainable care but did not always have systems in place or were using the systems in place effectively.

- Leaders were not always knowledgeable about issues and priorities relating to the quality and future of services. We saw that oversight, auditing and quality assurance systems were limited or not in place, policies had not always been followed and protocols were not always in date or effective in relation to medicines. The provider was unable to demonstrate that they had an awareness of these, understood the challenges or were addressing them effectively. Following the inspection, the provider supplied us with some assurances, but significant concerns remained outstanding.
- The provider did not have effective processes to develop leadership capacity and skills, including planning for the future leadership of the service. We explored this with the provider who explained that this would be a priority going forward, as they wanted the business to continue to grow and expand.
- The small structure allowed leaders to be visible and approachable. They worked alongside staff and others and told us that they prioritised compassionate and inclusive leadership. No other staff were available to speak with.

Vision and strategy

The service had a vision to deliver their treatments and promote good outcomes for patients but there were gaps.

- There was a clear vision and set of values. The service had a strategy and supporting business plan.
- The service could not always demonstrate that it had systems in place that were working effectively, to monitor progress against delivery of the strategy. Following the inspection, we saw the provider had established audit and quality assurance processes but did not provide any evidence to verify their effectiveness.

Culture

The service had room for development in relation to establishing a sustainable and positive culture.

- The service told us they focused on the needs of clients and feedback we were supplied with confirmed client satisfaction.
- The service leader we spoke with told us they would act on behaviour and performance inconsistent with the vision and values. They had policies and procedures in place to allow them to do so, but we saw no evidence of employment contracts or required recruitment information, which could have enabled them to take action should they need to.
- We were verbally assured by the provider that openness, honesty, and transparency would be demonstrated when responding to incidents and complaints, but the provider had not had the opportunity to respond to any formal written complaints, had had no incidents and had not recorded any verbal complaints or concerns. The provider was aware of and had a policy to ensure compliance with the requirements of the duty of candour.

Inadequate

Are services well-led?

- Processes for providing all staff with the development they needed were limited. This included appraisal and career development conversations. We saw no evidence of annual appraisals when these were asked for. The provider was unable to demonstrate that documented checks were kept in relation to supporting all appropriate staff to meet the requirements of professional revalidation where necessary. For example, the provider was unable to provide us with up-to-date NMC revalidation information, although we did see that valid registration was in place.
- The service could not demonstrate that equality and diversity was actively promoted. Staff had not received equality and diversity training.

Governance arrangements

There were limited structures of roles and systems of accountability to support good governance and management. Governance arrangements had multiple gaps.

- Structures, processes and systems to support good governance and management were often in place in the form of policies but were ineffective in their implementation. We found that policies were not always followed by the provider. They were unable to demonstrate that 'fit and proper person' checks had been completed, or demonstrate understanding of the need for these to be completed. We asked for confirmation evidence that checks had been completed following the inspection and the provider was unable to do so.
- Policies and procedures did not name individuals for the purposes of identifying roles and lines of accountability, but the small size of the staff team mitigated this risk.
- Leaders had established policies, procedures, and activities to ensure safety and had some systems in place to assure themselves that they were operating as intended, such as audits, but these were not fully effective.

Managing risks, issues, and performance

There was limited clarity around processes for managing risks, issues, and performance.

- There was a process to identify, understand, monitor, and address current and future risks including risks to patient safety. These were not fully effective; we saw that safety audits were incomplete and had not prompted the provider to address areas that they had identified as lacking. We saw that the provider was developing iterations of their systems based on our feedback following the inspection, but these were not yet fully effective or embedded.
- The service established processes to manage current and future performance during the inspection. Performance of clinical staff could not be fully demonstrated. Following the inspection, we saw rudimentary audit activity of consultations, prescribing and referral decisions. We saw that the staff member, whose role it was to complete these (employed since 2020) could not demonstrate any audit activity prior to the 2023 audit submitted to us. Leaders told us they had oversight of safety alerts, incidents, and complaints, but were unable to provide evidence. We were told that this documentation had been deleted (safety alerts), had not occurred (incidents and written complaints) or was not supported by a system that required them to be recorded (in terms of verbal complaints).
- There was no evidence supplied when asked, that clinical audits had been completed in order to have a positive impact on quality of care and outcomes for patients. The provider did not audit quality of the treatments provided and relied on feedback and return business from clients. There was no clear evidence of action to change services to improve quality.

Appropriate and accurate information

The service did not have appropriate and accurate information.

Inadequate

Are services well-led?

- Quality and operational information was not used to ensure and improve performance. There were no systems in place to combine the views of patients with performance information as an overview of quality.
- Quality and sustainability were not discussed in meetings minutes supplied to us and there was no evidence that attending persons had sufficient access to information needed to make a meaningful contribution.
- The service had no systems to use their own performance information or that of local or national services delivering the same or similar services as benchmarking.
- The provider could not demonstrate that they were able to access or use information they did have about services delivered to monitor performance and the delivery of quality care. No weaknesses had been identified, preventing the provider from developing plans to address these gaps or learn from them.
- The service told us they had arrangements to submit data or notifications to external organisations as required. The provider was unable to provide appropriate evidence during or since the inspection.
- The provider told us that there were arrangements in line with data security standards for the availability, integrity and confidentiality of patient identifiable data, records, and data management systems. The provider could not provide us access to their system to verify this.

Engagement with patients, the public, staff and external partners

The service involved clients in providing feedback about services, but engagement systems were not working as intended.

- The service encouraged and heard views from the public and clients but had not had the opportunity to demonstrate that they had acted on any concerns or issues to shape services and culture. The service told us this was due to a lack of any complaints or issues but acknowledged that verbal complaints had not been recorded and we found that systems in place to identify issues or concerns were not always effective.
- The provider could describe to us the systems in place to give feedback. Clients were sent surveys following their interaction with the service and asked to give feedback. We saw no evidence of feedback opportunities for staff and how the findings were fed back to staff. We also saw no staff engagement in responding to these findings. When asked, the provider was unable to provide details of the survey questions asked of clients.

Continuous improvement and innovation

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

- There was a limited focus on continuous learning and improvement.
- The service was unable to make use of internal and external reviews of incidents and complaints, nor to share learning to make any improvements.
- There were no effective designated systems to support improvement and innovation work.

This section is primarily information for the provider

Enforcement actions

Action we have told the provider to take

The table below shows the legal requirements that were not being met.

Regulated activity	Regulation
Diagnostic and screening procedures Surgical procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance Regulation 17 HSCA (RA) Regulations 2014 Safe care and Treatment **Systems or processes must be established and operated effectively.** **How the regulation was not being met:** The registered person had systems or processes in place that operated ineffectively in that they failed to enable the registered person to assess, monitor and mitigate the risks relating to the health, safety and welfare of service users and others who may be at risk. In particular: • Health and safety, fire and infection control risk systems were ineffective. • Systems relating to coordinated communication with external partners to ensure patient safety were not in place. • Systems to ensure safe recruitment were ineffective, including director and staff checks. • Systems to ensure adherence to evidence-based guidance, both locally and nationally were ineffective. Particularly in relation to prescribing. There were no systems or processes that enabled the registered person to ensure that accurate, complete, and contemporaneous records were being maintained securely in respect of each client. In particular: • When asked the provider was unable to demonstrate any notes or clinical records. There was additional evidence of poor governance. In particular: • Systems to ensure learning from safety and other incidents were limited and ineffective. • Oversight and supervisory systems were ineffective, including quality auditing.

This section is primarily information for the provider

Enforcement actions

- The provider demonstrated a lack of recording systems for significant events or near misses and systems to ensure all complaints were logged were ineffective.

This was in breach of Regulation 17(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.