AL Aesthetics

Inspection report

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

Overall summary

This service is rated as Requires improvement overall.

The key questions are rated as:

Are services safe? – Requires improvement

Are services effective? – Good

Are services caring? – Good

Are services responsive? – Good

Are services well-led? – Requires improvement

We carried out an announced comprehensive inspection at AL Aesthetics on 14 March 2023 as part of our inspection programme.

This is the first time this service has been inspected by the Care Quality Commission (CQC) following its registration as a new service in August 2020.

AL Aesthetics is a private clinic in the West Midlands. The service provides consultations and treatment for minor surgery (removals of lipoma, moles, skin tags), and Botox for migraines and hyperhidrosis (excess sweating).

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. AL Aesthetics provides a range of non-surgical cosmetic interventions, for example facial rejuvenation, anti-wrinkle treatments and non-surgical rhinoplasty, which are not within CQC scope of registration. Therefore, we did not inspect or report on these services.

The service manager was also 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:

- The provider had produced policies and processes to keep patients safe, however, not all policies were comprehensive or fully embedded.
- Clinicians collected and assessed relevant medical information before making a decision on what treatment to offer.
- Patients had enough time to review information before making a decision about whether to proceed with treatment.
- The provider had systems in place to monitor performance and to improve the quality of services delivered.
- Patient feedback we viewed was positive about the service.
- Patients were able to get an appointment or access the clinic for aftercare advice in a timely manner.
- We found that not all governance systems were robust and although the provider had taken action to mitigate risks, systems in place did not allow the provider to identity and manage all potential risks.

Overall summary

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

(Please see the specific details on action required at the end of this report).

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

- Improve the safeguarding policy to include training requirements and include information on what to do if staff have a concern about a child.
- Take action to formally assess how accessible the service is and take relevant action, so that anyone wishing to use the service can access it on an equal basis to others.

Dr Sean O'Kelly BSc MB ChB MSc DCH FRCA

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

Our inspection team

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

Background to AL Aesthetics

AL Aesthetics Ltd is the registered provider. The clinic is located at 131 Union Road, Shirley, Solihull, B90 3BZ. More information about the service can be found on their website www.alaesthetics.co.uk/solihull-clinic/

The provider also has clinics in London and Wolverhampton. The provider does not provide regulated activities from these clinics and so they were not inspected as part of this inspection.

The clinic facilities at the Solihull clinic are on the ground floor of a converted house which has been renovated to provide appropriate facilities. These include reception, a consulting room, a treatment room (minor operating room), patient toilet facilities and car parking.

The provider is registered with the Care Quality Commission to carry out the following regulated activities: Surgical procedures and treatment of disease, disorder or injury.

AL Aesthetics is a private clinic offering services to fee-paying patients. Services include consultation and treatment for Botox for migraines and hyperhidrosis (excess sweating) and minor surgery (removal of moles, lipoma and skin tags).

The service is open for queries and appointment bookings Monday to Friday 10am to 7pm and 11am to 4pm on Saturdays.

The clinic is open for consultations on Mondays and Wednesdays 11am to 4pm and for surgical procedures on Saturdays 11am to 4pm.

Clinic staff include 2 surgeons, a clinic manager and nurse.

The service provides 24 hours telephone cover for post-operative support. Staff explain to people when aftercare information is given, if it is an emergency they need to attend accident and emergency (A&E).

How we inspected this service

Before our inspection we reviewed information we held about the provider. We also requested and reviewed information from the provider before the inspection and information available on the providers' website. We carried out a site visit, reviewed records and interviewed the provider and clinic staff.

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:

The provider had implemented systems to keep patients and staff safe and protected from harm, however, not all systems were robust. For example, processes to manage infection prevention control required improvement.

We identified safety concerns that were rectified on the day of inspection/soon after our inspection. The likelihood of this happening again in the future is low and therefore our concerns for patients using the service, in terms of the quality and safety of clinical care are minor. (see full details of the action we asked the provider to take in the Requirement Notices at the end of this report).

Safety systems and processes

The service had systems to keep people safe and safeguarded from abuse. However, some processes required improvement.

- The provider had produced safety policies that had been reviewed yearly and were relevant to the services delivered. However, not all policies were comprehensive, for example the safeguarding policy did not include the training requirements for staff or contain any information about what staff should do if they had concerns about children.
- Staff had completed adult safeguarding training, however one clinician had not completed the relevant children's safeguarding training.
- Staff told us they did not treat patients under the age of 18 and there were safeguards in place at registration, where staff asked patients for identification if they appeared under 25 years of age. We discussed this with the provider who told us they would review their policy immediately and ask all patients for identification regardless of age with immediate effect.
- Staff received safety information from the service as part of their induction and refresher training.
- From staff files we viewed we found the provider carried out staff checks at the time of recruitment for example, identity checks, professional qualifications and registration with governing bodies and requested references. We saw they had processes in place for carrying out these checks on an ongoing basis where appropriate.
- The provider had a policy for ensuring Disclosure and Barring Service (DBS) checks were undertaken during recruitment and on an ongoing basis. (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). We found the policy was not always followed and a staff member had been recruited using a previous DBS check that had been completed 2 and half years previous to their employment with this service. The provider had not completed a risk assessment to assess if this DBS check was still acceptable.
- Staff who acted as chaperones were trained for the role and had received a DBS check.
- There was a system to monitor and manage risks related to infection prevention and control (IPC) and staff took action to mitigate identified risks. However, we found the systems and processes in place were not robust. For example, the IPC risk assessment and IPC audits were not comprehensive and had not identified all potential areas for concern.
- While we found the clinic to be clean and tidy. We did identify some minor infection control issues that had not been identified by the provider.
- We also found that staff were not handling clinical waste in line with the provider's policy.
- The provider could not provide evidence of a comprehensive Legionella risk assessment. However, staff were carrying out actions to monitor and mitigate risk.
- We saw that staff carried out daily checks on IPC in the minor operating room each day it was used and staff monitored the quality of cleaning standards.

Requires Improvement

Are services safe?

- The provider's policy for IPC made reference to protecting staff from blood borne viruses, however the policy did not include the collection and monitoring of staff immunisation information. The provider took immediate action to collect this information, following the inspection.
- The provider had produced safety sheets for chemicals used in the clinic, however there was no COSHH risk assessment. The provider took immediate action following the inspection, and sent us evidence of a COSHH risk assessment.
- There were systems in place for the collection of healthcare waste.
- The provider had arranged for equipment to be PAT (portable appliance test) tested to ensure it was safe. However, the provider did not have processes in place for medical equipment to be calibrated. The provider told us staff checked medical equipment before use to ensure it was in good working order.
- The provider had conducted safety and environmental risk assessments. However, not all were comprehensive.
- A fire risk assessment had been carried out in June 2020. We saw that most actions following this assessment had been completed. A repeat fire risk assessment had not been carried out since. A comprehensive Fire Alarms & Emergency Lighting Maintenance and Compliance check had been completed in March 2023 and the provider was in communication with the company to arrange a date for all the actions to be completed including a comprehensive fire risk assessment. We saw that staff carried out appropriate checks on fire fighting equipment. We saw evidence of fire drills taking place and staff had completed relevant training.
- We saw evidence of a Health and Safety risk assessments; however, they were not comprehensive.
- We did not see evidence of a security risk assessment however, there was a security alarm for the building and there were appropriate security arrangements in place for letting people in and out of the building. We found that medicines and patient records were stored securely.

Risks to patients

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

- There were arrangements for planning and monitoring the number and mix of staff needed.
- There was an effective induction system for staff tailored to their role.
- Staff understood their responsibilities to manage emergencies and to recognise those in need of urgent medical attention. They knew how to identify and manage patients with severe infections, for example sepsis.
- The provider had evidence to demonstrate they had arranged professional indemnity insurance. This insurance is intended to protect professionals and their businesses in the event of claims made by a client (or third party) suggesting that they have suffered loss as a result of non-performance, breach of contract and/or professional negligence by the service received.
- The provider had processes in place to check that monthly processes such as stock check, deep clean, checking emergency medicines and fire test had been carried out
- The provider stocked most of the suggested emergency medicines that would be required to deal with medical emergencies. We saw these were stored appropriately and checked regularly. We found there were 2 items that were not kept, a medicine used to treat epilepsy and a medicine suggested if minor surgery is carried out. The provider had not carried out a risk assessment to explain their decisions for not keeping these medicines on site. We discussed this with the provider. Following the inspection, they sent us evidence to show they had ordered both of these medicines and told us they would be stocking these medicines going forwards.
- The clinic did not have oxygen or a defibrillator, to help deal with a medical emergency. We saw the provider had risk assessed this. However, the risk assessment was not comprehensive. Staff told us they had verbally discussed keeping these items on site prior to the inspection. The provider sent us evidence to show these items had been ordered following the inspection.

Information to deliver safe care and treatment

Requires Improvement

Are services safe?

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

- We reviewed 5 patient records.
- They demonstrated a comprehensive health assessment had been completed by the surgeon before the recommendation of any treatment.
- We found that patient information was stored securely, and information needed to deliver safe care and treatment was available to relevant staff in an accessible way.
- The service had systems for sharing information with staff and other agencies to enable them to deliver safe care and treatment.
- 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.
- Staff told us they would write back to the patients registered GP. They requested patients consent to do this. We saw evidence of this when we reviewed patient records.
- The clinic had appropriate processes to monitor and review patient histology results.

Safe and appropriate use of medicines

The service had reliable systems for appropriate and safe handling of medicines. However, systems to monitor prescription stationery and confirm identity required improvement.

- The systems and arrangements for managing medicines and emergency medicines minimised risks. The service kept prescription stationery securely. They kept a copy of the prescription in the patients record and kept a log of what each patient had been prescribed. However, they did not have a robust system in place to monitor its use.
- Patients received personalised care, taking account of their individual needs including relevant past medical history. 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).
- They did not prescribe schedule 4 or 5 controlled drugs.
- Patient identity was confirmed when patients attended for an appointment. Patients were asked to confirm their name, date of birth and contact details, as well as the details of their registered GP practice.
- If patients looked under 25 years old they had to show photographic ID to confirm they were above 18 years of age. The provider told us they immediately amended their policy, following the inspection, to ask all patients for photographic identification to confirm identity and age, regardless of age.
- Staff prescribed or administered 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.
- We saw that staff monitored that medicines stored in the refrigerator were kept at the correct temperature.

Track record on safety and incidents

The service had implemented measures to mitigate risk.

- There was evidence of some risk assessments in relation to safety issues. However, not all risk assessments were comprehensive for example, health and safety. We found the provider had implemented measures to reduce risk related to COSHH and Legionella and the provider had safety sheets for COSHH however there was no formal/ comprehensive risk assessments for Legionella or COSHH.
- The provider had risk assessed taking blood samples from patients. However, had not considered collecting and monitoring staff immunisation status as part of the risk assessment.

Requires Improvement

Are services safe?

- To mitigate risk from trips and falls the provider had identified where the floor was not level including where there were steps. We saw evidence there were signs and/or tape on the floor to warn patients.
- 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.
- Throughout the inspection process the provider responded appropriately to our concerns, to improve safety.

Lessons learned and improvements made

The service had processes in place to discuss and learn when things went wrong.

- There was a system for recording and acting on significant events. Staff understood their duty to raise concerns and report incidents and near misses.
- There were adequate systems for reviewing and investigating when things went wrong.
- The provider was responsive to concerns we raised during the inspection and took immediate action to improve safety.
- The provider held regular quality and safety meetings. From minutes we viewed we saw that complaints, patient feedback and incidents were standing agenda items.
- The provider was aware of and complied with the requirements of the Duty of Candour. The provider encouraged a culture of openness and honesty. The service had systems in place for knowing about notifiable safety incidents
- The service acted on and learned from external safety events as well as patient and medicine safety alerts. The service had an effective mechanism in place to disseminate alerts to all members of the team including sessional and agency staff.

Good

Are services effective?

We rated effective as Good because:

The provider had implemented appropriate systems to monitor care and treatment

Effective needs assessment, care and treatment

The provider had systems to keep clinicians up to date with current evidence based practice. We saw evidence that clinicians assessed needs and delivered care and treatment in line with current legislation, standards and guidance (relevant to their service)

- The provider assessed needs and delivered care in line with relevant and current evidence based guidance and standards such as the National Institute for Health and Care Excellence (NICE) best practice guidelines.
- The provider carried out an initial health assessment, face to face, to ensure they had enough information to make or confirm the decision for a treatment plan.
- Patients' immediate and ongoing needs were fully assessed. Where appropriate this included their clinical needs and their mental and physical wellbeing.
- From records we reviewed we found clinicians had enough information to make or confirm a diagnosis
- We saw no evidence of discrimination when making care and treatment decisions.
- Arrangements were in place to deal with repeat patients. For example, if patients needed a follow up appointment.
- Staff assessed and managed patients' pain where appropriate.
- The provider allowed at least 2 weeks in between the initial consultation and the procedure. This allowed patients time to consider the information they had received from the surgeon before choosing to go ahead with the procedure.
- All patients received a telephone call post operatively to monitor for any complications and to arrange a follow up appointment if required.

Monitoring care and treatment

The service was actively involved in quality improvement activity.

- The service used information about care and treatment to make improvements. The service made improvements through the use of completed audits and from collecting patient feedback.
- The provider monitored the quality of record keeping, including that clinicians sought and documented consent appropriately.
- Staff kept a log of each patient, the procedure and if there were any post operative complications or histology results that would need monitoring and follow up. At the time of the inspection, the clinic had been providing minor surgery for approximately 5 months and had not been delivering this service long enough to complete a full years audit. We saw that information was documented clearly and when the provider came to audit this information, it would be easily accessible to them.
- The provider contacted patients 3 months after their procedure to request feedback about the service they had received. From information we viewed, we saw that patient feedback was positive about the service they had received, including that patients felt that clinicians explained the procedure to them, they had adequate time to consider risks and effects before the procedure and patients responded positively about aftercare advice.
- All patients were also given information immediately after their appointment, on how they could provide patient feedback. Staff monitored feedback daily and contacted patients if any negative comments were reported.

Effective staffing

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

Good

Are services effective?

- All staff were appropriately qualified. The provider had an induction programme for all newly appointed staff.
- Relevant professionals (medical and nursing) were registered with the General Medical Council (GMC)/ Nursing and Midwifery Council and were up to date with revalidation
- The provider had processes in place to monitor that staff had completed required training and provided staff with protected time to complete it.
- However, on reviewing staff files, we found one clinician's training in adult life support, health and safety and infection control had expired. The provider told us the staff member would complete the training as soon as possible.

Coordinating patient care and information sharing

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

- Patients received coordinated and person-centred care. Staff referred to, and communicated effectively with, other services when appropriate. For example, the patients registered GP.
- Before providing treatment, doctors at the service ensured they had adequate knowledge of the patient's health, any relevant test results and their medicines history.
- Patients were asked to complete a health questionnaire before their consultation.
- The provider had systems in place to request analysis of histology samples.
- From records that we viewed we saw 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.
- Patient information was shared appropriately, and the information needed to plan and deliver care and treatment was available to relevant staff in a timely and accessible way.
- There were clear and effective arrangements for booking follow up appointments

Supporting patients to live healthier lives

Staff were consistent and proactive in empowering patients and supporting them to manage their own health and maximise their independence.

- Where appropriate, staff gave people advice so they could self-care.
- Risk factors were identified, highlighted to patients and where appropriate highlighted to their normal care provider for additional support.
- Where patients needs could not be met by the service, staff redirected them to the appropriate service for their needs.

Consent to care and treatment

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

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

Good

Are services caring?

We rated caring as Good because:

Staff demonstrated an understanding of treating patients with kindness and respect.

Kindness, respect and compassion

Staff treated patients with kindness, respect and compassion.

- The service sought feedback on the quality of clinical care patients received.
- Feedback from patients was positive about the way staff treat people.
- Staff understood patients' personal, cultural, social and religious needs. They displayed an understanding and non-judgmental attitude to all patients.
- The service gave patients timely support and information.

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. Patients were also told about multi-lingual staff who might be able to support them.
- Patients were sent information to read through before their appointment, giving them time to think about any questions they may want to ask during their consultation.
- From patient feedback we viewed we saw that patients felt supported by staff and had sufficient time and information to make an informed decision about the choice of treatment available to them.

Privacy and Dignity

The service respected patients' privacy and dignity.

- Staff recognised the importance of people's dignity and respect.
- During the inspection, we found that conversations taking place in the consultation room could be heard in the waiting area. The provider told us, they were aware of this and they timed appointments accordingly so that only one patient attended the clinic at a time. We found that demand for the service was such that the clinic could accommodate this without causing delays in patients care or treatment.

Good

Are services responsive to people's needs?

We rated responsive as Good because:

The provider had not formally assessed how accessible the service was, however, they could demonstrate how they supported most patients to access the service on an equal basis to others.

Responding to and meeting people's needs

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

- The provider understood the needs of their patients and improved services in response to those needs. For example, the provider was continually reviewing what services they offered and if there was demand for additional services to help improve patient's wellbeing.
- The facilities and premises were appropriate for the services delivered. We saw that there was step access into the building and into the minor surgery room, as well as an unlevel floor into the toilet. The provider had not formally risk assessed this. However, explained if patients were wheelchair users and required access into and around the building, they had a suitable ramp that could be obtained from one of their other clinics.
- Staff told us they asked about additional requirements at the time of booking an appointment.
- The provider had arrangements in place if an interpreter was needed.
- The clinic did not have a hearing loop.

Timely access to the service

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

- Patients had timely access to initial assessment, test results, diagnosis and treatment.
- Waiting times, delays and cancellations were minimal and managed appropriately.
- From patient feedback we viewed we saw that 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 had processes in place to respond to them to improve the quality of care.

- Information about how to make a complaint or raise concerns was readily available in the waiting area.
- The service informed patients of any further action that may be available to them should they not be satisfied with the response to their complaint.
- The service had complaint policy and procedures in place.
- The provider requested and monitored patient feedback.
- We saw that clinic staff met regularly to discuss complaints and patient feedback.
- At the time of the inspection, the clinic had not received any complaints.

Requires Improvement

Are services well-led?

We rated well-led as Requires improvement because:

The provider had produced safety policies and carried out risk assessments, however they were not all comprehensive. All possible risks had not been considered and mitigated.

We found the provider responded appropriately to all of our concerns and took immediate action to improve safety. The likelihood of these issues happening again in the future is low and therefore our concerns for patients using the service, in terms of the quality and safety of clinical care are minor. (see full details of the action we asked the provider to take in the Requirement Notices at the end of this report).

Leadership capacity and capability;

Leaders took appropriate action to improve safety

- Leaders were knowledgeable about issues and priorities relating to the quality and future of services. They had completed relevant training to help them understand the legal requirements of providing a safe service, however, were not able to demonstrate during the inspection that all possible risks had been identified and mitigated.
- Leaders were visible and approachable. They worked closely with staff and others to make sure they prioritised compassionate and inclusive leadership.
- During the inspection, we shared our concerns around safety and governance with the provider, who responded appropriately and took immediate action to improve safety processes.

Vision and strategy

The service had systems in place to review the service and monitor and discuss quality.

- The provider had not produced a formal business plan however told us they discussed the service and reviewed performance each week and how to develop the service further with the director.

Culture

The service had a culture of wanting to deliver high-quality care.

- Staff felt respected, supported and valued.
- We observed positive relationships between clinical and non clinical staff.
- The service focused on the needs of patients.
- The provider had produced policies that supported being open, honest and transparent when responding to incidents and complaints. The provider was aware of and had systems to ensure compliance with the requirements of the duty of candour.
- Staff told us they could raise concerns and were encouraged to do so. They had confidence that these would be addressed.

Governance arrangements

Governance arrangements were not robust and required improvement.

- Structures, processes and systems to support good governance and management and support staff in their governance roles required improvement.

Requires Improvement

Are services well-led?

- Leaders had established policies, procedures and activities to ensure safety, however not all were comprehensive, and the provider could not assure themselves that they were operating as intended.
- The provider met with staff to discuss risks and performance and we saw evidence of the provider taking appropriate action when risks were identified.

Managing risks, issues and performance

There were processes for managing risks, issues and performance. However, not all risks had been identified and mitigated.

- Processes to identify, understand, monitor and address current and future risks including risks to patient safety required improvement.
- The provider had taken action to mitigate risk, for example most staff had completed relevant health and safety training and we saw evidence of activities to monitor and mitigate risk related to Legionella, fire risk and COSHH.
- However, we found there was no Legionella or COSHH risk assessment, the IPC and Health and Safety risk assessment were not comprehensive and the fire risk assessment had not been repeated since 2020. Although there was evidence of PAT testing, there was no evidence of calibration of medical equipment.
- Staff were not following the policy for managing health care waste and this had not been identified on IPC audits. We found that the sharps bin and clinical waste was not being stored in the minor surgery room in line with the provider's policy.
- The service had processes to manage current and future performance.
- Performance of clinical staff could be demonstrated through audit of their consultations, prescribing and referral decisions. Leaders had oversight of safety alerts, incidents, and complaints. The process for monitoring staff training was not effective. We found that clinician's had not completed all required training.

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.
- The service used performance information which was reported and monitored and management and staff were held to account
- The information used to monitor performance and the delivery of quality care was accurate and useful. There were plans to address any identified weaknesses.
- The service submitted 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.

Engagement with patients, the public, staff and external partners

The service involved patients and staff to support high-quality sustainable services.

- The service encouraged and heard views and concerns from patients and acted on them to shape services and culture.
- Staff could describe to us the systems in place to give feedback. Staff told us the provider had listened to their suggestions and had implemented new processes to improve the safety and quality of the service delivered.

Continuous improvement and innovation

Requires Improvement

Are services well-led?

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

- The provider responded appropriately to all of our concerns and took immediate action to improve safety and quality.
- The service had processes in place to investigate and learn from incidents and complaints.
- Leaders encouraged staff to take time out to review processes. Newly employed staff told us they had already improved processes including management of patient information, histology process.
- The provider was considering other treatments they could offer to improve wellbeing. This included intravenous (IV) vitamin supplementation. We advised the provider to submit any relevant policies and processes they had developed to us before we agreed they could start to deliver this service.

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 Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance Systems or processes must be established and operated effectively to ensure compliance with the requirements of the fundamental standards as set out in the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 **How the regulation was not being met:** The provider could not demonstrate that the DBS policy was always followed. Systems and processes to manage IPC risks were not fully effective or always followed. The provider could not demonstrate that medical equipment including the refrigerator where medicines were stored had been calibrated in line with manufacturers guidance. Systems to manage and mitigate risk related to health and safety and fire were not effective. There was no risk assessment for the emergency medicines the provider had chosen not to stock. There was no process in place to monitor the security of blank prescription stationery. The provider's process for monitoring staff training was not effective and we found one clinician's training in adult life support, health and safety and infection control had expired. **This was in breach of Regulation 17 (1)(2) Good governance.**