Perfect Image Consultants Limited

Roberts House

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

Summary of findings

Overall summary

Roberts House is operated by Perfect Image Consultants. The service provides surgical procedures to adults only. We inspected the service using our comprehensive inspection methodology. The service was previously inspected in April 2019 but was not rated at this time. To get to the heart of patients' experiences of care and treatment, we ask the same five questions of all services: are they safe, effective, caring, responsive to people's needs and well led?

We rated it as inadequate because:

- Staff did not have training in key skills or how to protect patients from abuse or the risk of abuse. They were not able to demonstrate they provided safe care. The service was not controlling infection risk well in the theatre environment. Staff were potentially unable to care for deteriorating patients as some equipment was out of date or not functional. The service was not clear about how to manage safety incidents.
- Managers did not monitor the effectiveness of the service and had not provided staff with guidance to provide care based on national guidance. Staff did not work with other healthcare professionals for the benefit of patients. Patients were not always given a 14-day cooling off period before cosmetic surgery was carried out.
- The service did not work with others in the wider system to support patient care and did not provide translation services for patients with barriers to communication.
- Leaders lacked insight into the problems identified at the service and there were no clear governance processes. The service had no clear vision or values for staff to work towards. The service did not engage well with patients, staff or wider health care providers to plan and manage services and staff were not committed to improving services continually.

However:

- The service had enough staff to care for patients and the environment was visibly clean. They stored medicines safely.
- There was the correct pain relief to give patients and key services were contactable seven days a week. Managers made sure staff were clinically competent to carry out their role.
- Eligible patients could access care promptly and were able to make a complaint about the care they received if they were unhappy.

As a result of this inspection, we took urgent action to suspend the registration of the provider for an initial period of eight weeks. We are also placing the service into special measures.

Services placed in special measures will be inspected again within six months. If insufficient improvements have been made such that there remains a rating of inadequate overall or for any key question or core service, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating the service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. The service will be kept under review and, if needed, could be escalated to urgent enforcement action. Where necessary another inspection will be conducted within a further six months, and if there is not enough improvement we will move to close the service by adopting our proposal to vary the provider's registration to remove this location or cancel the provider's registration.

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Surgery	Inadequate 	Surgical procedures were a small component of the total activities that the provider offered and were the only part of the service that CQC regulates. We rated this service as inadequate as we found safe and well led were inadequate and effective and responsive required improvement. We were not able to rate caring, as there was not enough evidence to rate.

Summary of findings

Contents

Summary of this inspection

Background to Roberts House

Roberts house is run by Perfect Image Consultants Limited. The service opened in August 2009. Roberts house is an independent healthcare service. The services the Care Quality Commission regulate that are offered by Roberts house include surgical removal of cysts, lipomas and moles, blepharoplasty, liposuction, ear correction and labiaplasty. The service offers consultations for other surgical procedures which are carried out at other locations. The service also offered numerous beauty treatments at the clinic that are not regulated by the Care Quality Commission. Since the beginning of 2021 the service had carried out three cosmetic surgeries, and a number of consultations that fell into the Care Quality Commission regulations. Patients are self-funded and can self-refer from outside of the local area.

The service has had a registered manager in post since May 2011. It is registered to provide diagnostic and screening and surgical procedures to people over the age of 18. We previously inspected this service in April 2019 but did not rate it at that time.

How we carried out this inspection

The inspection was undertaken by two CQC inspectors using our comprehensive methodology. The inspection was overseen by Nicola Wise, Head of Hospital Inspection.

During the inspection we inspected the theatre, consultation room and the waiting room. We spoke with four members of staff and reviewed three patient records.

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

Areas for improvement

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

Action the service MUST take to improve:

- The service must ensure that they have adequate checking procedures to ensure the contents of the resuscitation trolley are within the manufacturer's expiry dates.
- The service must ensure any resuscitation equipment is functioning.
- The service must ensure any equipment in the operating theatre complies with infection control principles.
- The service must ensure they have processes to check for waterborne bacteria.
- The service must ensure fire evacuation plans are up to date and all staff are trained to complete them.
- The service must ensure all staff have completed mandatory training to keep patients safe and maintain records of these checks.
- The service must ensure it disposes of clinical waste in line with national guidance and regulations.
- The service must ensure there are systems or processes in place to keep all staff up to date with changes to practice.
- The service must ensure policies are kept up to date with national guidance.

Summary of this inspection

- The service must ensure policies guide staff to complete all aspects of their job in a safe manner, in line with national guidance.
- The service must ensure it reviews the surgical outcomes, to ensure surgical procedures are safe.

Our findings

Overview of ratings

Our ratings for this location are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Surgery	Inadequate	Requires Improvement	Insufficient evidence to rate	Requires Improvement	Inadequate	Inadequate
Overall	Inadequate	Requires Improvement	Insufficient evidence to rate	Requires Improvement	Inadequate	Inadequate

Inadequate

Surgery

Safe	Inadequate
Effective	Requires Improvement
Caring	Insufficient evidence to rate
Responsive	Requires Improvement
Well-led	Inadequate

Are Surgery safe?

Inadequate

Mandatory training

The service did not provide regular mandatory training in key skills.

Staff did not receive regular mandatory training. We reviewed staff files and could not find records of staff training. We found a record that showed two members of staff had received fire safety training in January 2019 in the fire safety policy, however five members of staff had not received this training.

The service did not have a plan for the training staff should have to keep patients safe.

The clinical director told us staff received training in their NHS roles and did not need further training. We did not find records of staff NHS training in their staff files. Additionally, as this was a separate service with their own specific requirements there was no guarantee that training staff received in the NHS would translate across to this service. Non-clinical staff did not work in the NHS and had not received any mandatory training.

The lack of mandatory training contradicted the service's health and safety policies which stated that first aid training would be provided for the responsible person, manual handling training would be provided and safe medical gas handling training would be provided.

Safeguarding

Staff were not trained on how to recognise and report abuse. Not all staff understood how to protect patients from abuse.

Staff did not receive training on how to recognise and report abuse and there was no safeguarding policy to guide staff how to identify and protect potentially vulnerable patients. We were told staff had last been trained in safeguarding in 2019, however when we asked for records of this, we were not given them. Following the inspection, we were told clinical members of staff received their safeguarding training in the NHS, proof of this was not found in their staff files when we checked them while we were on site.

Inadequate

Surgery

Not all staff were able to give examples of who they would consider potentially vulnerable patients. Non-clinical staff did not recognise the importance of their role in identifying and protecting vulnerable patients, saying they only had responsibility for their own areas.

There was no identified safeguarding lead for the service. Staff told us they would speak to the clinical director if they were concerned about a patient. However, their level of training was not clear as we were not provided with safeguarding training records when we requested them.

Cleanliness, infection control and hygiene

The service did not always control infection risk well. The service had no systems to identify surgical site infections. Staff were not always using equipment and control measures to protect patients from infection. They kept equipment and the premises visibly clean.

The theatre did not have suitably maintained equipment to allow proper cleaning to be carried out. The surgical couch cover peeled away at the corners and this exposed a sticky surface that could not be wiped clean. This meant patients were put at risk of cross contamination and surgical site infection.

Staff followed most infection control principles including the use of personal protective equipment (PPE). We inspected the service during the COVID-19 pandemic. At the time we inspected although the wearing of face masks was no longer mandated we saw staff were still using appropriate PPE while patients were in the clinic. We were told, as they were a healthcare setting, they were asking patients to wear masks also. However, not all staff followed bare below the elbow principles. We saw one member of clinical staff wearing a watch while seeing patients.

Staff did not formally audit surgical site infections. Due to the small number of procedures carried out they knew there had been none in the past year.

We found one open bottle of cleaning solution that was out of date in the theatre.

Staff cleaned equipment after patient contact but did not label equipment to show when it was last cleaned. However, the environment was visibly clean and there were daily cleaning audits to check all applicable areas had been cleaned.

Environment and equipment

The design, maintenance and use of equipment and environment did not work to keep people safe. Staff did not always manage clinical waste well.

The design of the environment followed national guidance however, all relevant safety checks were not carried out. We asked staff how water quality was tested to ensure waterborne bacteria was not in the water system. The clinical lead said they thought this was the landlord's responsibility, but this was not mentioned in the lease. We found no evidence water system or water quality checks were carried out, as per health and safety executive guidance. This meant patients and staff were at risk of coming into contact with waterborne bacteria, such as legionella, and becoming acutely unwell.

The clinic gas safety checks were last completed in January 2019, these should be completed annually. In addition to this, the fire risk assessment had not been completed since February 2020. Therefore, any potential current fire or gas hazards were not known by the service, posing a risk to staff and patients.

Inadequate

Surgery

Staff were not always completing daily safety checks of equipment. When checks were completed, they were not thorough and did not identify concerns. We found unaccounted for gaps in the resuscitation trolley checklist on days patients were seen in the clinic. We found multiple pieces of equipment on the trolley that were out of date by several months. This was not identified in the checklist, nor had the expired pieces of equipment been removed or replaced.

The automatic external defibrillator was not working. An automatic external defibrillator is a device that is used during resuscitation to check a heart rate and, when required, to give an electric shock to try and restart the heart. We highlighted this to the clinical director, who told us they thought it did work. They were unable to start the defibrillator and said it might need new batteries. One of the Resuscitation Council UK core standards is that patients have access to defibrillation within three minutes, a non-functional defibrillator would delay this.

Staff were not always disposing of clinical waste safely. We found that sharps bins in the theatre were not labelled with who started them and when, as required by the sharps bin providers. In addition to this we found bins for clinical waste had domestic waste bin bags in. In a healthcare setting waste should be divided into separate bins at the point of disposal to ensure it is destroyed in a safe way when it is collected. Having the wrong colour waste bags in the wrong bins could mean staff were incorrectly disposing of waste. This practice was not consistent with the section on waste management in the clinic's clinical governance policy.

The service had enough equipment to help them to safely care for patients. The service used single use aseptic surgical kits which meant it was easier for them to manage stock.

The service had records of annual PAT testing for electrical goods. PAT testing is a test for portable electrical goods to ensure they are safe to be plugged into electrical sockets and must be carried out annually.

Assessing and responding to patient risk

Staff completed patient histories for each patient.

Staff completed patient histories during consultations, and we were told they did not treat patients who were considered a "high risk". Following the inspection, we were sent a document that clarified inclusion and exclusion criteria called the "admissions/exclusion criteria". However, the criteria contradicted other documents we were sent. The admissions/exclusion criteria stated the service would not see patients under the age of 18, but the patient guide stated that patients "between the age of 16 and 18 must be accompanied by a parent or guardian". This lack of clarity meant staff might accept patients for treatment who should not have been accepted.

The admissions/exclusion criteria stated that before patients were accepted the lesion proposed for surgical removal would need to have been assessed as safe to remove by a GP. However, while on site we were told the service did not communicate with patients GPs, therefore it would not be possible to know whether this was happening for all patients.

The service had current Resuscitation Council UK algorithms to guide staff to care for deteriorating patients. However, as identified in the environment and equipment section, their ability to deliver prompt care to a deteriorating patient was impaired due to expired equipment and an automatic external defibrillator that was not working.

They also had a policy to guide staff to identify people with suspected sepsis which had clear steps to take if sepsis was suspected.

All patients who underwent surgery at the service were given the clinical director's telephone number to contact him at any time if they were concerned about side effects.

Inadequate

Surgery

Staffing

The service had enough staff with the right qualifications and experience to provide the care and treatment.

There were two doctors at the service who were able to carry out surgery. Appointments were only booked for days these doctors were working if a patient required surgery. There was one further doctor who was being trained by the clinical director to provide cover in the future.

We were told there had only been one occasion in the past year when a clinic had to be cancelled due to the unavailability of a doctor.

There were also three members of non-clinical staff to support the clinical team and to take bookings, organise payments and ensure patient records were ready when required.

Records

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

Patient notes were clear, and all staff could access them easily. Records were kept on paper and there was a well organised system to enable staff to find them.

Patient records we reviewed were clear and easy to navigate.

Staff stored records securely. They were stored in a locked cabinet in an area of the clinic patients did not enter unattended. Appointments were booked and recorded on a computer system. We saw the security certificate meaning these were also adequately protected.

It was made clear to patients how long records would be kept for, following being seen in clinic.

Medicines

The service did not support staff to safely prescribe medicines. However, they did safely store medicines.

We were told regular drug stock checks were recorded in the master theatre drug logbook. Following inspection, we requested the up to date documentation showing this. We were sent copies of pages from February and March 2020 and nothing more recent. The service was no longer reconciling their drug stocks.

There were not any procedures or policies guiding staff to prescribe medicines consistently or safely. We were told by the clinical director it was down to clinical judgement and they did not feel their clinicians needed it to be written down. This meant there was a risk clinicians were either over or under prescribing medicines as they were not supported to remain consistent.

Medicines were now stored appropriately. There were no temperature-controlled medicines stored in cupboards in the theatre.

There was a section of the clinical governance policy about controlled drugs which explained how controlled drugs must be recorded and who was responsible for this.

Inadequate

Surgery

The service received email alerts from the Medicines Healthcare products Regulatory Agency (MHRA) to ensure the clinical director knew about safety alerts and incidents. We were told recent MHRA alerts had not been applicable to their practice but that the clinical director would follow up on any that were applicable.

The service prescribed minimal amounts of pain relief, local anaesthesia to directly numb the area being operated on and did not prescribe post-surgical pain relief.

Incidents

The service was not clear about how to manage patient safety incidents. Staff were not clear about what was an incident or a near miss, and none had been reported in the past year.

Staff were not clear about what incidents were or how to report them. Some staff we spoke with told us they had no accidents and so there was nothing to report. They were unaware that an incident could be something that was not a slip trip or fall. Therefore, although no incidents had been reported we could not be sure none had happened.

We asked staff how they would report an incident and they told us they would speak with their manager; this was not in line with provider policy. The provider's health and safety policy stated they should be reported in the accident book and then this should be raised with the practice manager afterwards.

The incident reporting policy was unclear. At the start of the policy staff were directed to report an incident in the accident book. Throughout the rest of the policy it mentions using incident forms. This discrepancy could lead to staff following different practices and not consistently reporting incidents.

The service had no never events.

As there were no incidents reported in the past year, we saw no evidence of learning from local incidents.

In the incident reporting section on the health and safety policy there was no mention of how or when to apply duty of candour. The incident reporting form did not mention duty of candour and the "procedure for the investigation of incidents" also did not mention when to consider applying out duty of candour. We found no standalone duty of candour policy. Clinical staff they were unsure who would carry out duty of candour if it was required. They told us they felt they had responsibility for their patients, so would "probably do it", but it might be the clinical director.

Are Surgery effective?

Requires Improvement

Evidence-based care and treatment

The service could not demonstrate they provided care and treatment based on national guidance and evidence-based practice as there were no clinical policies and procedures.

Staff were not able to follow up-to-date policies to plan and deliver high quality care according to best practice and national guidance as the service did not have any clinical pathway policies. There were elements of other policies and procedures that could be used to guide parts of clinical care but these were not version controlled and did not have review dates and therefore staff may use out of date versions.

Inadequate

Surgery

We were told by the clinical director they believed their clinicians were “capable” and therefore they did not have to work in the same way and so there were no procedures. We asked how changes to practice would be shared with staff, if they were not written down and we were told that clinical staff regularly worked together and so it would be communicated verbally.

Nutrition and hydration

Patients were only in the service for minimal amounts of time, therefore it was not necessary for the service to provide nutrition and hydration for them.

Pain relief

Staff told us they assessed patients to see if they were in pain.

Staff did not assess patients’ pain using a recognised tool. We were told staff would inject the surgical area with local anaesthetic and would then assess whether this was effective by touching the area with a scalpel. If a patient was able to feel the scalpel they would wait until the anaesthetic was effective, or prescribe more, if required.

Staff prescribed and recorded pain relief accurately in patient records.

Patient outcomes

Staff did not monitor the effectiveness of care and treatment.

The service did not audit their clinical performance. We were told patient outcomes were not specifically monitored as patients rarely returned to the service and the service felt it was not possible to audit outcomes. We were told that immediately following surgery patients were asked how happy they were with the outcome on a scale of 1-10. Patients often scored the service highly.

There were no surgical site infections in the past 12 months.

Competent staff

The service made sure staff were competent for their roles.

Staff were experienced, qualified, and had the right skills and knowledge to meet the needs of patients. We reviewed staff files and found evidence of courses clinicians had attended to prove competence. In addition, we were told clinicians worked closely with the clinical director when they first started at the service and shadowed him until they felt comfortable to work alone. They were able to ask questions and often still worked alongside him.

Staff who had started at the service in the past two years told us they had an induction tailored to their role before they started working alone. This did not apply to staff who had worked at the service for longer.

Staff had appraisals and told us these were done annually, but they did not always set themselves targets to develop. When we reviewed staff files, we found records of appraisals being carried out every two years and not annually. The content of the appraisals was the same from one review to the next and not all appraisals were signed by the clinical director, or any manager. Following inspection the clinical director told us they aim to carry out appraisals every two years, and not annually.

The service had no staff meetings to share information with staff. We were told if there were changes to practices staff would be made aware of these verbally, there was no written record of these conversations.

Inadequate

Surgery

We were told if an employee working under practising privileges was not working to the standards for the clinic they would no longer be asked to work for the service.

Multidisciplinary working

There was limited evidence of multidisciplinary working within the service and none with external healthcare providers.

The service carried out simple cosmetic procedures and did not have any multidisciplinary meetings. In the records we reviewed we did not see evidence of treatment options being discussed with other healthcare professionals.

The service's admission criteria noted they would only remove lesions if they had been assessed by the GP to not need further investigation. However, we saw no evidence of communication between the clinic and the patient's GP to confirm this was the case in the records we reviewed.

Seven-day services

Patients were able to access telephone support seven days a week.

The service was open six days a week for appointments. Outside of opening hours patients who had undergone surgery were given the clinical director's telephone number to call if they had a concern.

Health promotion

Due to the nature of the care provided at the service there were limited opportunities for health promotion.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

Staff supported patients to make informed decisions about their care and treatment.

Staff understood how and when to assess whether a patient had the capacity to make decisions about their care. However, there was no formal documentation for staff to complete in the event a capacity assessment needed to be completed. The service did not treat patients who were assessed as lacking capacity; we were told if a patient attended for a consultation and was deemed to not have capacity the clinic would not proceed with their appointment.

Staff gained consent from patients for their care and treatment in line with legislation. We saw consent was gained in patient records. There were specific consent forms for different procedures. We were told by one clinician they had been able to add content to the standard consent form for the surgical procedures they carried out, as they felt not all possible outcomes were covered.

Staff did not follow best practice guidance from the Royal College of Surgeons with regards to a cooling off period. The royal college of surgeons suggest that for cosmetic procedures there should be a 14-day cooling off period between consultation and the procedure. In one patient record we reviewed the consultation and consent was signed on the same day as the procedure. There was no explanation in the patient record why a cooling off period had not been given. We were told this was normal and if patients agreed to treatment they were able to have the surgery on the same day, the service did not mandate a 14-day cooling off period.

Are Surgery caring?

Inadequate

Surgery

Insufficient evidence to rate

Compassionate care

Staff treated patients with compassion and kindness.

Staff took time to interact with patients and those close to them in a respectful and considerate way. We overheard the receptionist speaking with patients on the telephone. They took their time to explain what the service was able to offer the patient and made pricing structures clear to patients from the initial phone conversation.

Staff kept patient care and treatment confidential. Only one patient was allowed in the clinic at a time, due to COVID restrictions, therefore all care was confidential.

Staff told us they understood and respected the personal, cultural, social and religious needs of patients and how they may relate to care needs. There was a chaperone policy and patients were able to request a chaperone if they wanted one. The clinic allowed chaperones to either be staff or somebody the patient knew personally and brought with them to the appointment. Non-clinical staff sometimes acted as chaperones, however they had received no training to act as a chaperone.

Emotional support

We were unable to directly observe any patient care and therefore cannot comment on the emotional support provided by the service.

Understanding and involvement of patients and those close to them

Staff supported patients to make decisions about their care and treatment.

Staff made sure patients and those close to them understood their care and treatment. We saw evidence in patient records that patients were given an opportunity to ask questions about their care.

Staff supported patients to make informed decisions about their care. In care records we saw that options for care or treatment had been discussed and patients were not pressured into accepting care immediately. In two of the three records we reviewed we saw there had been an initial consultation, but the patient was going to consider their options and make a decision at a later date.

The clinic did not charge a consultation fee for appointments instead they took a booking fee to hold the slot. The booking fee was later deducted from any ongoing fees. This meant patients had not had a significant financial outlay that may influence their decision to have treatment at the clinic.

Patients could give feedback on the service and their treatment. Patients were able to leave online feedback about the service. However, following inspection we asked for the feedback provided in the past 12 months and the service was unable to provide us with a summary of what they had been told.

Are Surgery responsive?

Inadequate

Surgery

Requires Improvement

Service delivery to meet the needs of local people

The service provided care that met the needs of their patients. It did not work with others in the wider system and local organisations to plan care.

Managers planned and organised services so they met the needs of their patients. The service offered removal of lesions that would not be removed under NHS treatment.

The service had an admissions criteria and only treated patients who didn't have complex needs.

Managers had a system to minimise missed appointments. The day before an appointment a member of staff would call patients to remind them of their appointment. In addition to this the service took a booking fee at the time an appointment was booked, this was later refunded when they attended the appointment, or was deducted from the cost of any future treatment. We were told this small financial incentive had reduced the number of missed appointments.

Meeting people's individual needs

The service only accepted patients without complex needs.

The service did not provide translation services Patients were asked to arrange their own professional translator or use relatives or loved ones. The service did not provide written information in any language other than English.

Staff told us if patients attended for a consultation and were identified as having additional needs, or health concerns that prevented them from having treatment at the clinic they would be asked to arrange to see their GP again..

Access and flow

People could access the service and received care promptly.

The service did not monitor the time between when a patient requested an appointment to when an one was booked. We heard patients being offered appointments within one week of calling to request one. Where possible patients were offered different appointment times to suit their needs.

Clinicians told the service their availability months in advance so appointments could be booked. If a clinician was unwell and unable to see their booked patients, we were told these patients would be rescheduled.

Managers were unable to tell us how many appointments were cancelled in the past year; they did not routinely record this information.

We were told the clinic rarely ran late. If appointments were running late whoever was working behind reception told the next patient and estimated the amount of time until they would be seen.

Patients were offered a follow up appointment, to remove stitches between one week and 12 days following their surgery. We were told it was dependent on where the surgery had been carried out. This was not written into a policy or patient pathway and relied upon clinician decision.

Inadequate

Surgery

Learning from complaints and concerns

People were able to give feedback and raise concerns about care received.

The service clearly displayed information about how to raise a concern in patient areas. The complaints policy was displayed in the reception area.

Staff were aware of the policy on complaints and told us how they how they managed them. We were told the service had received no formal complaints in the past 12 months but had responded to some negative reviews online. If a patient reviewed the service negatively online the clinic reached out to them to offer them another appointment to review their concern.

Managers were not able to identify themes from the negative online reviews.

Managers did not formally share feedback from complaints with all staff. We were told if a negative review was about a single clinician, they would be told about it. However, the service did not have any staff meetings or mechanisms to share learning from complaints with all staff.

Staff could not give examples of how they used patient feedback to improve daily practice.

Are Surgery well-led?

Inadequate

Leadership

Leaders did not have insight into the concerns found at this inspection. They had good clinical knowledge but lacked wider oversight. They were visible and approachable in the service for patients and staff.

The clinical director ran the service and also worked clinically. They had years of experience of working clinically in both the NHS and in independent healthcare. However, they had not identified the concerns we did at this inspection. They spoke confidently about their staff's experience and professionalism but, did not appear to recognise the seriousness of the concerns we identified and shared with them.

They were available most days at the service and supported their staff, but due to the number of roles they were carrying out they did not have the capacity to do everything that was required by the regulations. We found a wide range of concerns, some that needed actioning immediately, for example the resuscitation trolley containing expired equipment. Due to their clinical responsibilities on the day of our inspection we did not see any immediate changes happening.

Our previous unrated inspection report, from the 2019 inspection, highlighted a number of concerns we found again at this inspection. There had been no change in the leadership of the service in this time and no substantial changes had been made.

Vision and Strategy

The service did not have a vision for what it wanted to achieve or a strategy to turn it into action.

Inadequate

Surgery

We asked the clinical director what the service values or vision was. They were unable to answer this despite the employee handbook having a mission statement, philosophy and vision clearly stated. Staff we spoke with were also unable to tell us what the vision or values of the service were.

While on inspection we found a business plan written in 2019. We asked for a current version of this following inspection and were told it had not been updated since 2019. There was therefore no formal strategy for the service.

Culture

Staff felt respected, supported and valued. They were focused on patients receiving care.

Staff told us they enjoyed working at the service and two members of non-clinical staff had worked for the clinic for several years. The clinical staff had not worked for the service for as long but told us they did not have any concerns and enjoyed the variety of work that working at the clinic gave them.

All staff told us they felt supported by the clinical director and they regularly worked alongside each other.

The service carried out a staff survey and following inspection we requested the results. We were not provided with this information as the person who held it was on annual leave. This meant no other member of staff was able to act on the staff feedback either.

Permanently employed staff told us they had annual appraisals, but they did not always set themselves targets if they did not want to. We reviewed the appraisals and could not find evidence they were always carried out annually, we found they were completed every two years. When we reviewed the content of the appraisal, we saw the information was the same from one appraisal to the next and they were not always signed by the manager. Following inspection the clinical director told us they aim to carry out appraisals every two years, and not annually

Governance

Leaders were not operating effective governance processes. Staff had no opportunities to meet, discuss or learn from the performance of the service. **Staff were not always trained to carry out their roles and accountabilities.**

The service hired three members of staff on part time contracts, to carry out non-clinical work. There were two nurses working under practising privileges, who carried out clinical work that did not fall into CQC regulatory remit. There was also one doctor working under with practising privileges who carried out the work that was regulated by CQC. In addition to this they were employing another doctor under practising privileges to train to work for the service. All staff reported into the clinical director, who managed the service, worked clinically and supported other clinicians.

There were no governance or staff meetings. This meant staff did not have a forum to discuss changes that were needed or share any learning. We were told when changes happened the clinical director shared this information verbally with members of staff, this was not recorded anywhere.

There was no mechanism in place for updated policies and procedures to be shared. This meant there was no way to know if all applicable members of staff had read updated versions, meaning some may be working using old methods. Documents were not version controlled and did not name dates for review. This added to the likelihood that staff would use old versions of documents, and therefore out of date guidance.

There was no formal system for storing and organising policies and procedures. There was a section on the computer for policies and audits to be saved and a document that listed the policies and procedures and when they were updated. However, this document had not been updated since 2019. During our inspection we asked the clinical director about their medicines policy and it took several minutes for them to identify which was the most up to date policy.

Checklists were not always signed by whoever had completed the check. The resuscitation trolley checklist did not have a row for members of staff to sign to show who had completed the check. We were told it was the responsibility of non-clinical staff members to check the trolley, but they were not trained to do this. Due to the lack of signatures it was unclear who was checking the trolley on a day to day basis and to therefore identify who had missed the expired equipment.

Records were not always completed accurately. For example, we found the fire risk assessment had been signed to say a fire drill had been completed in February 2020. We asked the clinical director whether this was correct, they told us there had not been a fire drill since 2019.

Management of risk, issues and performance

Leaders did not identify or escalate relevant risks and issues or identify actions to reduce their impact.

The service carried out a number of risk assessments to identify potential risks facing staff and patients. We saw these were carried out regularly, however they did not identify all the risks we found while on inspection, therefore the validity of these risk assessments, or the way they were carried out was concerning. Poorly executed risk assessments missed risks which meant the risks were not identified and subsequently reduced or removed.

Records of risk assessments were not always kept accurately. As described in governance the fire risk assessment was inaccurate and was completed, even though a fire drill had not been carried out since 2019. This led to concern other risk assessments or audits might be being treated like a tick list and not a tool to identify genuine risks.

Some risk assessments referred to other pieces of documentation that did not exist or contained information that was not accurate. For example, the annual clinic risk assessment referred to the “maintenance risk management plan”, following inspection we requested this and were sent the clinic risk assessment and not the risk management plan. The risk assessment also stated there were quarterly control of substances hazardous to health (COSHH) reviews. COSHH refers to procedures to keep people safe from chemicals, in this instance predominantly cleaning chemicals. Following inspection, we requested the quarterly reviews and were told they were completed annually.

We asked the clinical director what happened with the results of risk assessments when they were completed. We were told risk assessments were completed regularly to identify risks, but the results were not then fed into a risk register with actions to reduce the risk. This meant there was a lack of oversight of identified risks and we did not identify any action plans to reduce or remove risks.

Staff we spoke with had not identified any of the risks we found and were not aware of them. We were told by all staff we spoke with they believed the service was a safe place to work and there was nothing that concerned them.

There was no formal clinical performance monitoring or audits completed. Staff told us they worked closely with the clinical director and they had a good understanding of the clinician revalidation process and relied upon this and patient feedback to identify concerns with clinicians.

Inadequate

Surgery

We were told if a member of staff was identified as not meeting their annual NHS appraisal targets and were not maintaining the standards of the clinic they would have their practising privileges removed. However, this did not align with the disciplinary procedure written in the employee handbook. The disciplinary procedure described a multistage process where employees were given the chance to explain and appeal decisions.

Information Management

The service did not collect data. The information systems were secure.

The service did not submit data to any national audits, we were told there were none that were applicable

Information was not always readily available when requested. We asked the service for any staff survey results and were told these were not accessible as the member of staff responsible for them was not working.

The service had secure and backed up computer systems and a named information security officer. We saw in date computer security certificates and were told data was backed up on a separate system in case the live system was to crash.

We were told data or notifications would be submitted to external organisations as required, however this had not been needed.

Engagement

Leaders did not openly engage with patients, staff or other local healthcare providers to plan and manage services.

The service was not able to easily extract information about patient feedback. Following inspection, we asked for a summary of any patient feedback in the past 12 months. The service was not able to provide this and told us patient feedback was collected online. The service did not use the feedback provided by patients. There were no meetings with staff where feedback could be discussed.

Following inspection, we asked the service for the results of any staff surveys. We were told the information was held by a member of staff who was on leave and could not be accessed by other members of staff. The results had not been discussed with the clinical director and had not led to any changes in the service.

The service did not engage with other health care providers in the local area. We were told the service did not have any contact with their patient's GPs either before or after surgery.

Learning, continuous improvement and innovation

We were told by the clinical director there was no innovation or service development happening.