Sain Baba Aesthetics Ltd

Dr Victoria Cosmetic Dermatology and Anti-Ageing Medicine Clinic

Inspection report

34 Thomas Street
Winchester
Hampshire
SO23 9HJ
Tel: 01962809937
Website: https://drvictoriag.co.uk/

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Ratings

Overall rating for this service	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

Summary of findings

We carried out an announced comprehensive inspection at Dr Victoria Cosmetic Dermatology and anti-ageing Medicine Clinic on 18th July 2019 as part of our inspection programme. This is a newly registered service and thus their first inspection.

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. Dr Victoria Cosmetic Dermatology and Anti-Ageing Medicine Clinic provides a range of non-surgical cosmetic interventions, which are not within CQC scope of registration. Therefore, we did not inspect or report on these services. The clinic provides a number of skin care and beauty treatments. The inspection was in relation to specific treatments which are in the scope of registration, such as facial thread lifts, treatment of excessive sweating and the removal of minor skin lesions.

One of the doctors (who is also joint business 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.

There were no clients available to speak to on the day, but feedback was obtained through 36 completed comment cards.

Our key findings were:

- Health and Safety risk assessments had been undertaken by the landlord or external agencies. The clinic had not kept copies of these risk assessments.
- The clinic was not undertaking routine checks of water temperature to monitor the risk of Legionella nor was there a risk assessment in place.
- Not all staff had undertaken safeguarding training. This had been rectified within two days of the inspection.
- Checks of emergency medicine and infection control were undertaken but not documented.
- Fire safety checks had been undertaken by an external company and the clinic was awaiting a copy of the report.
- Not all recruitment checks had been documented in staff files but had been undertaken for example by obtaining verbal references.
- Individual care records were written and managed in a way that kept patients safe.
- Patients immediate and ongoing needs were fully assessed. Where appropriate this included their clinical needs as well as their mental and physical wellbeing.
- Staff recognised the importance of peoples' privacy, dignity and respect.
- Patients had timely access to consultation and treatment.
- The clinic was unable to offer services to wheelchair bound patients as there was no lift access to the first floor of the building.
- Staff felt respected and supported. They were proud to work for the clinic.
- Leaders had invested in training and development of staff, in relation to clinical competencies but not in relation to staff training.
- There were multiple examples of the two doctors engaging in career professional development courses and conferences to continue learning and development as well as share best practice.

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 consistency in implementing its recruitment policies and procedures.
- Review the process for documenting vaccine storage cold chain temperature checks.
- Obtain copies of the health and safety risk assessments undertaken by external organisations or landlord to assure themselves that actions had been taken to mitigate risks identified.

Summary of findings

- Review policies and procedures to ensure they contain clinic specific information.
- Review processes for chaperoning to include training for all non-clinical staff undertaking these duties.

Dr Rosie Benneyworth BM BS BMedSci MRCGP Chief Inspector of Primary Medical Services and Integrated Care

Dr Victoria Cosmetic Dermatology and Anti-Ageing Medicine Clinic

Detailed findings

Background to this inspection

Dr Victoria Cosmetic Dermatology and Anti-ageing Medicine Clinic is located at 34 St Thomas Street, Winchester, Hampshire, SO23 9HJ.

Dr Victoria Cosmetic Dermatology and Anti-Ageing Medicine Clinic is the registered location of the provider Sain Baba Aesthetics Limited and is registered to provide the following regulated activities: surgical procedures and treatment of disease, disorder or injury. They provide tailored aesthetic treatments to men and women over the age of 18. Aesthetic medicine is a term for improving cosmetic appearance. Only specific treatments are regulated by The Care Quality Commission (CQC) and these include Polydioxanone (PDO) thread lifts, botox injections for treatment of excessive sweating and the removal of minor skin lesions. The clinic also is registered for service provisions for children aged 13-17 as they do see patients of this age but only for the treatment of acne. .

The clinic is run by two doctors who also undertake the consultations and procedures. They are supported by another staff member who works part time as a receptionist and part time as an aesthetic practitioner. The clinic employs on a contractual basis someone to oversee HR and recruitment processes and someone to manage the information governance and website. Not all staff are involved in providing treatments regulated by CQC. Further information about the clinic can be found on their website: https://drvictoriag.co.uk/

Dr Victoria Cosmetic Dermatology and Anti-ageing Medicine Clinic is open Tuesday to Friday 9.30am to 5pm and also offers Saturday opening. The clinic is closed Sundays and Mondays.

How we inspected this service

During our visit we:

- Spoke with staff including the registered manager.
- Looked at comment cards submitted by clients about their experiences of using the service.
- Looked at information that the clinic used to deliver care and treatment plans.
- A sample of patient records.

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?

Our findings

We rated safe as Requires improvement because:

Systems and processes to maintain safety for staff and clients were not always in place and when they were they were not always embedded or in line with the clinics own policies or best practice guidance. For example, being trained to the appropriate level for their role and undertaking health and safety risk assessments such as for Legionella.

Safety systems and processes

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

- We were informed Health and safety risk assessments were undertaken by the landlord.. The clinic had a range of appropriate policies in place. Not all policies contained clinic specific information, such as who to go to for guidance, and there was no evidence that a review of policies had been undertaken. Staff were aware of where to access the policies. There was no documented evidence to demonstrate what safety information training staff had received on induction, but we were informed that they received a verbal walk through of the building and reading of the policies. The service had systems to safeguard children and vulnerable adults from abuse.
- The service worked with other agencies to support patients and protect them from neglect and abuse. Staff took steps to protect patients from abuse, neglect, harassment, discrimination and breaches of their dignity and respect.
- The service employed a person to provide HR support for recruitment of new staff (this individual was employed on an ad hoc basis when required and had no client contact). We did not view recruitment files for this person. The clinic informed us that staff checks were undertaken at the time of recruitment but that these were not always documented for example when verbal references were obtained. The clinic was run by a husband and wife team, one of whom was the registered manager. Both were doctors and although there was no recruitment documents for these individuals we saw evidence of their GMC registration and other documents to verify identify. A Disclosure and Barring Service (DBS) check had been undertaken for their only other employee that worked directly at the clinic. (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).
- On the day of the inspection we saw evidence that two out of the three staff directly working at the clinic had completed safeguarding training. The practice provided evidence of the other staff members safeguarding training with a certificated date of 22nd July. Not all staff had received training appropriate to their roles in line with intercollegiate guidance published in January 2019. They knew how to identify and report concerns. Staff who acted as chaperones had not undertaken formal training but had received a DBS check.
- There was a system to manage infection prevention and control however this was not embedded into practice and the clinic did not have full oversight of systems and processes for monitoring. For example, daily cleaning was undertaken by an external cleaning company, but the clinic had no record of what cleaning was being undertaken by them. There was no record of any staff having undertaken infection control training at the time of the inspection. The registered manager submitted evidence to show that all three staff had completed online infection control training within 24 hours of our inspection. There was no infection control audit undertaken of the premises, but the registered manager had undertaken an audit of patients to look at infection rates. The clinic had not undertaken any checks of hot or cold water to mitigate the risk of legionella and there was no risk assessment in place for Legionella. Legionella is a bacterial infection which can cause respiratory problems. We discussed the lack of water testing and risk assessments with the provider who informed us they were unaware of a need to undertake these but would implement systems.
- The provider ensured that facilities and equipment were safe and that equipment was maintained according to manufacturers' instructions. There were no visible stickers on equipment to confirm that checks had been undertaken to ensure equipment was safe and working correctly. However, the clinic produced a document which confirmed testing had taken place. This document was for portable appliance testing and

calibration but did not contain a breakdown of all items tested and therefore the clinic had no way of determining what had been included in the test and what required re-doing.
- There were systems for safely managing healthcare waste.
- Appropriate environmental risk assessments, which took into account the profile of people using the service and those who may be accompanying them, had been undertaken by external companies. The clinic did not have copies of these risk assessments on site.

Risks to patients

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

- There were arrangements for planning and monitoring the number and mix of staff needed. The clinic was in the process of recruiting for an additional receptionist.
- There was an effective induction system for agency 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.
- When reporting on medical emergencies, the guidance for emergency equipment is in the Resuscitation Council UK guidelines and the guidance on emergency medicines is in the British National Formulary (BNF).
- When there were changes to services or staff the service assessed and monitored the impact on safety.
- There were appropriate indemnity arrangements in place to cover all potential liabilities

Information to deliver safe care and treatment

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

- Individual care records were written and managed in a way that kept patients safe. The care records we saw showed that 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.
- Clinicians made appropriate and timely referrals in line with protocols and up to date evidence-based guidance.

Safe and appropriate use of medicines

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

- The systems and arrangements for managing medicines, including vaccines, controlled drugs, emergency medicines and equipment minimised risks. However, oversight and monitoring of processes were not always in place or embedded. For example, we were told that the emergency medicines box was checked on a regular basis but there was no documentation in place to verify this. We found a box of adrenaline that had expired in June 2019. We were told that this had been identified at their last check and was on order. The out of date adrenaline was replaced with in date medicine during the inspection. Cold chain storage was in accordance with guidance but the clinic were not recording maximum and minimum temperatures in line with best practice. The service kept prescription stationery securely and monitored its use.
- Staff prescribed, administered or supplied medicines to patients and gave advice on medicines in line with legal requirements and current national guidance. Processes were in place for checking medicines and staff kept accurate records of medicines. Where there was a different approach taken from national guidance there was a clear rationale for this that protected patient safety.
- There were effective protocols for verifying the identity of patients including children.

Track record on safety and incidents

We were unable to verify the clinic's safety record as documentation was not available at the time of the inspection.

- There were comprehensive risk assessments in relation to safety issues. The clinic had a fire risk assessment undertaken by an external company. At the time of our inspection the clinic was awaiting a copy of their report but told us they had been informed by the company that there were no concerns with fire safety.

Requires improvement

Are services safe?

- The service monitored and reviewed activity, but this was not always routinely done. This helped it to understand risks and gave a clear, accurate and current picture that led to safety improvements.

Lessons learned and improvements made

The service learned and made improvements when things went wrong.

- There was a system for recording and acting on significant events. Staff understood their duty to raise concerns and report incidents and near misses. Leaders and managers supported them when they did so. There was no formal process for recording significant events other than through an accident book but events were discussed in meetings for learning.
- There were adequate systems for reviewing and investigating when things went wrong. The service learned and shared lessons identified themes and took action to improve safety in the service.
- 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?

(for example, treatment is effective)

Our findings

We rated effective as Good because:

We found the clinic was providing effective care in accordance with the relevant regulations.

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)

- Patients' immediate and ongoing needs were fully assessed. Where appropriate this included their clinical needs and their mental and physical wellbeing.
- Clinicians had enough information to make or confirm a diagnosis or determine an appropriate course of treatment.
- We saw no evidence of discrimination when making care and treatment decisions.
- Staff assessed and managed patients' pain where appropriate.

Monitoring care and treatment

The service was 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. Clinical audit had a positive impact on quality of care and outcomes for patients. There was clear evidence of action to resolve concerns and improve quality.

Effective staffing

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

- All staff were appropriately qualified. The provider had an induction programme for all newly appointed staff, however there was no documentation to demonstrate that the induction process had been completed or what was covered. There was no single process in place for monitoring staff training to ensure they have undertaken update training in a timely manner.
- 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 understood the learning needs of staff and provided protected time and training to meet them. Staff had records for career personal development training undertaken. However, not all staff had completed training in areas such as information governance. The registered manager sent through training certificates to demonstrate that staff had received training within 48 hours of inspection. Staff were encouraged and given opportunities to develop including training to become aesthetic practitioners.

Coordinating patient care and information sharing

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

- Patients received coordinated and person-centred care. Staff referred to and communicated effectively with other services when appropriate. For example, we were told that if clinically appropriate, details would be shared with the client's GP. Likewise, clients were referred to their GP for treatment for follow up, particularly around lesion removal. The clinic was expanding its portfolio with many GPs in the area referring patients to the clinic for treatment that was not readily available on the NHS.
- 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. We saw examples of patients being signposted to more suitable sources of treatment where this information was not available to ensure safe care and treatment.
- All 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.
- The provider had risk assessed the treatments they offered. They 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

Good

Are services effective?

(for example, treatment is effective)

long-term conditions such as asthma. Where patients agreed to share their information, we saw evidence of letters sent to their registered GP in line with GMC guidance.
- Care and treatment for patients in vulnerable circumstances was coordinated with other services.
- Patient information was shared appropriately (this included when patients moved to other professional services), 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 following up on people who had been referred to other services.

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?

Our findings

We rated caring as Good because:

We found that this clinic was providing good care in accordance with regulations.

Kindness, respect and compassion

Staff treated patients with kindness, respect and compassion.

- Feedback from patients was positive about the way staff treat people. All 36 cards received spoke positively about the service.
- 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 told us through comment cards, that they felt listened to and supported by staff and had sufficient time during consultations to make an informed decision about the choice of treatment available to them.
- For patients with learning disabilities or complex social needs family, carers or social workers were appropriately involved.
- Staff communicated with people in a way that they could understand, for example, communication aids and easy read materials were available if required.

Privacy and Dignity

The service respected patients' privacy and dignity.

- Staff recognised the importance of people's dignity and respect.
- Staff knew that if patients 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?

(for example, to feedback?)

Our findings

We rated responsive as Good because:

We found that this clinic was providing responsive care in accordance with regulations.

Responding to and meeting people's needs

The service organised and delivered services to meet the needs of patients, However it did not take into account the needs of patients with mobility issues.

- The provider understood the needs of their patients and improved services in response to those needs.
- The facilities and premises were appropriate for the services delivered.
- The facilities were not appropriate for individuals in wheelchairs or with mobility issues. The premises was situated on the first floor of an old building with no lift access therefore, the clinic was unable to offer services to these individuals.
- Reasonable adjustments had been made so that people in vulnerable circumstances could access and use services on an equal basis to others.
- Patient feedback was collected via online submissions such as google reviews and also through direct verbal feedback.

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.
- We were told that sometimes consultations overran and caused a delay to the next client waiting treatment or consultation. All clients received an apology.
- Patients with the most urgent needs had their care and treatment prioritised.

Listening and learning from concerns and complaints

The service took complaints and concerns seriously and responded/did not respond to them appropriately to improve the quality of care.

- Information about how to make a complaint or raise concerns was available. Staff treated patients who made complaints compassionately.
- 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 service learned lessons from individual concerns, complaints and from analysis of trends. It acted as a result to improve the quality of care. We saw a copy of the complaints annual report which listed three reports, two unjustified and one justified. Complaints were split by type and month in order to monitor themes and trends.

Are services well-led?

Requires improvement

(for example, are they well-managed and do senior leaders listen, learn and take appropriate action?)

Our findings

We rated well-led as Requires improvement because:

Systems and processes put in place by the clinic were not always embedded into practice. There was a lack of documentation to demonstrate that routine checks undertaken by the clinic had taken place. Policies had been in place but not reviewed in a timely manner and did not contain clinic specific information. There was a lack of oversight of processes to ensure all staff had the correct recruitment documents, received training and appraisals to provide assurances they maintained up to date with competencies.

Leadership capacity and capability;

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

- Leaders were knowledgeable about issues and priorities relating to the quality and future of services. They understood the challenges and were addressing them. For example, the leaders took on a formerly unregistered provider with CQC and undertook refurbishment work at the clinic to ensure that the premises was fit for purpose in line with regulation 15 of the Health and Social Care Act (2008) and also completed the relevant paperwork to ensure they were operating as a registered provider with CQC and had a nominated individual as the registered manager. The provider was aware of what services they offered were within the scope of registration and in line with plans for the future.
- Leaders at all levels were visible and approachable. They worked closely with staff and others to make sure they prioritised compassionate and inclusive leadership.
- The provider had effective processes to develop leadership capacity and skills, including planning for the future leadership of the service. The leaders had successfully trained staff to undertake additional roles and responsibilities including developing a staff member into the role of an aesthetic practitioner.

Vision and strategy

The service had a clear vision and credible strategy to deliver high quality care and promote good outcomes for patients.

- There was a clear vision and set of values. The service had a realistic strategy and supporting business plans to achieve priorities.
- The service developed its vision, values and strategy jointly with staff and external partners (where relevant).
- Staff were aware of and understood the vision, values and strategy and their role in achieving them
- The service monitored progress against delivery of the strategy.

Culture

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

- Staff felt respected, supported and valued. They were proud to work for the service.
- The service focused on the needs of patients.
- Leaders and managers acted on behaviour and performance inconsistent with the vision and values.
- Openness, honesty and transparency were demonstrated 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.
- There were processes for providing all staff with the development they need. This included appraisal and career development conversations. We saw evidence that an appraisal was held for the two doctors as part of their professional development and revalidation however, there was no evidence to demonstrate that appraisals had been undertaken for other staff such as receptionists. We viewed files of their only current staff member and a previous staff member who had left employment. There was no record of supervision or other types of managerial discussions in the event a staff member had been employed for less than 12 months. Staff were supported to meet the requirements of professional revalidation where necessary.
- There was a strong emphasis on the safety and well-being of all staff.
- The service actively promoted equality and diversity. It identified and addressed the causes of any workforce inequality. Staff had received equality and diversity training. Staff felt they were treated equally.

Are services well-led?

Requires improvement

(for example, are they well-managed and do senior leaders listen, learn and take appropriate action?)

- There were positive relationships between staff and teams.

Governance arrangements

There were no clear responsibilities, roles and systems of accountability to support good governance and management.

- Some structures, processes and systems to support good governance and management were clearly set out, understood and effective. However, these were not always embedded into practice and in some instances not in place.
- The governance and management of partnerships, joint working arrangements and shared services promoted interactive and co-ordinated person-centred care.
- Staff were clear on their roles and accountabilities however; lead roles were not clearly identified meaning not all staff knew who the responsible person was. However, the clinic was run by two doctors with one other member of staff so roles were shared between them.
- Leaders had established proper policies, procedures and activities to ensure safety, however, there was no evidence to demonstrate that the policies were reviewed in a timely manner or updated in line with changes to the service. For example, the cold chain policy was created in May 2018 and had a review date of May 2019 but the provider could not demonstrate that this had been undertaken. Policies, although titled with the clinics headers, contained generic information and did not always relate to the processes and governance structures in the practice. For example, we saw infection control policies which referred to nursing staff undertaking key duties, but the clinic does not employ any nurses. There were no clear leads for key roles and responsibilities such as fire safety and safeguarding, however the number of staff in the service was small. Not all processes had been followed thoroughly or documented. For example, we saw evidence that cold chain storage was being maintained and documented but this was not in line with guidance. There was no audit of infection control or oversight of cleaning checks undertaken by an external company and no documentation to demonstrate that checks of the emergency medicines trolley had been completed. The lack of oversight of this process by leaders had resulted in a medicine for use in an emergency having passed its expiry date.

Managing risks, issues and performance

There was no clarity around processes for managing risks, issues and performance. Some processes were in place but these were either incomplete or not fully embedded into practice.

- There was not an effective, process to identify, understand, monitor and address current and future risks including risks to patient safety. The clinic had not obtained copies of any risk assessments undertaken by external organisations or the landlord and were unaware of the need to undertake risk assessments to maintain patient safety, for example legionella water sample testing.
- 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.
- Clinical audit had a positive impact on quality of care and outcomes for patients. There was clear evidence of action to change services to improve quality. For example, one of the doctors had undertaken an audit of patients to look at infection rates and the outcome was that infection rates were in line with expected practice.
- The provider had plans in place and had trained staff for major incidents.

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.

Are services well-led?

Requires improvement

(for example, are they well-managed and do senior leaders listen, learn and take appropriate action?)

- 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, the public, staff and external partners to support high-quality sustainable services.

- The service encouraged and heard views and concerns from the public, patients, staff and external partners and acted on them to shape services and culture.
- Staff could describe to us the systems in place to give feedback. We saw evidence of feedback opportunities for staff and how the findings were fed back to staff. We also saw staff engagement in responding to these findings.
- The service was transparent, collaborative and open with stakeholders about performance.

Continuous improvement and innovation

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

- There was a focus on continuous learning and improvement. We saw multiple examples of both doctors engaging in Continued Professional Development courses and attending international conferences to maintain up to date knowledge. We heard of plans for adapting services (including those that were out of scope for CQC registration) to enhance potential treatment options for the public.
- The service made use of internal and external reviews of incidents and complaints. Learning was shared and used to make improvements.
- There were systems to support improvement and innovation work.

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
Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance How the regulation was not being met: The provider had systems or processes in place that were operating ineffectively in that they failed to enable to registered person to assess, monitor and improve the quality and safety of the services being provided, In particular: Routine temperature checks to monitor for the risk of Legionella were not undertaken. There was no risk assessment in place. There was no oversight of health and safety risk assessments undertaken by the landlord or external companies. Policies were in place but had not been reviewed on a regular basis. Policies were generic and did not contain practice specific information (for example referencing nursing staff undertaking lead roles when no nurses are employed at the clinic). Routine checks for the monitoring of medicines and infection control were undertaken but not documented or were documented but not in line with best practice.

This section is primarily information for the provider

Requirement notices

There was a system to allow staff to access routine training but the registered manager did not have a process in place to monitor what staff had received training or when update training was required particularly around infection control, safeguarding and information governance.

Recruitment checks had been completed but not always documented.

There was no single process in place for recording significant events to aid learning and development.

Processes were in place to ensure safety of equipment but not always clearly documented for example, identifying what equipment had been checked in PAT and calibration tests.

There was a lack of oversight of cleaning undertaken by external companies.