Light Touch Clinic

Inspection report

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Date of inspection visit: 08 December 2022
Date of publication: 25/01/2023

This report describes our judgement of the quality of care at this service. It is based on a combination of what we found when we inspected, information from our ongoing monitoring of data about services and information given to us from the provider, patients, the public and other organisations.

Ratings

Overall rating for this location	Good
Are services safe?	Requires Improvement
Are services effective?	Good
Are services caring?	Good
Are services responsive to people's needs?	Good
Are services well-led?	Good

Overall summary

This service is rated as Good overall.

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? – Good

We carried out this announced comprehensive inspection of Light Touch Clinic on 8 December 2022, under Section 60 of the Health and Social Care Act 2008. This inspection was planned to check whether the service was meeting the legal requirements and regulations associated with the Health and Social Care Act 2008. This was the provider's first inspection of the service since it registered with the Care Quality Commission (CQC).

How we carried out the inspection:

This inspection was carried out in a way which enabled us to spend a minimum amount of time on site.

This included:

- Speaking with staff in person, on the telephone and using video conferencing.
- Requesting documentary evidence from the provider.
- A site visit.

We carried out an announced site visit to the service on 8 December 2022. Prior to our visit we requested documentary evidence electronically from the provider. We spoke to staff on the telephone and using video conferencing prior to our site visit.

Light Touch Clinic is an independent provider of consultations and treatment for dermatological conditions, including acne, and Botox (Botulinum toxin) injections for the treatment of excessive sweating and teeth grinding.

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. Light Touch Clinic also provides a wide range of non-surgical aesthetic interventions. These include cosmetic Botox injections, dermal fillers, body contouring and skin tightening treatments, which are not within CQC scope of registration. Therefore, we did not inspect or report on those services.

Light Touch Clinic is registered with the Care Quality Commission to provide the following regulated activities: Treatment of disease, disorder or injury; Diagnostic and screening procedures.

Overall summary

There was no registered manager for the service at the time of our inspection. 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. The provider's practice manager, who was about to leave their employment, had previously held the role of registered manager. The medical director was in the process of submitting their application to CQC to become the registered manager.

Our key findings were:

- There were safeguarding systems and processes to keep people safe.
- There were records to demonstrate that recruitment checks had been carried out in accordance with regulations.
- There were processes in place for the training, performance review and monitoring of staff. There were some current gaps in required training for the one clinician involved in regulated activities which were addressed immediately following our inspection.
- There were effective systems and processes to assess the risk of, and prevent, detect and control the spread of infection. There were processes to maintain and monitor the immunisation status of staff.
- Cold chain monitoring processes were ineffective in ensuring the safe storage of medicines.
- There were some arrangements to manage medical emergencies but no oxygen supply on site and no supporting risk assessment in place to assess the level of risk to patients in the event of a medical emergency, such as anaphylaxis.
- Fire safety processes were in place. Staff had participated in fire drills and had received fire safety training.
- There were comprehensive health and safety and premises risk assessments in place.
- There was evidence of regular auditing of clinical record keeping processes.
- Clinical record keeping sampled was clear and complete.
- There were governance and monitoring processes, including assessment by external advisors, to provide assurance to leaders that systems were operating as intended.
- Policies and procedures were monitored, reviewed and kept up to date with sufficient information, to provide effective guidance to staff.
- There was regular and open communication amongst the staff team and staff felt well supported.
- Patients were routinely asked to provide feedback on the service they had received.
- Complaints were managed appropriately.

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

- Ensure care and treatment is provided in a safe way to patients.

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

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

- Continue to monitor staff training completion to ensure timely training updates.
- Complete development of risk assessments to support the control of substances hazardous to health (COSHH).
- Review the service's infection control manual to ensure it provides clear and relevant guidance for staff.

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 and included a GP specialist advisor.

Background to Light Touch Clinic

Light Touch Clinic is an independent provider of consultations and treatment for dermatological conditions, including acne, and Botox (Botulinum toxin) injections for the treatment of excessive sweating and teeth grinding.

Services are provided to patients over the age of 18 years only.

The Registered Provider is CYM Limited.

Light Touch Clinic is located at 50 Church Street, Weybridge, KT13 8DP.

The service is open from 9am to 5.30pm on Monday to Saturday, with evening appointments available until 7pm on Thursdays.

The service is run from self-contained premises over 4 floors which are leased by the provider. Only the ground and the first floor of the premises are accessed by patients. The basement and the third floor are used for storage purposes only. The premises include a suite of consultation, treatment and administration rooms, a reception and waiting area. Patients are able to access toilet facilities on the ground floor. Access to the premises at street level, is available to patients with limited mobility.

The service is led by the medical director, an aesthetic doctor, who provides all services which fall within CQC scope of registration. The staff team is comprised of a practice manager, supported by front of house staff and aesthetic practitioners who provide only non-regulated aesthetic treatments. One aesthetic practitioner acts as the lead for infection prevention and control within the service.

How we inspected this service

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?

Safety systems and processes

The service had systems to keep people safe and safeguarded from abuse.

- The service had systems and processes to safeguard children and vulnerable adults from abuse. The provider's safeguarding policy provided appropriate guidance for staff. Staff we spoke with had a clear understanding as to how to raise safeguarding concerns about a patient. All staff had received training in the safeguarding of children and vulnerable adults at an appropriate level to support their role.
- The provider carried out all required staff checks at the time of recruitment and all required ongoing monitoring, such as professional registration status and medical indemnity confirmation. Disclosure and Barring Service (DBS) checks were undertaken for all staff. (DBS checks identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable).
- The service offered treatment to those aged over 18 years of age. Patients were asked to confirm they were age 18 years or over. The service had a policy to ensure staff carried out identification checks if a patient appeared to be under the age of 18 years. No children were treated by the service.
- We saw there was signage on display within the service which invited patients to request a chaperone. All staff who acted as chaperones were trained for the role and had undergone a DBS check.
- There were effective systems to manage infection prevention and control within the service. Cleaning and monitoring schedules were in place and all cleaning was carried out by staff employed by the service. The premises were maintained to a high standard. There were sufficient stocks of personal protective equipment, including masks, aprons and gloves, available to staff.
- Auditing of infection prevention processes had been undertaken and staff had received training in infection prevention and control. We noted that the practice manager and the infection control lead had received comprehensive, enhanced infection prevention training to support their roles. Clinical staff had been subject to hand hygiene assessments. The provider utilised an external supplier to support their implementation and monitoring of infection control processes.
- The provider was able to demonstrate that they held appropriate records relating to staff immunisations, in line with current guidance.
- There were systems for safely managing healthcare waste, including sharp items. We saw that clinical waste disposal was available in clinical rooms. Bins used to dispose of sharps items were signed, dated and not over-filled. A lockable bin located within a secure area, was used to store healthcare waste awaiting collection by a waste management company.
- The service had systems to manage health and safety risks within the premises. The provider had employed the services of external consultants to undertake, health and safety, legionella and fire safety risk assessments. (Legionella is a particular bacterium which can contaminate water systems in buildings). We found that required actions had been completed. For example, regular monitoring of water temperatures was undertaken to minimise the risk of legionella bacterial growth.
- There was guidance and information, including safety data sheets, available to staff to support the control of substances hazardous to health (COSHH). We noted that a health and safety risk assessment, undertaken immediately prior to our inspection, had identified a lack of specific risk assessments relating to each hazardous substance. The provider was in the process of acting upon this finding at the time of our inspection.
- The provider had carried out regular fire safety risk assessments. We saw the latest fire risk assessment had been undertaken in November 2022. There was appropriate fire-fighting equipment and a fire alarm located within the premises which were regularly serviced and maintained. We noted that fire extinguishers had last been serviced in August 2022. The service had designated staff who were trained as fire marshals and staff had undertaken fire safety training. Staff had participated in a fire drill at six-monthly intervals.

Requires Improvement

Are services safe?

- The provider ensured that facilities and equipment were safe for use. Equipment was maintained according to manufacturers' instructions. We reviewed records to confirm that electrical equipment had undergone portable appliance testing in May 2022.

Risks to patients

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

- There were planned induction processes in place and a plan of required training for staff to complete as part of the induction process. Induction plans were tailored to meet the needs of the individual staff member and their role.
- Staff were required to complete training in key areas via an online platform. There were monitoring processes to ensure leaders had oversight of all training completed. However, we noted that the lead clinician had not completed some required training updates in infection control, fire safety and health and safety. The provider sent us evidence to confirm this outstanding training was completed immediately following our inspection site visit.
- We reviewed arrangements to respond to medical emergencies. We found that staff had completed training in basic life support. There was some equipment available to staff in the event of a medical emergency. For example, there was a defibrillator and pulse oximeter on site. However, there was a lack of a supply of oxygen to support patients who might develop for example, anaphylaxis, in line with current guidance. There was no documented risk assessment in place to assess the level of risk to patients in the event of a medical emergency and no assessment of the need for an oxygen supply which may support staff in responding to a medical emergency.
- The service had first aid kits in place which were appropriately stocked, and their contents regularly checked.
- The provider had in place a public and employer's liability insurance policy.

Information to deliver safe care and treatment

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

- We reviewed clinical records relating to patients who had received treatment within the service.
- The care records we saw showed information needed to deliver safe care and treatment was available to relevant staff in an accessible way.
- Individual care records were written and managed in a way that kept patients safe. Clear, accurate and contemporaneous patient records were consistently kept.
- Consent processes were consistently applied. Clinicians ensured patients had been provided with sufficient information about the risks and benefits of treatment prior to proceeding. There was a documented consent policy.
- The provider utilised a cloud-based, password protected, electronic system to ensure consistency and security of clinical record keeping.
- The service had systems for sharing information with staff and other agencies where necessary, to enable them to deliver safe care and treatment.
- Due to the nature of treatments provided, patients did not require referral by their NHS GP to access services and treatment information was not routinely shared with the GP. Patients' GP details were requested and were recorded when the patient provided that information.
- 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 they ceased trading.

Safe and appropriate use of medicines

- The service monitored prescribing to ensure it was in line with best practice guidelines for safe prescribing. Our review of clinical records confirmed that staff prescribed and administered medicines to patients, and gave advice on medicines, in line with legal requirements and current national guidance.

Requires Improvement

Are services safe?

- There were systems and arrangements for managing the safe handling of medicines and prescribing practices in a way which minimised risks to patients. All medicines were prescribed electronically via an online supplier. There were clear processes to ensure security of access arrangements for online prescription ordering. Prescriptions were delivered directly to the patient's home or to the service for collection.
- Appropriate processes were in place for the ordering, receipt and monitoring of stock medicines held and staff kept accurate records of those medicines.
- Emergency medicines were readily available and in date and supplies were regularly checked. There were documented records of those checks.
- Medicines were stored securely in a locked cupboard in a consulting room. Botox was the only medicine held by the service which required refrigeration. Botox supplies were stored in a refrigerator which was monitored to ensure it maintained the correct temperature range for safe storage. However, we found that fridge temperature monitoring records had highlighted temperatures repeatedly falling significantly above the recommended maximum temperature of 8 degrees centigrade, from September 2022 up to the time of our inspection. No action had been taken to report the findings or to ensure that those medicines, stored outside of the recommended range, were safe for use.
- We noted that an audit of medicines management arrangements, undertaken in October 2022, had included a review of fridge temperature monitoring but had not identified those concerns.
- Immediately following our inspection, the provider took action to replace the fridge thermometer as they considered this to be the reason why recordings were out of range. They sent us evidence to confirm that temperatures recorded now fell within the recommended range. The provider had determined that failure to report the findings was due to a lack of staff understanding of the monitoring process and provided immediate staff training in this regard.
- The provider sought advice from their supplier of Botox, with regard to the potential breach of the cold chain and the impact on patient safety and treatment efficacy. As a result, they removed existing supplies of Botox from use and disposed of them appropriately. They told us that all patients affected would be assessed to monitor any impact upon treatment outcomes.

Track record on safety and incidents

- There were monitoring and auditing processes in place to provide assurance to leaders that systems were operating as intended. There were risk assessments in place in relation to safety issues to support the management of health and safety within the premises.
- There was monitoring and review of activities to support the provider in identifying potential risks within the service. The practice manager maintained a register of all risks and risk assessment activity. Managers responded promptly when safety concerns or risks were identified.
- The provider maintained an incident and complaints log in order to identify and investigate risks and incidents and implement effective corrective or preventive actions to reduce the risk of recurrence. We saw incidents were discussed and reviewed within regular team meetings. For example, we noted that findings of hand hygiene assessments had been fed back to the staff team and discussed within a team meeting.

Lessons learned and improvements made

The service had systems to ensure they learned when things went wrong.

- There was a system for recording and acting on significant events. Staff clearly understood their duty to raise concerns and report incidents and near misses. Leaders and managers supported them when they did so.
- There were systems for reviewing and investigating when things went wrong. Incident reporting processes promoted a culture of openness and transparency. For example, we noted that a needlestick injury had been reported immediately to managers and responded to and managed in a timely and appropriate manner.

Requires Improvement

Are services safe?

- 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. They 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.

Good

Are services effective?

Effective needs assessment, care and treatment

The provider had systems to keep clinicians up to date with current evidence-based practice.

- Clinicians employed by the service had appropriate levels of skills, knowledge and experience to deliver the care and treatment offered by the service. The medical director provided clinical leadership and oversight across the service.
- Clinicians kept up to date with current evidence-based practice. We found clinicians assessed needs and delivered care and treatment in line with relevant current legislation, standards and guidance. For example, clinicians followed an established pathway for the treatment of patients with excessive seating which was in line with guidance issued by the National Institute for Health and Care Excellence (NICE).
- We reviewed clinical records relating to patients who attended the service and found clear, accurate and contemporaneous clinical records were kept. Treatment planning and information were fully documented.
- The service ensured they provided information to support patients' understanding of their treatment, including pre- and post-treatment advice and support.
- We saw no evidence of discrimination when making care and treatment decisions.

Monitoring care and treatment

The service was able to demonstrate quality improvement activity.

- The service used information about care and treatment to assess the need to make improvements.
- Staff employed by the service were subject to regular review of their performance.
- There was a programme of quality improvement activity and auditing processes within the service. The provider employed a range of external advisors to regularly review and assess the quality and safety of services provided. For example, an external consultant had been employed to undertake auditing of clinical record keeping processes in March and October 2022. Findings were shared with the staff team following each audit and in response to ongoing shortfalls identified, the provider undertook a further internal audit of consent processes in November 2022 which demonstrated improvements required had been made.

Effective staffing

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

- Staff had the appropriate skills and training to carry out their roles. There were planned induction processes in place. There was a plan of required training for staff to complete as part of the induction process.
- The provider understood the learning needs of staff and provided protected time and training to meet them. Where we noted the lead clinician had not completed some required training updates within the required time period, the provider sent us evidence to confirm this outstanding training was completed immediately following our inspection site visit.
- There was regular review of individual performance of staff employed by the service. Staff underwent regular one-to-one review meetings with the practice manager and annual appraisal. Staff who had completed their probationary period were subject to a probationary review.
- The service held records which confirmed medical professionals were registered with the General Medical Council (GMC) and were up to date with revalidation.

Coordinating patient care and information sharing

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

Good

Are services effective?

- Patients who used the service received coordinated and person-centred care. Staff referred to, and communicated effectively with, other services when appropriate.
- Due to the nature of treatments provided, patients did not require referral by their NHS GP to access services and treatment information was not routinely shared with the GP. However, patients' GP details were requested and were recorded when the patient provided that information.
- Before providing treatment, doctors at the service ensured they had adequate knowledge of the patient's health, previous medical and medicines history. We noted that patients were required to complete a medical questionnaire prior to treatment. Where patients returned for repeated treatments the service requested that this information was updated on a six-monthly basis.
- Staff told us that they had established connections with other local aesthetic doctors and also cosmetic surgeons, where support or onward referral was deemed necessary to provide optimum support to patients.
- Patient information needed to plan and deliver care and treatment was stored and available to relevant staff in a timely and accessible way. Staff were able to highlight individual patient needs and preferences within the patient's electronic record in order to share this information across the staff team.

Supporting patients to live healthier lives

Staff empowered patients and supported them to manage their own health and maximise their independence.

- The service provided access to timely advice and support to patients, at all stages of their treatment.
- Patients were provided with clear information about treatments, including the benefits and risks.
- Patients were provided with an individual treatment plan to consider prior to proceeding with treatment.
- Following treatment, patients were contacted by the patient care team to confirm satisfaction with the treatment outcome and to discuss any concerns.

Consent to care and treatment

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

- Staff we spoke with understood the requirements of legislation and guidance when considering consent and decision making. Staff described processes for the assessment of patients' suitability for treatment which included their psychological well-being, mental capacity and vulnerability. Staff told us they would not agree to treat patients about whom they had any concerns.
- There was a documented consent policy. Consent processes were consistently applied. We noted that the provider had recently implemented a series of audits of clinical records. Where shortfalls in fully recording the consent process were identified, staff were provided with additional training and reminders. Further monitoring of records by the provider confirmed that required improvements had been achieved. Patient records we reviewed at the time of inspection clearly documented the consent process and discussions between the practitioner and patient.

Good

Are services caring?

Kindness, respect and compassion

Staff treated patients with kindness, respect and compassion.

- The service gave patients timely support and information in relation to their care and treatment.
- Staff understood patients' personal, cultural, social and religious needs. They displayed an understanding and non-judgmental attitude to patients.
- The service actively invited feedback on the quality of care patients received via a variety of means to suit the needs of the patient. We noted that feedback forms and a posting box were available within the reception and waiting area. Patients were also able to scan a barcode using their mobile phone which enabled them to leave feedback directly on social media platforms. In addition, patients were invited to utilise online review sites and were sent electronic links to encourage them to do so, following their treatment.
- These arrangements provided patients with the opportunity to provide feedback and make suggestions for improvements to services. The service collated this information in order to identify areas for improvement and feedback which required a direct response to the patient.
- Patients who provided feedback consistently commented on the way in which staff within the service acted professionally, put them at ease and were knowledgeable about treatments provided.

Involvement in decisions about care and treatment

Staff helped patients to be involved in decisions about care and treatment.

- We saw the service provided comprehensive information about the service on their website, including the provider's complaints procedure and pricing information.
- The service ensured patients were provided with all the information they required to make decisions about their care prior to undergoing treatment.
- Translation services were available for patients who did not have English as a first language.

Privacy and Dignity

The service respected patients' privacy and dignity.

- Staff recognised the importance of people's dignity and respect. Consultations and treatments took place behind closed doors and conversations could not be overheard.
- Patients were collected from the waiting area by the clinician and escorted into the consultation room.
- Front of house staff were aware that if patients wanted to discuss sensitive issues or appeared distressed, they could offer them a private room to discuss their needs.
- Chaperones were available should a patient choose to have one. All staff who provided chaperoning services had undergone required employment checks and received training to carry out the role.
- Staff complied with the service's information governance arrangements. Processes ensured that all confidential electronic information was stored securely on computers. There were no hard copy patient records held within the service.

Good

Are services responsive to people's needs?

Responding to and meeting people's needs

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

- The provider understood the needs of their patients and arranged services in response to those needs. For example, staff told us that the medical director would provide additional treatment sessions to meet patient demand or individual patient needs.
- The facilities and premises were maintained to a high standard and were appropriate for the services and treatments delivered. All consulting rooms were located on the ground floor or first floor. Access to the premises at street level, was available to patients with limited mobility.
- Reasonable adjustments were made so that people in vulnerable circumstances could access and use services on an equal basis to others. For example, translation support services were available. Staff also told us of a recent occasion whereby the most accessible ground floor room was made available to one patient with a visual impairment, attending for treatment.

Timely access to the service

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

- Appointments could be booked in person or by telephone. Appointment enquiries could also be made via the provider's website. Patients usually received appointments within a short time from their request. Evening and weekend appointments were available.
- Waiting times, delays and cancellations were minimal and managed appropriately.
- Patients were contacted by the service on the day prior to their appointment as a reminder of their appointment and to answer any queries they may have.
- The service responded to patient feedback with regard to appointment scheduling. For example, staff told us that additional time was allowed for some appointments following feedback from patients about waiting times on the day of an appointment.

Listening and learning from concerns and complaints

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

- Information about how to make a complaint or raise concerns was available within the service. There was clear and comprehensive information about how to make a complaint on the provider's website.
- The service received low numbers of complaints and staff treated patients who made complaints compassionately.
- We found patients had received timely and appropriate responses to their complaints. For example, patients had been provided with additional treatment where treatment outcomes did not meet their expectations.
- There was evidence complaints had been discussed and the learning shared across the organisation. Complaints were discussed at regular team and operational meetings.
- The service clearly informed patients that further action may be available to them should they not be satisfied with the response to their complaint. The service's written complaints policy included up to date information to support patients should their complaint remained unresolved.

Good

Are services well-led?

Leadership capacity and capability:

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

- Leaders demonstrated the capacity to implement systems and processes to support the delivery of high-quality care. Leaders had awareness and understanding of the issues and priorities relating to the quality and future of the service.
- Leaders within the service were visible and approachable. They worked closely with the team of staff and told us they prioritised compassionate and inclusive leadership.
- There was a clear staffing structure in place across the service and staff were aware of their individual roles and responsibilities. The medical director maintained operational and strategic oversight of services and employed a practice manager to lead on the day-to-day management of services.
- Where additional specialist advice and support was required, the provider employed the services of external consultants. For example, a provider of infection prevention and control services provided policy, procedural and auditing support; specialist health and safety advisors carried out fire safety, legionella and health and safety risk assessment processes on behalf of the provider; an external consultant provided clinical record keeping auditing services and quality assurance support to the staff team.
- There were effective formal and informal lines of communication between staff working within the service. Staff spoke of team meetings they attended, and we saw records of those meetings.

Vision and strategy

- The provider had a vision and desire to provide high-quality, local services which promoted 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 their priorities.
- Leaders told us of plans to expand upon the services provided in the near future, which would fall into scope of CQC regulation. We saw that changes to premises and the staff team were underway to support delivery of those additional services.
- Staff were aware of and understood the vision, values and strategy of the organisation and their role in achieving them. Staff felt motivated to contribute to driving improvement within the service and were fully engaged in ensuring the promotion of optimum outcomes for patients.
- The service monitored progress against delivery of the strategy and performance indicators.

Culture

There were systems and processes to support a culture of high-quality sustainable care.

- Leaders and managers encouraged behaviour and performance consistent with the vision and values.
- The service was focused upon the needs of patients and ensuring the best possible outcomes.
- Staff we spoke with told us they felt respected, supported and valued. Staff told us they could raise concerns and suggestions for improvement and were encouraged to do so.
- The provider was aware of and had systems to ensure compliance with the requirements of the duty of candour.
- There were processes for providing staff with the development they needed. There were planned induction processes in place and a plan of required training for staff to complete as part of the induction process.
- Staff were required to complete training in key areas via an online platform and this was generally up to date. Where we noted that the lead clinician had not completed some required training updates in infection control, fire safety and health and safety, this was completed immediately following our inspection visit.
- Clinical staff were supported to meet the requirements of professional revalidation where necessary.

Good

Are services well-led?

- Staff employed by the service had received regular review of their performance in the form of one-to-one review and annual appraisal. Newly recruited staff were subject to a probationary review and were formally confirmed in post.
- The service actively promoted equality and diversity. Staff had received equality and diversity training. Staff felt they were treated equally.
- There was a culture of promoting positive relationships and prompt and effective communications between staff.

Governance arrangements

Responsibilities, roles and systems of accountability to support good governance and management were effective.

- Structures, processes and systems to support good governance and management were clearly set out and understood for all areas of the service.
- There was a staff meeting structure and systems for cascading information within the organisation. For example, staff participated in regular team meetings following which, minutes were circulated to all staff, including those unable to attend. Quarterly clinical governance meetings included management review of service delivery and where required, review of the care and treatment of individual patients.
- The provider utilised the services of an external supplier to provide support with policy development.
- Leaders had mainly established appropriate policies, procedures and activities to ensure the safety of staff and patients, across all services, and assure themselves they were operating as intended. However, we found the provider's infection control manual included large volumes of information which did not apply to the service and may therefore lead to some confusion for staff.
- There was a range of monitoring and auditing processes in place across the service. These included a programme of daily, weekly, monthly and quarterly checks undertaken by staff, to ensure the safety of the premises and equipment. For example, weekly testing of the fire alarm and emergency equipment and monthly testing of emergency lighting and water temperature monitoring. External consultants were employed to undertake annual monitoring and risk assessment processes in relation to for example, fire safety, legionella monitoring and infection control.
- Auditing and quality monitoring processes included regular review of clinical record keeping processes by an external consultant and internal auditing of infection control processes, including cleaning and hand hygiene, by the internal infection control lead.
- Staff understood their individual roles and responsibilities and were well supported by the practice manager and the medical director in fulfilling those roles. Appropriate role-specific guidance and training was provided for staff. For example, we saw that the lead for infection control had received an appropriate level of training to support the role.
- The service submitted data and notifications to external organisations as required.

Managing risks, issues and performance

There were some processes for managing risks, issues and performance.

- There were governance processes to ensure leaders were mostly able to identify, understand, monitor and address current and future risks including risks to patient safety. The provider maintained a risk register for all aspects of the service which was regularly reviewed and updated. However, the provider had not adequately identified or addressed risks associated with the monitoring of medicines requiring refrigeration or the equipment available to support the management of medical emergencies.
- Leaders had oversight of safety alerts, incidents, and complaints. There was a system for recording and acting upon significant events. Staff clearly understood their duty to raise concerns and report incidents and near misses. Leaders and managers supported them when they did so.

Good

Are services well-led?

- There was clear evidence of a commitment to change services to improve quality where necessary. Immediately following our inspection, and in response to initial feedback of our findings, the provider took prompt action to address our findings. For example, in reviewing processes for the monitoring of medicines requiring refrigeration.
- Auditing of patient records was undertaken to review compliance with the provider's expected standards of clinical record keeping.
- The provider had business continuity plans in place.

Appropriate and accurate information

The service acted upon appropriate and accurate information.

- The service used feedback from patients combined with performance information, to drive improvement. Collated information was reviewed at regular team meetings.
- The provider carried out all required staff checks at the time of recruitment and all required ongoing monitoring, such as professional registration status and medical indemnity confirmation.
- 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. Clear, accurate and contemporaneous patient records were kept.
- Staff told us they had attended regular staff meetings. We saw documented evidence of staff meetings, where for example, patient feedback and monitoring activities had been discussed, and outcomes from the meetings cascaded to staff.
- There were arrangements in line with data security standards for the availability, integrity and confidentiality of patient identifiable data, records and data management systems. Processes ensured all confidential electronic information was stored securely on computers.
- The provider ensured document management protocols were followed, which included version control, author and review dates.

Engagement with patients, the public, staff and external partners

The service involved patients, staff and external partners to support sustainable services.

- The service encouraged and valued feedback from patients, the public and staff. Feedback was closely monitored and acted upon to shape services.
- Staff could describe to us the systems in place for them to give feedback.
- The service was transparent and open with stakeholders about the feedback received. For example, patient reviews were visible on the provider's website.

Continuous improvement and innovation

- There was evidence of improvements made to the service as a result of feedback received.
- Leaders and managers encouraged staff to review individual and team objectives, processes and performance.
- There was evidence of quality improvement activity and ongoing review of quality improvement processes.
- Staff within the service told us they were enrolled in an on-line training and support programme to promote motivation, well-being, team engagement and sales techniques.

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 12 HSCA (RA) Regulations 2014 Safe care and treatment The provider had not done all that was reasonably practicable to ensure care and treatment was provided in a safe way for service users. In particular: • To ensure emergency equipment held on site is sufficient to respond to medical emergencies within the service. • To implement fridge temperature monitoring processes which ensure the correct temperature range for the safe storage of medicines. This was in breach of regulation 12(1)(2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.