London Professional Aesthetics

Inspection report

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Date of inspection visit: 18 May 2022
Date of publication: 26/08/2022

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

Ratings

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

Overall summary

This service is rated as Requires improvement.

The key questions are rated as:

Are services safe? – Requires improvement

Are services effective? – Good

Are services caring? – Good

Are services responsive? – Good

Are services well-led? – Requires improvement

We carried out an announced comprehensive inspection at London Professional Aesthetics as part of our inspection programme of a new provider registration for the service. This was a first rated inspection for the service that was registered with the Care Quality Commission (CQC) in August 2019. During this inspection we inspected the safe, effective, caring, responsive and well led key questions.

London Professional Aesthetics is an independent Skin Clinic located in Islington, London. The clinical director of the service 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.

The service is registered with the Care Quality Commission to provide the regulated activities of Treatment of disease, disorder or injury and Diagnostic and Screening procedures

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.

London Professional Aesthetics provides a range of non-surgical cosmetic interventions, for example dermal fillers, lip fillers and Botox injections which are not within the CQC scope of registration. Therefore, we did not inspect or report on these services.

Our key findings were:

- There was evidence that some risks were not assessed and well-managed; the service did not have an effective system of premises checks.
- Procedures for managing medical emergencies including access to emergency medicines and equipment were not safe. There was no defibrillator on site.
- The provider did not have a defined set of mandatory training that staff needed to complete to carry out their role effectively.
- There was limited evidence of systems to support good governance and management.

Overall summary

- The provider had a safeguarding policy. Staff had completed safeguarding training relevant to their role. The clinical staff had the appropriate level of safeguarding training for vulnerable adults and children.
- The premises were clean and well maintained. There were effective systems in place to reduce the risk and spread of infection.
- The clinic routinely reviewed the effectiveness and appropriateness of the care it provided. It ensured that care and treatment was delivered according to evidence based guidelines.
- There was evidence of activity which aimed to improve the quality of clinical procedures provided.
- Staff involved and treated patients with compassion, kindness, dignity and respect.

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

We have told the provider to take action (please see the specific details on action required at the end of this report).

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

- Consider extending quality improvement activity to include clinical audits of post treatment infections or side effects.

Dr Sean O'Kelly BSc MB ChB MSc DCH FRCA

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

Our inspection team

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

Background to London Professional Aesthetics

London Professional Aesthetics is a private clinic that carries out aesthetic treatments and medical procedures for people over the age of eighteen at 193 Whitecross Street, London EC1Y 8QP. The service provides a broad range of aesthetic services that are not regulated by the Care Quality Commission (CQC), but some services are, including thread lifts, diagnosis and treatment of skin conditions, treatment for excessive sweating, phlebotomy and weight management.

The service is located on the ground floor and has two treatment rooms. Services are available to any fee-paying patient. The service is open between 8.00am and 8.00pm Monday to Friday. The service is open on Saturday between 10am and 2pm. Services are available to people on a pre-bookable appointment basis. The clinic director is a registered advanced nurse practitioner, who conducts thread lifts at the service. Administrative support is provided by a service manager and one receptionist who work part time and oversee appointments and administration for all service users.

The clinic also provides non-surgical cosmetic interventions, for example dermal fillers, lip fillers and Botox injections which are not within CQC scope of registration. Therefore, we did not inspect or report on these services.

The location is registered with the CQC to provide the following regulated activities; treatment of disease, disorder or injury and diagnostic and screening procedures. The service does not treat children.

The team was led by a CQC inspector, accompanied by a GP specialist advisor. Before the inspection, we reviewed notifications received about the service, and a standard information questionnaire completed by the service. During the inspection, we interviewed staff, made observations and reviewed documents.

How we inspected this service

Throughout the pandemic CQC has continued to regulate and respond to risk. However, taking into account the circumstances arising as a result of the pandemic, and in order to reduce risk, we have conducted our inspections differently.

This inspection was carried out in a way which enabled us to spend a minimum amount of time on site. This was with consent from the provider and in line with all data protection and information governance requirements.

We carried out an announced comprehensive inspection at London Professional Aesthetics on 18 May 2022. Our inspection team was led by a CQC Lead Inspector who was accompanied by a GP specialist advisor. Before visiting, we looked at a range of information that we hold about the service. We reviewed information submitted by the service in response to our provider information request. During our visit we interviewed staff, observed practice and reviewed documents.

To get to the heart of patients' experiences of care and treatment, we always ask the following five questions:

- Is it safe?
- Is it effective?
- Is it caring?
- Is it responsive to people's needs?
- Is it well-led?

These questions therefore formed the framework for the areas we looked at during the inspection.

Requires Improvement

Are services safe?

We rated safe as Requires improvement because:

The building's management service carried out safety assessments, however staff did not have access to these reports and the provider could not demonstrate they effectively monitored this. For example, at this inspection, there was no fire risk assessment available for us to look at when we inspected.

Safety systems and processes

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

- The provider conducted safety risk assessments. It had appropriate safety policies, which were regularly reviewed and communicated to staff including locums. They outlined clearly who to go to for further guidance. Staff received safety information from the service as part of their induction and refresher training. 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 practice had a safeguarding policy. The policy was accessible to all staff and contained the names of the appointed safeguarding leads within the service and the process for reporting and taking action in response to concerns.
- Staff we spoke with knew how to identify and report concerns but at the time of our inspection, the provider was not able to evidence easily which staff had undertaken safeguarding training. Three members of staff had completed training the week before our inspection. There was no record of completed training in safeguarding for one non clinical member of staff. After our inspection, the service sent us evidence that this training had been completed, before we inspected the service.
- The provider carried out staff checks at the time of recruitment and on an ongoing basis where appropriate. Disclosure and Barring Service (DBS) checks were undertaken where required. (DBS checks identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable).
- There was a chaperone policy in place and notices on display advertising chaperones. Staff who acted as chaperones were trained for the role and had received a DBS check.
- There were systems to manage infection prevention and control (IPC). An infection control policy was in place. Staff used an infection control checklist tool with which to inspect the premises for infection control purposes. However, at this inspection, there was no IPC training documented for the locum nurse. Staff told us that the locum nurse had only been in the role for one week and was yet to finish required safety induction training. We checked the infection control policy which stated that infection control training is undertaken for all new recruits within four weeks of starting work.
- Although there was a procedure for the recruitment of suitably qualified and trained temporary staff, there was no record that the provider had satisfied themselves that the locum nurse was appropriately trained in infection control in line with pre-employment checks. Immediately following the inspection, the clinic director sent us evidence of IPC training completed by the locum nurse in June 2020.
- An infection prevention and control (IPC) audit had been undertaken in the previous 12 months and there was an action plan to address any concerns identified. Staff had carried out a hand hygiene audit. We saw evidence that the clinic carried out weekly checks of cleaning of the premises and clinical areas. Single use supplies were used, for example needles and syringes. Clinical equipment was cleaned after each use. There was an annual maintenance agreement for an external company to service the clinical equipment.

Requires Improvement

Are services safe?

- The premises were visibly clean, and the level of cleanliness was monitored. The premises were cleaned once a week by a cleaner and daily and weekly cleaning schedules were in place and followed.
- There was a record of immunity for staff who handled specimens or dealt with spillages of waste or bodily fluids.
- The provider ensured that facilities and equipment were safe, and that equipment was maintained according to manufacturers' instructions. There were systems for safely managing healthcare waste.
- The provider carried out environmental risk assessments, which took into account the profile of people using the service and those who may be accompanying them. For example, the practice had carried out risk assessments to monitor safety of the premises such as control of substances hazardous to health and legionella. There was a legionella risk assessment and a record of monthly water temperature checks. Legionella is a term for a particular bacterium which can contaminate water systems in buildings.
- All electrical equipment had been tested to ensure it was safe to use.
- There was a record that medical equipment had been calibrated. Portable appliance testing (PAT) was carried out by an external service.

Risks to clients

In the main, risks to people were assessed and their safety monitored and managed, so they were supported to stay safe. There was a lack of systems to assess, monitor and manage some risks to patient safety.

- There were systems to manage health and safety risks. Staff shared a copy of a health and safety risk assessment completed by the clinic director, on 10/05/2022.
- The fire safety policy stated that the Fire Safety Risk Assessment should be maintained and updated annually by the clinic director. However, there was no evidence that a fire risk assessment had been completed within the last 12 months. We spoke to staff who told us that the clinic had arranged for an external assessor to carry out a fire risk assessment on 11 May 2022, but this was not available for us to look at when we inspected. Following our inspection, the service sent us evidence that a fire safety assessor had carried out an inspection of the premises. The assessor had identified a number of actions required and the service sent us a copy of a quote for the remedial work recommended by the fire risk assessor.
- Staff told us that the property management services were responsible for installing and maintaining the fire alarm system. The clinic staff kept an up to date log of weekly fire alarm tests but had no system to assure themselves that any faults identified had been investigated and actions taken to mitigate risks.
- The service told us they were responsible for assessing risks associated with fire. The fire extinguishers had been inspected in May 2022 but no record of maintenance or a service certificate was kept by the service.
- The service displayed information on what patients should do in the event of a fire.
- The clinic director carried out fire drills every six months.
- The practice was able to show us up to date fire safety training for the two members of staff who carried out the Fire Officer role at the clinic.
- There was some evidence of risk assessment activity in relation to infection prevention and control. For example, the provider had effective processes to protect staff and patients using the service and had completed an infection prevention and control risk assessment and a COVID19 risk assessment.
- The service had a waste disposal policy. We saw a signed agreement with a company who disposed of clinical waste. The service used orange waste bags to dispose of clinical waste.
- There was a sharps safety policy and information was displayed next to sharps bins to instruct people on what to do if they sustain a needlestick injury.
- There were arrangements for planning and monitoring the number and mix of staff needed.
- The clinic had an induction policy and there was an induction pack for staff tailored to their role, including for agency staff.

Requires Improvement

Are services safe?

- There were arrangements in place to respond to emergencies and major incidents. Staff had completed training in emergency resuscitation and first aid. There was a first aid kit, and accident book.
- The service held a supply of oxygen and there was a process in place to check these regularly to ensure they would be available in an emergency. However, there was no defibrillator in the premises.
- Staff understood their responsibilities to manage emergencies and to recognise those in need of urgent medical attention. Although there was no sepsis awareness policy, staff we spoke with knew how to identify and manage patients with severe infections, for example sepsis.
- When there were changes to services or staff the service assessed and monitored the impact on safety.
- There was a documented business continuity plan for major incidents such as power failure, flood or building damage.
- Patient records were stored securely on the service computer, which was backed up.
- The clinic stocked adrenaline and aspirin but had not risk assessed the need for other emergency medicines recommended in national guidance. For example, the clinic did not stock hydrocortisone injection for treatment of anaphylaxis. Anaphylaxis is a severe allergic reaction.

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. If the service identified that patients needed to be referred to another service, they would tell the patient to contact their GP.
- Staff checked and verified patient identity prior to treatment.
- There were information management policies in place; the clinic manager had undertaken information governance training.
- 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 had reliable systems for appropriate and safe handling of medicines.

- The service did a small amount of prescribing. 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 was no repeat prescription system.
- All the medicines we checked were in date and stored securely. There were effective cold chain arrangements in place. Fridge temps were regularly monitored.
- There was evidence of risk assessment of systems for managing and storing emergency medicines, oxygen and equipment.
- There was a record of calibration carried out in November 2021 to reassure the provider that the medical equipment was functioning appropriately.
- The service carried out medicines audit to ensure prescribing was in line with best practice guidelines for safe prescribing.

Requires Improvement

Are services safe?

- The service does not prescribe Schedule 2 and 3 controlled drugs (medicines that have the highest level of control due to their risk of misuse and dependence). Neither did they prescribe schedule 4 or 5 controlled drugs.

Track record on safety and incidents

- In some areas, the service had not monitored and reviewed activity to understand risks and where identified made necessary safety improvements. For example, there was no record of a fire risk assessment carried out within the last 12 months and no evidence that actions identified were completed. Staff told us they had arranged a fire risk assessment on 11 May 2022 but there was no record of this at the time of our inspection. Following our inspection, the service sent us evidence that a fire safety assessor had carried out an inspection of the premises. The assessor had identified a number of actions required and the service sent us a copy of a quote for the remedial work recommended by the fire risk assessor.
- The service monitored and reviewed activity through staff meetings. We saw staff used an electronic note pad to record items discussed and any actions identified.

Lessons learned and improvements made

The service learned and made improvements when things went wrong.

- There was a system for reporting and recording significant events and sharing lessons to make sure action would be taken to improve safety.
- Staff understood their duty to raise concerns and report incidents and near misses. Leaders and managers supported them when they did so
- 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.
- 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.
- There was a process to manage patient safety alerts. The clinic director was a registered nurse and received alerts directly by email or through the post and would act where necessary.

Good

Are services effective?

We rated effective as Good because:

Most staff had completed mandatory training at the appropriate level for their role and to enable them to carry out their duties. We saw evidence that staff assessed needs and delivered care and treatment in line with current legislation, standards and guidance (relevant to their service).

Effective needs assessment, care and treatment

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

- The provider assessed needs and delivered care in line with relevant and current evidence-based guidance and standards such as the National Institute for Health and Care Excellence (NICE) best practice guidelines and Aesthetic Complications Expert Group (ACE).
- Clients' immediate and ongoing needs were fully assessed. Where appropriate this included their clinical needs and their mental and physical wellbeing.
- We looked at five clients' records. Records we looked at were clearly recorded and included comprehensive detail of consultations, treatment and advice.
- Clinicians had enough information to make or confirm a diagnosis.
- We saw no evidence of discrimination when making care and treatment decisions.
- Staff advised clients what to do if their condition got worse and where to seek further help and support.
- Staff assessed and managed clients' pain where appropriate.

Monitoring care and treatment

The service was actively involved in quality improvement activity.

- The provider had systems in place to monitor and assess the quality of the service including the care and treatment provided to clients. We saw evidence that feedback was requested from clients following treatments.
- The service provided treatment of disease, disorder or injury and assessed the outcomes of the treatments they administered. The service made improvements through the use of completed audits. We saw an example of a completed prescribing audit to demonstrate improved outcomes for clients on a weight management programme. At the time of our inspection, there were fourteen clients following a lifestyle weight management programme.
- There was clear evidence of action to resolve concerns and improve quality. The service said that clients were reviewed post procedure to ensure that they were satisfied with the outcome.

Effective staffing

We saw a policy that explained relevant training for staff at the service who saw clients for CQC regulated activities. However, at the time of this inspection the service did not have a set schedule of what training all staff needed to complete, or frequency required.

- There was a staff training policy that explained relevant training for staff to complete, including basic life support, fire safety, infection control, health and safety and cyber security.
- There was no ongoing schedule of mandatory or additional training for staff to undertake and update, and as a result there were gaps in training records. For example, at the time of our inspection, the clinic director had not undertaken training in the mental capacity act and health and safety. The service sent us evidence that this had been completed

following the inspection. The clinic director had completed safeguarding, infection control, fire safety, CPR and information governance during the two weeks before our inspection. There was no IPC training documented for the agency nurse. At the time of our inspection, the locum nurse had only been in the role for one week and was yet to finish required safety induction training.

- There were some records to demonstrate that non-clinical staff had completed role appropriate training to cover the scope of their work including safeguarding, infection control, basic life support, fire safety and information governance. However, at the time of our inspection there was no record of completed training in safeguarding for one non clinical member of staff. The service sent us evidence that this had been completed following the inspection.
- Relevant professionals (nursing) were up to date with revalidation. The provider was registered with the Nursing and Midwifery Council (NMC) and was up to date with revalidation.
- The learning needs of staff were identified through meetings and informal reviews. The provider encouraged staff to choose training that they felt would improve their skills and the quality of the service.
- Staff had access to and made use of e-learning training modules, in-house training and external training.
- The clinic had a staff recruitment and induction policy. There was role specific induction training which ensured staff were competent for the role to which they had been appointed.
- Individuals working at the practice had access to one to one support but supervision arrangements for the agency nurse were informal. There was some informal monitoring of the agency nurse through weekly meetings. The agency nurse's consultation notes we reviewed were clear and comprehensive.
- There was an appraisal system in use to ensure competency was demonstrated and reviewed.

Coordinating client care and information sharing

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

- Clients received coordinated and person-centred care. Where clients' required referral to third party organisations, these were completed quickly and clearly. The clinic shared reports of consultations, test results and treatments with clients.
- Before providing treatment, staff at the service ensured they had adequate knowledge of the client's health, any relevant test results and their medicines history. The consent procedures at the service were thorough in this regard.
- All clients 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.
- Client information was shared appropriately (this included when clients 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.
- The service monitored the process for seeking consent appropriately.

Supporting clients to live healthier lives

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

- Where appropriate, staff gave people advice so they could self-care.
- The nurse gave lifestyle advice during consultations.
- Where clients needs could not be met by the service, staff redirected them to the appropriate service for their needs.

Consent to care and treatment

Good

Are services effective?

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. Client consent forms were completed fully and signed appropriately in all the records we reviewed.
- Staff supported clients to make decisions. Where appropriate, they assessed and recorded a client's mental capacity to make a decision. However, at this inspection staff were not able to provide evidence of completed Mental Capacity Act training.

Good

Are services caring?

We rated caring as Good because:

We saw the clinic had arrangements to ensure patients were treated with kindness and respect and maintained patient and information confidentiality.

Kindness, respect and compassion

Staff treated patients with kindness, respect and compassion.

- The service sought feedback on the quality of clinical care patients received. For example, clients received an automated email following each appointment inviting them to feedback about their experience. The provider reviewed feedback to identify areas for improvement.
- Feedback from clients was positive about the way staff treat people
- Staff understood patients' personal, cultural, social and religious needs. They displayed an understanding and non-judgmental attitude to all patients.
- The service gave patients timely support and information.
- The clinic was offered on a private, fee-paying basis only and was accessible to people who chose to use it.
- Patients were involved in decisions about their care and treatment.

Involvement in decisions about care and treatment

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

- Feedback from clients included comments that staff took time to talk through care and treatment options.
- The service had a website which provided patients with information about the range of treatments available including costs.
- There was no interpreting or translation service available for patients who did not have English as a first language. Staff told us they were able to access translation software on their computers, to help them to communicate with service users.

Privacy and Dignity

The service respected patients' privacy and dignity.

- Staff recognised the importance of patients' dignity and respect. We observed the treatment rooms to be clean and private. Conversations being held in the treatment rooms could not be heard by those outside.
- The reception computer screens were not visible to patients and staff did not leave personal information where other patients might see it.
- 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?

We rated responsive as Good because:

The service was providing responsive care. The service provided appointments to see practitioners in short timescales, and appointment times met patient needs.

Responding to and meeting people's needs

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

- The facilities and premises were appropriate for the services delivered.
- The provider understood the needs of their patients and improved services in response to those needs. For example, the website for the service was very clear and easy to understand. In addition, it contained clear information about the procedures offered.
- Appointment times were scheduled to ensure people's needs and preferences were met.
- The waiting area was large enough to accommodate the number of patients who attended on the day of the inspection.
- The service was accessible to people if they used a wheelchair or mobility aid. However, the practice was unable to offer unrestricted access for patients with wheelchair mobility needs due to the layout of the building. Patients were informed of this at registration and the practice was able to provide information about alternative accessible services. There were no disabled toilet facilities.

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.

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.

- The service had complaint policy and procedures in place. Staff treated patients who made complaints compassionately. The service reviewed complaints to identify areas for improvement. The Clinic Manager was responsible for dealing with complaints. The service had received four complaints in the last 12 months. Information about how to make a complaint or raise concerns was available. However, there was no information about how to make a complaint on the service website.
- 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 clinic learned lessons from individual concerns and complaints. Team meetings were used to inform staff of incidents and ensure lessons were learnt. The clinic acted to improve the quality of care. For example, we reviewed one complaint from a client who was not happy that they were not able to receive treatment when they were late for their appointment. This was discussed in the team meeting and resulted in changes being made to improve the information provided to people when booking appointments.

Requires Improvement

Are services well-led?

We rated well-led as Requires improvement because:

Governance arrangements in terms of the policies in place, required improvement. There was a lack of assessment and regular review to manage safety risks related to the premises. The service did not have a set schedule of what training all staff needed to complete, or the frequency required.

Leadership capacity and capability;

- Leaders had the capacity and skills to deliver high-quality, sustainable care; however, there was insufficient oversight of health and safety and risks. For example, fire safety.
- The provider had the experience, capability and integrity to deliver the strategy of the service but had not assessed all risks associated with the delivery of the service.
- Leaders at all levels were visible and approachable. They worked closely with staff and others to make sure they prioritised compassionate and inclusive leadership.

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 with a strategy to achieve priorities.
- The service had a mission statement which staff were aware of. Staff understood the vision, values and strategy and their role in achieving them
- The service planned its services to meet the needs of service users.
- 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.
- Although there had only been one incident recorded, openness, honesty and transparency were demonstrated within the system for 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.
- 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.

Governance arrangements

Requires Improvement

Are services well-led?

There were clear responsibilities, roles and systems of accountability, however some governance arrangements at this service were lacking or not effective. For example, there was a lack of systems to ensure effective oversight and management of key areas of risk and safety.

- Although staff were clear on their roles and accountabilities. Leaders had not established proper policies, procedures and activities to ensure safety and to assure themselves that they were operating as intended.
- There were areas where the provider had not met all the regulatory requirements. For example, staff training had not been defined and there was no effective system to monitor essential staff training.
- The practice could not evidence staff completion of mandatory training relevant to their role and did not have a system to flag in an effective way when training was coming due for renewal. Following our inspection, the clinic director told us they would review all essential training monthly to ensure staff remained up to date with mandatory training.
- Patient names and other identifiable information were handled by staff members who had signed confidentiality agreements in place.
- The service submitted information or notifications to external organisations as required.
- Arrangements for the availability, integrity and confidentiality of patient identifiable data, records and data management systems were in line with data security standards.

Managing risks, issues and performance

There was no clarity around processes for managing risks, issues and performance.

- The processes to identify, understand, monitor and address current and future risks including risks to patient safety were not effective. For example, although risk assessments relating to the premises were the responsibility of the building's management, there was a lack of monitoring by the clinic to ensure these assessments were up to date.
- There was limited evidence of monitoring the performance of employed clinical staff. There was no formal supervision or review of the locum nurse, in relation to their practice.
- Leaders had oversight of safety alerts, incidents, and complaints.
- There was evidence of measures to improve and address quality. The provider carried out clinical audits to identify areas to improve the quality of care and outcomes for patients.
- 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 sustainability were discussed in relevant meetings where all staff had sufficient access to information.

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 views and concerns of patients, staff and external partners were encouraged and acted on to inform the development of services
- Staff could describe to us the systems in place to give feedback. For example, staff told us they could always feedback during staff meetings.

Requires Improvement

Are services well-led?

- The service was transparent, collaborative and open with stakeholders about performance.

Continuous improvement and innovation

There were some processes and opportunities for learning, continuous improvement and innovation.

- The service made use of internal and external reviews of incidents and complaints. Learning was shared and used to make improvements.
- There was a focus on continuous learning and improvement at all levels within the service. The clinic director was proactive in attending events to network with local practitioners and keep up to date with best practice.
- The practice website contained a post-treatment and wellbeing blog which was regularly updated by the clinic nurse.
- The director told us that staff at this location consistently sought ways to improve the service.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

The table below shows the legal requirements that were not being met. The provider must send CQC a report that says what action they are going to take to meet these requirements.

Regulated activity	Regulation
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:** There were limited systems or processes that enabled the registered person to assess, monitor and mitigate the risks relating to the health, safety and welfare of service users and others who may be at risk. In particular: • There were limited effective governance arrangements for the undertaking of safety risk assessments and checks for the premises. • The service did not have an effective system to ensure oversight of training for staff. • Leaders had not established proper policies, procedures and activities to ensure safety and to assure themselves that they were operating as intended. **This was in breach of regulation 17(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014**

Regulated activity	Regulation
Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment **How the regulation was not being met:** The provider had failed to ensure that care and treatment is provided in a safe way to service users. In particular: • There was a lack of systems to identify, understand, monitor and address safety risks related to the premises. • There was no effective system of fire risk assessment.

This section is primarily information for the provider

Requirement notices

- The service had not assessed the need for other emergency medicines not stocked to deal with medical emergencies.
- There was no sepsis awareness policy for staff.

This was in breach of regulation 12(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.