Enterprise Healthcare Solutions Ltd

Enterprise Health Care

Inspection report

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Overall summary

We carried out an announced comprehensive inspection on 27 June 2018 to ask the service the following key questions; Are services safe, effective, caring, responsive and well-led?

Our findings were:

Are services safe?

We found that this service was not providing safe care in accordance with the relevant regulations.

Are services effective?

We found that this service was providing effective care in accordance with the relevant regulations.

Are services caring?

We found that this service was providing caring services in accordance with the relevant regulations.

Are services responsive?

We found that this service was providing responsive care in accordance with the relevant regulations.

Are services well-led?

We found that this service was not providing well-led care in accordance with the relevant regulations.

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. 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.

Enterprise Health Care (also known as London Dermatology Clinic) is a private service providing general dermatology consultations and treatments. it also conducts minor cosmetic treatments to day-clients using a range of non-invasive or minimally invasive procedures. It is located in Eastcheap, London. It provides services to adults and children between the ages of four to 18.

The registered manager is a qualified GP with a special interest in dermatology, who shares the day-to-day management of the service with a director of the service who is a qualified pharmacist. 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.

As part of this inspection we asked for CQC comment cards to be completed. We received 11 completed CQC comment cards. All the completed cards indicated that patients were treated with kindness and respect. Staff

Summary of findings

were described as friendly, caring and professional. Some patients commented on how using the service had helped them with their individual care needs and to resolve their concerns.

Our key findings were:

- Not all the information we would expect to find on staff personnel records was stored on the records that we reviewed, including, interview summaries and evidence of training in the Mental Capacity Act and information governance.
- Systems were in place to deal with medical emergencies and staff were trained in basic life support. However, there was no record that all medicines and equipment for use in an emergency were being regularly checked.
- Screens provided in consulting rooms to maintain patients' privacy and dignity during examinations, investigations and treatments were not made of a suitable material that could be kept clean within a clinical environment.
- The service did not have a suitable system in place for reporting, recording and analysing significant events.
- The service was offered on a private, fee paying basis.
- There was a clear procedure for handling alerts from organisations such as MHRA (Medicines and Healthcare products Regulatory Agency).
- Information about services and how to complain was available and easy to understand.
- All health assessment rooms were well organised and equipped, with good light and ventilation.
- Clinicians regularly assessed patients according to appropriate guidance and standards such as those issued by the National Institute for Health and Care Excellence.
- Staff were kind, caring, competent and put patients at their ease.
- Patients were provided with information about their health and with advice and guidance to support them to live healthier lives.
- The provider was aware of, and complied with, the requirements of the Duty of Candour.
- Systems were in place to ensure that all patient information was securely stored and kept confidential.

We identified regulations that were not being met and the provider must:

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

There were areas where the provider could make improvements and should:

- Review and consider replacing the screens in consultation and treatment rooms with screens that can be kept clean in a clinical environment.
- Review and consider putting warning signs outside all treatment room doors to prevent staff entering during a patient consultation.
- Continue to review and monitor that care and treatment is provided in a safe way to patients.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?

We found that this service was not providing safe care in accordance with the relevant regulations.

The impact of our concerns is minor for patients using the service, in terms of the quality and safety of clinical care. The likelihood of this occurring in the future is low once it has been put right. We told the provider to take action (see details of this action in the report).

- Personnel files did not contain all the information we would expect to find, including: interview summaries and evidence of training in the Mental Capacity Act and information governance.
- The service did not have a suitable system in place for reporting, recording and analysing significant events.
- Not all staff had received training to an appropriate level in adult and child safeguarding.
- Following our inspection, the service took immediate action regarding the issues and provided us with evidence that: staff personnel files contained all of the information that was missing; it had implemented an appropriate system for reporting, recording and analysing significant events; it had obtained and installed appropriate screens in clinical rooms; and staff were trained in safeguarding adults and to an appropriate level for child safeguarding.
- The service had some systems, processes and risk assessments in place to keep staff and patients safe.
- The service had contact details to enable them to report any safeguarding concerns for patients who lived locally. However, given the location of the service, in the City of London, and the patient population it served, most patients of the service lived elsewhere and commuted in to work. Following our inspection, the service immediately obtained contact information for adult and child safeguarding teams throughout England.
- Staff had the information they needed to provide safe care and treatment and shared information as appropriate with other services.
- The service had a good track record of safety and had a learning culture, using safety incidents as an opportunity for learning and improvement.
- The staffing levels were appropriate for the provision of care provided.
- We found the equipment and premises were well maintained with a planned programme of maintenance.

Are services effective?

We found that this service was providing effective care in accordance with the relevant regulations.

- Staff had the skills, knowledge and experience to deliver effective care and treatment.
- Staff used current guidelines such as National Institute for Health and Care Excellence, to assess health needs.
- Staff encouraged and supported patients to be involved in monitoring and managing their health.

Are services caring?

We found that this service was providing caring services in accordance with the relevant regulations.

- Screens in treatment rooms for patient privacy and dignity were made of a material that was unsuitable for clinical environments, as it could not be kept adequately clean.
- Not all treatment rooms had signs to warn staff not to enter during a consultation.
- Following our inspection, the service took immediate action regarding the issues we identified, and provided us with evidence that it had installed signs to warn staff not to enter during a consultation outside of all treatment rooms.

Summary of findings

- The service treated patients courteously and ensured their dignity was respected.
- The service involved patients fully in decisions about their care and provided reports detailing the outcome of their health assessment.
- Information was available to patients to help them to live healthier lifestyles.
- We found the staff we spoke to were knowledgeable and enthusiastic about their work.

Are services responsive to people's needs?

We found that this service was providing responsive care in accordance with the relevant regulations.

- The service was responsive to patient needs and patients could contact individual doctors to further discuss treatment options following any tests carried out.
- The service proactively asked for patient feedback and identified and resolved any concerns.
- There was an accessible complaints system in the waiting area of the clinic.
- All forums for patient feedback were closely monitored and responded to.
- The service had good facilities and was well equipped to meet the needs of the patient.
- The service could accommodate patients with a disability or impaired mobility. The consulting rooms could all be reached by lift or stairs, and there were disabled facilities that were wheelchair accessible.

Are services well-led?

We found that this service was not providing well-led care in accordance with the relevant regulations. We have told the provider to take action (see full details of this action in this report).

- The service held staff meetings but these were not recorded.
- The service had a suite of policies systems and processes in place to identify and manage risks and to support good governance. However, staff we spoke to were not aware of how to access the policies and procedures.
- Following our inspection, the service took immediate action regarding the issues we identified, and provided us with evidence that: it had implemented meeting minute templates to record the minutes of meetings; and that staff had been instructed in how to access all policies and procedures.
- The provider had a clear vision and strategy for the service and the service leaders had the knowledge, experience and skills to deliver high quality care and treatment.
- Staff told us they felt well supported and could raise any concerns with the provider or the registered manager.
- The service actively engaged with staff and patients to support improvement and had a culture of learning.
- There was a clear management structure in place and staff understood their responsibilities.
- The culture within the service was open and transparent.

Enterprise Health Care

Detailed findings

Background to this inspection

Enterprise Health Care (also known as London Dermatology Clinic) is registered with the Care Quality Commission to provide the regulated activities of: diagnostic and screening; and treatment of disease, disorder; and injury and surgical procedures.

The service provides dermatologist and plastic surgeon consultations to patients with skin conditions and imperfections. Any surgical procedures are performed on a day patient basis using local anaesthetic. Any patients requiring further investigations or any additional support are referred to other services, for instance, their own GP.

The service address is:

Peek House; 20 Eastcheap, London, EC3M 1EB

It is open and clinics run:

Tuesdays 10.00am to 8.00pm,

Wednesdays 6.00pm to 9.00pm,

Fridays 5.00pm to 9.00pm,

Saturdays 10.00am to 2.00pm and 2.00pm to 6.00pm.

The clinical staff team at the service consists of three part-time female consultant dermatologists and a part-time male plastic surgeon. The non-clinical team is led by the registered manager (a practising GP) and a director (a qualified pharmacist) who both work part-time. The registered manager and director share the management responsibilities between them and one or the other is always present during clinic hours. In addition, there are three part-time assistants/administrators. The service employs an independent call answering service to take and pass on messages outside of clinic hours.

We carried out an announced comprehensive inspection at Enterprise Health Care (also known as London Dermatology Clinic) on 27 June 2018. Our inspection team was led by a CQC Lead Inspector who was accompanied by a GP Specialist Advisor. Before visiting, we reviewed a range of information we hold about the service and asked other organisations to share what they knew. We also reviewed any notifications received, and the information provided from the pre-inspection information request sent to the service prior to this inspection.

The service, which commenced trading in November 2017, has not previously been inspected by CQC.

During our visit we:

- Spoke with a range of staff including the registered manager, a consultant dermatologist, consultant plastic surgeon and a clinical assistant/administrator.
- Looked at the systems in place for the running of the service.
- Looked at rooms and equipment used in the delivery of the service.
- Viewed a sample of key policies and procedures.
- Explored how clinical decisions are made.
- reviewed 11 CQC comment cards which included feedback from patients about their experience of the 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.

Are services safe?

Our findings

We found that this service was not providing safe care in accordance with the relevant regulations.

Safety systems and processes

The provider had some systems, processes and practices in place to keep patients safe and safeguarded them from abuse.

Recruitment procedures were in place to ensure that staff were suitable for their role. Records showed that most of the appropriate recruitment checks had been undertaken prior to employment. However, we found that not all information was kept for all staff. For example, interview summaries, evidence of training in the Mental Capacity Act and information governance were not recorded on all files. Following our inspection, the service provided us with evidence that the information missing from personnel files had been placed on their files.

During the inspection we found that sharps bins were not properly labelled to ensure that the date of assembly was recorded. Following the inspection, the service provided us with evidence that the boxes had been correctly labelled.

Disclosure and Barring Service (DBS) checks were undertaken for all staff with a clinical role, and those undertaking chaperoning duties. 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 premises were suitable for the service provided. The service had conducted safety risk assessments, and it had a range of safety policies that were regularly reviewed and communicated to staff. Safety information was provided to staff as part of their induction and refresher training.

The service had some systems to safeguard children and vulnerable adults from abuse. Safeguarding policies were regularly reviewed and were accessible to all staff. They outlined clearly who to go to for further guidance. Although the provider had an appointed safeguarding lead we noted that personnel files did not evidence that all staff had received appropriate safeguarding training that reflected legislation and local requirements. Following our inspection, the service provided us with evidence that safeguarding training had been completed to an appropriate level.

The provider carried out staff checks on recruitment and on an ongoing basis, including checks of professional registration, for example, revalidation for dermatologists and the plastic surgeon (Doctors who practise medicine in the UK must go through a process of revalidation every five years to remain licenced to practice medicine. The process of revalidation is a review of evidence from their annual appraisals to ensure their skills are up-to-date and they remain fit to practise medicine).

We observed the premises to be clean and there were arrangements to prevent and control the spread of infections. The practice had a variety of risk assessments and procedures in place to monitor safety of the premises such as control of waste management, infection prevention and control and legionella (Legionella is a term for a bacterium which can contaminate water systems in buildings). Most equipment was monitored and maintained to ensure it was safe and fit for use. We saw evidence of regular legionella risk assessments being undertaken. However, we found that fire extinguishers did not have visual checks or documentary evidence that they were regularly checked to confirm they remained safe to use. After the inspection, the service provided us with evidence that the fire extinguishers had been appropriately labelled, and that regular checks were taking place.

Notices advised patients that chaperones were available. Several members of the administration team, and doctors, acted as chaperones and all had received training for the role. All staff carrying out chaperone duties had received a DBS check.

Risks to patients

Staffing numbers and skill levels were monitored and there were procedures in place to source additional trained staff when required.

There were effective systems in place to manage referrals and test results, and the service had arrangements in place for prompt processing of any tests patients underwent.

Risks to patients, such as fire, with the exception of labelling of the fire extinguishers, had been assessed and actions taken to manage any risks identified.

Are services safe?

There were some arrangements in place to respond to emergencies and major incidents:

- We checked staff records for two clinical staff, and one non-clinical member of staff. These showed that staff had completed a range of mandatory training, including training in: annual basic life support (BLS), fire safety and infection prevention and control. However, some information we would expect to find on staff records was missing, this included records of induction training, and training in: information governance; and safeguarding of adults and children. Following our inspection, the provider took immediate action to ensure that all mandatory training and other records were completed and placed on staff files.
- There was oxygen, a defibrillator, and a supply of emergency medicines. A risk assessment had been carried out to determine which emergency medicines to stock. All were checked by the service through regular checks of expiry dates to make sure they would be effective when required. However, it was not maintaining a record of the checks undertaken. Following our inspection, the provider took immediate action to implement a checklist and to provide staff with instructions for regularly checking all emergency equipment and medicines, we were provided with evidence of these changes.
- The service had contact details to enable them to report any safeguarding concerns for patients who lived locally. However, given the location of the service, in the City of London, and the patient population it served, most patients of the service lived elsewhere and commuted in to work. Following our inspection, the service immediately obtained contact information for adult and child safeguarding teams throughout England. This information was added to the safeguarding policies.
- There was a business continuity plan for major incidents such as power failure or building damage. This contained emergency contact details for suppliers and staff, and copies were accessible off-site.

Clinical staff working at the service were required to hold sufficient professional indemnity cover for the full scope of their work with the service.

Information to deliver safe care and treatment

The service had worked with an independent supplier to develop an electronic patient record system that met the needs of the service. The patient record system had safeguards to ensure that patient records were held securely. Paper based records were held securely in locked cabinets.

Information needed to plan and deliver care and treatment was available to relevant staff in a timely and accessible way through the service's patient record system. This included investigation and test results.

There were arrangements in place to check the identity of patients.

The service had adopted a protocol to ensure that it received and acted on safety alerts, including Central Alerting System alerts from the Department of Health (CAS alerts) and Medicine and Healthcare products Regulatory Agency (MHRA Alerts). This entailed receipt of email alerts directly by the registered manager and director who distributed them to all clinicians, followed by appropriate logging and review.

Safe and appropriate use of medicines

The service routinely reviewed updates to national guidelines from National Institute for Health and Care Excellence (NICE) and the British Association of Dermatologists and medicine safety alerts to ensure safe prescribing.

From the evidence seen, the clinicians prescribed and gave advice on medicines in line with legal requirements and current national guidance.

The arrangements for managing emergency medicines in the service kept patients safe, including obtaining, storage and security.

Track record on safety

There was a system in place for reporting incidents, but this only applied to events that resulted in death or life-changing injury. Following discussion, the service agreed to change its definition of significant events to include a wider range of incidents. It subsequently provided us with a suitable revised significant events policy together with a copy of an appropriate event reporting form.

Are services safe?

We found that there was a clear procedure for handling alerts from organisations such as MHRA. Alerts were received by email and disseminated by the registered manager and director to staff. Alerts were then reviewed, filed and logged.

Lessons learned and improvements made

The provider was aware of and complied with the requirements of the Duty of Candour. The Duty of Candour is a set of specific legal requirements that providers of services must follow when things go wrong with care and treatment. The service encouraged a culture of openness and honesty. It had systems in place for knowing about notifiable safety incidents

The service did not have an effective system in place for reporting, recording and analysing significant events. However, following our inspection the service implemented, and provided us with evidence that when there were unexpected or unintended safety incidents, they carried out a thorough analysis of significant events, affected people were given an apology and were told about any actions to improve processes to prevent the same thing happening again. Records of significant events were stored on the service's computer system, this included records of verbal interactions as well as written correspondence.

Are services effective?

(for example, treatment is effective)

Our findings

We found that this service was providing effective care in accordance with the relevant regulations.

Effective needs assessment, care and treatment

- There was evidence that the service carried out assessments and treatment in line with relevant and current evidence based guidance and standards. The service assessed patients' needs and delivered care in line with National Institute for Health and Care Excellence (NICE), the British Association of Dermatologists evidence based practice for example regarding assessment and management of eczema.
- The practice offered a range of dermatological procedures including eczema and acne. The service only carried out surgical procedures for skin lesions that were suitable for removal under local anaesthetic. More complex issues were referred on to appropriate services.
- The clinicians had developed links with a wide range of specialists to facilitate appropriate referrals.

Monitoring care and treatment

The provider had systems in place to monitor and assess the quality of the service including the care and treatment provided to patients. Key performance indicators were in place for monitoring care and treatment and the quality of consultations with patients was monitored through observed practice.

As the service had only been running for approximately seven months it had not yet completed any clinical audits. It was however, gathering data to run clinical audits. For example, we were provided with a template that was being used to gather information for a peer review audit of the clinical consultations. The service had also undertaken a first cycle of an audit of consultation times. The service had recorded the start and end times of 15 dermatology clinics (153 patients were seen) and five minor operating lists (38 patients had minor operation appointments) during December 2017 and January 2018. The service found that dermatology appointments lasted for between eight to 44 minutes, with an average of 15 minutes. Minor operation appointments recorded were between seven to 58 minutes, with an average duration of 25 minutes. The service discussed this and decided to add in a single 15-minute catch-up slot for dermatology appointments, with no changes needed for minor operation lists. It agreed to re-run the audit in six months to assess the impact of the decisions made. The service had since reviewed its appointment system to provide extra time for patients to be seen without any sense of urgency. It had changed the appointment durations to 22 minutes for dermatology appointments and 45 minutes for minor operations.

Effective staffing

We found staff had the skills, knowledge and experience to deliver effective care and treatment. The service had an induction programme for newly appointed staff that covered such topics as safeguarding, infection prevention and control, fire safety, health and safety and confidentiality.

- The service understood the learning needs of staff and provided protected time to meet them. This included a comprehensive induction programme and in-house training programme. This ensured that all staff had up to date records of skills, qualifications and training.
- The service provided staff with on-going support. This included one-to-one meetings, appraisals, and support for revalidation. All staff were due to have an appraisal once they had completed 12 months service.
- Staff also received protected time to undertake administrative tasks.
- There was a clear approach for supporting and managing staff when their performance was poor or variable.

Coordinating patient care and information sharing

The service shared information to plan and co-ordinate patient care effectively.

We found that the service shared relevant information with other services in a timely way. For example, we saw evidence that the service sought patient's permission within the patient registration document to contact their NHS GPs, and of appropriate referrals to patients NHS GPs.

Supporting patients to live healthier lives

The service supported patients in living healthier lives. Information leaflets, display screens in the services' waiting area and the service website provided a range of information about skin conditions, treatments available and preventative care. In addition, the service provided patients with free samples of sun-screen creams to help prevent sun damage. The consultants also gave patients advice about skin care regimes to help protect their skin.

Are services effective?

(for example, treatment is effective)

Consent to care and treatment

Staff sought patients consent to care and treatment in line with legislation and guidance. Staff we spoke to understood the relevant consent and decision-making requirements of legislation and guidance, including the Mental Capacity Act 2005.

The service obtained written consent before undertaking procedures and specifically for sharing information with outside agencies such as the patient's GP. Authority for consent to contact a patients GP was included as a clause in the consent form that patients signed prior to treatment. The patients' signed consent was recorded in the patient record system. This showed that the service met its responsibilities within legislation and in line with relevant national guidance. Information about fees was transparent and available in the service' waiting area.

The lead consultant showed an understanding of consent issues and best interest. They detailed relevant competencies and guidance they would use. The registered manager and clinicians we spoke to were aware of Gillick Competency (used to help assess whether a child has the maturity to make their own decisions and to understand the implications of those decisions).

Are services caring?

Our findings

We found that this service was providing caring services in accordance with the relevant regulations.

Kindness, respect and compassion

We observed that members of staff were courteous and helpful to patients and treated people with dignity and respect.

The feedback we received about patient experience of the service was positive. We made CQC comment cards available for patients to complete prior to the inspection visit. We received 11 completed comment cards all of which were very positive and indicated patients were treated with kindness and respect. Comments included that patients felt the service offered was very good and that staff treated them in a caring professional manner and with dignity and respect.

Staff we spoke with demonstrated a patient centred approach to their work which reflected the feedback we received in CQC comment cards.

Involvement in decisions about care and treatment

Patient comment cards showed that patients felt involved in decision making about the care and treatment they received. They also told us they felt listened to and supported by the clinicians; and had sufficient information within consultations to make an informed decision about the choices of treatment available.

The service ensured that patients were provided with all the relevant information they required to make decisions about their treatment prior to treatment commencing, this included information leaflets in a range of languages.

Privacy and Dignity

The service respected and promoted patients' privacy and dignity. Staff recognised the importance of patients' dignity and respect and the service complied with current data protection legislation. All confidential information was stored securely, either on computers, or paper records which were stored in locked cabinets.

Screens were provided in consulting rooms to maintain patients' privacy and dignity during examinations, investigations and treatments. However, the screens were not made of a suitable material that could be kept clean within a clinical environment. Following our inspection, the service purchased suitable screens and provided us with evidence of the purchases. We observed consultation and treatment room doors were closed during consultations, and conversations taking place in those rooms could not be overheard. Following a previous patient complaint when another clinician had entered a treatment room while they were being examined, the service had installed signs to warn clinicians when they should not enter rooms. However, not all the treatment rooms had these warning signs. We raised this with the service and following our inspection, the service provided us with evidence that it had immediately obtained and installed signs for all treatment rooms. Signs in the reception area advised patients chaperones were available should they want this and staff who acted as chaperones had received training to carry out the role.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

We found that this service was providing responsive care in accordance with the relevant regulations.

Responding to and meeting people's needs

The facilities and premises were appropriate for the services delivered. Consultant appointments were often available on a same day basis with patients being offered a choice of appointment times that were convenient for them.

Discussions with staff showed the service was person centred and flexible to accommodate patient needs. Patients received personalised reports tailored to their particular needs. They were also provided with a range of additional information to increase their knowledge and awareness of their health.

Timely access to the service

Appointments were available at varied times on Tuesday, Wednesday, Friday and Saturday. Staff advised there was rarely any difficulty in providing appointments that met patients' needs. Patients who needed to access care in an emergency or outside of normal opening hours were directed to the NHS 111 service.

The service offered evening appointments, that were preferred by many patients, on Tuesdays until 8.00pm, and Wednesdays and Fridays until 10.00pm. It also offered Saturday appointments between 10.00am to 6.00pm to meet patient demand for non-working day appointments.

There were arrangements to support patients outside of those hours. Telephones were answered from 9.00am to 9.00pm each working day. Outside of working hours, a phone answering service took and passed on messages to the registered manager.

Patients were given advice on what to do following procedures, including minor surgery. For example, in addition to giving patients a follow-up appointment to review progress, patients were advised of the actions to take if there were any complications following a treatment, such as to contact the service or their GP.

Listening and learning from concerns and complaints

There was a lead member of staff for managing complaints and all complaints were reported through the provider's quality assurance system. This meant any themes or trends could be identified and lessons learned from complaints were shared across the provider's locations.

The provider had a complaints policy and procedure and information about how to make a complaint. The complaints policy contained appropriate timescales for dealing with a complaint.

Information about how to make a complaint was available in the service waiting area. We reviewed the complaints system and noted there was an effective system in place which ensured there was a clear response with learning disseminated to staff about the event.

Four complaints had been received in the last year. We reviewed two complaints and found that both complaints had been satisfactorily handled and that patients were responded to in a timely and appropriate way.

Are services well-led?

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

Our findings

We found that this service was not providing well-led care in accordance with the relevant regulations.

Leadership capacity and capability

Leaders had the capacity and skills to deliver high-quality sustainable care, and to address risks. Leaders were visible and approachable, and worked closely with staff and others to make sure they prioritised compassionate and inclusive leadership.

There was a clear leadership structure in place and staff felt supported by management. Staff we spoke with told us management were approachable and always took the time to listen to them. Staff had been provided with good training opportunities linked to their roles, responsibilities and professional development goals.

Vision and strategy

The provider had a clear vision to provide a high quality, consultant led, responsive service that put caring and patient safety at its heart. There was a clear vision and set of values. The provider had a realistic strategy and supporting business plans to achieve its priorities. Staff were aware of and understood the vision, values and strategy and their role in achieving them.

Culture

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

- Staff we spoke to said they felt respected, supported and valued, and there was a strong emphasis on the safety and well-being of all staff.
- Leaders and managers acted on behaviour and performance inconsistent with the vision and values.
- Openness, honesty and transparency were demonstrated when responding to complaints. The provider was aware of and had systems to ensure compliance with the requirements of the duty of candour.
- Staff we spoke with told us they were able to raise concerns and were encouraged to do so. They had confidence these would be addressed.
- There were processes for providing all staff with the development they needed. This included appraisal and career development conversations. All staff were scheduled to have annual appraisals on completion of 12-months service. Staff were supported to meet the requirements of professional revalidation where necessary.
- Clinical staff were considered valued members of the practice team. They were given protected time for professional development and evaluation of their clinical work.
- The service actively promoted equality and diversity. Staff had received equality and diversity training. Staff we spoke to said they felt they were treated equally.
- There were positive relationships between staff members. We were told that there were staff meetings but minutes were not taken, accordingly the service could not show evidence that actions identified at meetings were followed up. Following our inspection, the service immediately implemented a meeting minute template and provided us with a copy.

Governance arrangements

There was a governance framework which supported the delivery of the strategy and good quality care. This outlined the structures and procedures and ensured that:

- There was a clear staffing structure and that staff were aware of their own roles and responsibilities.
- Practice specific policies were implemented. These were updated and reviewed regularly.
- There was a clear organisational structure and staff were aware of their roles and responsibilities. A range of service specific policies and procedures were in place to govern activity. These were available to all staff, and were reviewed regularly and updated when necessary.

However, during our inspection we found a number of issues that the provider had not adequately ensured:

- Not all the information we would expect to find on staff personnel files was present on all files that we reviewed. This included evidence of information governance and the Mental Capacity Act training. After the inspection the service provided us with evidence of the missing information, and placed copies on staff personnel files.
- At the inspection, not all staff, who had patient contact, had received safeguarding training for adults and for children to the appropriate level. The service subsequently provided us with evidence that staff safeguarding training, to the appropriate level, had been completed.

Are services well-led?

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

- There was oxygen, a defibrillator, and a supply of emergency medicines. However, the service was unable to provide evidence that these were checked to ensure they would be effective when required. The service later provided us with a copy of an appropriate checklist, together with a schedule for regular checking of all emergency equipment and medicines.
- The service had a number of policies and procedures in place to govern activity. All of the policies and procedures we saw had been reviewed and reflected current good practice guidance from sources such as the National Institute for Health and Care Excellence (NICE) and the British Association of Dermatologists. However, staff we spoke to were unaware how to access the service' policies and procedures. The service subsequently provided us with evidence that staff had been advised how to locate the policies and procedures.
- The service had contact details to enable them to report any safeguarding concerns for patients who lived locally. However, given the location of the service, in the City of London, and the patient population it served, most patients of the service lived elsewhere and commuted in to work. Following our inspection, the service immediately took action and provided us with evidence that it had had appropriate contact details for adult and child safeguarding teams throughout England.
- The service only held ad-hoc meetings including staff and clinical meetings, but systems were in place to monitor and support staff at all levels. This included having a system of key performance indicators, risk assessments and quality checks and actively seeking feedback from patients.

Managing risks, issues and performance

There were some processes for managing risks, issues and performance. There was a process to identify, understand, monitor and address current and future risks including risks to patient safety, for example:

- Risk assessments we viewed were comprehensive and were scheduled to be reviewed every 12 months. The registered manager and director had oversight of relevant safety alerts and complaints.
- The service was undertaking peer reviews of consultations. It had developed, and was using, a template to gather information, this was at an early stage and the service intended to formalise this into a peer review audit.

Appropriate and accurate information

Systems were in place to ensure that all patient information was securely stored and kept confidential. The service used a secure cloud-based patient storage system. Then ensured that should there be any issues with the location the service would be able to contact patients and operate from another suitable location.

There were policies and IT systems in place to protect the storage and use of all patient information. There was a business continuity plan in place which included minimising the risk of not being able to access or losing patient data. Copies of the plan were accessible off-site.

Engagement with patients, the public, staff and external partners

Patients were actively encouraged to provide feedback on the service they received. This was monitored and action would be taken where feedback indicted the quality of the service could be improved. Recent results showed that patients were satisfied with the care they received from the service. Patient feedback was published on the service' website.

Continuous improvement and innovation

There was a focus on continuous learning and improvement at all levels within the service. Staff were encouraged to identify opportunities to improve the service delivered through ad-hoc meetings, one to one meetings and the appraisal process.

The service had worked with an independent IT firm to develop its IT systems including the patients record system. This system met the services needs better than any proprietary systems it had considered.

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 Surgical procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance How the regulation was not being met: Systems or processes must be established and operated effectively to ensure compliance with the requirements of the fundamental standards as set out in the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 The registered person had systems or processes in place that were operating ineffectively in that they failed to enable the registered person to assess, monitor and improve the quality and safety of the services being provided. For example: • Staff personnel files did not contain interview summaries, and evidence of training in the Mental Capacity Act and information governance. • there was no record that all medicines and equipment for use in an emergency were being regularly checked. • Not all staff had received appropriate adult and children safeguarding training that reflected legislation and local requirements. • The system in place for reporting, recording and analysing significant events was not suitable. • Meeting minutes were not adequately recorded. • Fire extinguishers did not have labels confirming their inspection due date

This section is primarily information for the provider

Requirement notices

This was in breach of regulation 17(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.