London Claremont Clinic

Inspection report

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

Ratings

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

Overall summary

This service is rated as Requires improvement overall.

The key questions are rated as:

Are services safe? – Requires improvement

Are services effective? – Requires improvement

Are services caring? – Good

Are services responsive? – Good

Are services well-led? – Requires improvement

We carried out an announced comprehensive inspection at London Claremont Clinic as part of our inspection programme. This was the first inspection undertaken at this service.

The service offered ophthalmology (the diagnosis and treatment of eye disorders) and dermatology (the diagnosis and treatment of skin conditions) related healthcare services. The service was open to adults and children. The service was undergoing a transition from a mixed speciality private clinic to one which would only provide private patient services for ophthalmology by the end of 2022.

The senior consultant ophthalmologist 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.

Our key findings were:

- There was a lack of good governance in some areas.
- Information needed to deliver safe care and treatment was not always available to the relevant staff in a timely manner.
- The service did not have reliable systems for appropriate and safe handling of medicines.
- The service was unable to provide evidence that the consultations of all doctors were undertaken in line with relevant national UK guidelines or had a documented rationale for the treatment provided.
- Prescribing was not audited or reviewed to identify areas for quality improvement.
- There was insufficient quality monitoring of clinicians' performance.
- Some doctors had not received safeguarding children level three training relevant to their role.
- There were processes to ensure risks to patients were assessed and well managed in most areas, with the exception of those relating to safeguarding children training and sepsis awareness.
- Appointments were available on a pre-bookable basis. The service provided only face to face consultations.
- Staff involved and treated patients with compassion, kindness, dignity and respect.
- Information about services and how to complain was available.
- The provider was aware of and complied with the requirements of the Duty of Candour.

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

Overall summary

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

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

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

- Arrange sepsis awareness training for non-clinical staff members.
- Follow the complaint policy and include information on the complainant's right to escalate the complaint if dissatisfied with the response.

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

Our inspection team

Our inspection team was led by a CQC lead inspector who spoke with staff using video conferencing facilities and undertook a site visit. The team included a GP specialist advisor who spoke with staff using video conferencing facilities and completed records reviews without visiting the location.

Background to London Claremont Clinic

London Claremont Clinic is an independent clinic in central London.

Services are provided from: London Claremont Clinic, 50/52 New Cavendish Street, London, W1G 8TL. We visited this location as part of the inspection on 25 February 2022.

The service offers ophthalmology (the diagnosis and treatment of eye disorders) and dermatology (the diagnosis and treatment of skin conditions) related healthcare services. The service is undergoing a transition from a mixed speciality private clinic to one which would only provide private patient services for ophthalmology by the end of 2022.

The service was open to adults and children.

Online services can be accessed from the practice website: www.londonclaremontclinic.co.uk.

The service employs a number of self-employed doctors. All doctors are on the General Medical Council (GMC) register, and have indemnity insurance to cover their work.

The team consists of the clinic manager, a pharmacist, an ophthalmic technician, senior ophthalmic technicians, an ophthalmic science practitioner and a health care assistant. A senior consultant ophthalmologist (also the CQC registered manager) is supported by a team of administrative staff.

The service is registered with the Care Quality Commission to provide the regulated activities of diagnostic and screening procedures, treatment of disease, disorder and injury, transport services, triage and medical advice provided remotely, services in slimming clinics and surgical procedures. This service is registered with CQC under the Health and Social Care Act 2008 in respect of the services it provides.

The service has core opening hours from 8.30am to 8pm Monday to Wednesday. At the time of the inspection, the service was providing reduced hours due to ongoing building renovations.

How we inspected this service

Pre-inspection information was gathered and reviewed before the inspection. We spoke with a range of clinical and non-clinical staff. We looked at records related to patient assessments and the provision of care and treatment. We also reviewed documentation related to the management of the service. We reviewed patient feedback collected by 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.

Requires Improvement

Are services safe?

We rated safe as Requires improvement because:

- Information needed to deliver safe care and treatment was not always available to the relevant staff in a timely manner.
- The service did not have reliable systems for appropriate and safe handling of medicines.
- There were processes to ensure risks to patients were assessed and well managed in most areas, with the exception of those relating to safeguarding children training and sepsis awareness.

Safety systems and processes

The service had systems to keep people safe and safeguarded from abuse. However, some improvements were required.

- The provider conducted safety risk assessments. It had appropriate safety policies, which were regularly reviewed and communicated to staff. 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 treated children and had a system in place to ensure that children were protected.
- The service worked with other agencies to support patients and protect them from neglect and abuse. Staff took steps to protect patients from abuse, neglect, harassment, discrimination and breaches of their dignity and respect.
- The service 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. It was the service's policy to request a Disclosure and Barring Services (DBS) check 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).
- Some doctors (three out of 11 that had practising privileges to see children at the service) had not received child safeguarding training relevant to their role in line with intercollegiate guidance for all staff working in healthcare settings. However, they had received level two child safeguarding training and treated children at the service. (A practising privilege is the 'licence' agreed between individual medical professionals and a private healthcare provider). All non-clinical staff had received child safeguarding training relevant to their role in line with intercollegiate guidance for all staff working in healthcare settings. All staff had received adult safeguarding training relevant to their role.
- Staff we spoke with knew how to identify and report concerns. Staff who acted as chaperones were trained for the role and had received a DBS check.
- There was an effective system to manage infection prevention and control. The service had carried out regular infection control audits.
- The service had up to date legionella risk assessment in place and regular water temperature checks had been carried out. (Legionella is a term for a particular bacterium which can contaminate water systems in buildings).
- The service 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 appropriate environmental risk assessments, which took into account the profile of people using the service and those who may be accompanying them.

Risks to patients

There were systems to assess, monitor and manage risks to patient safety. However, some improvements were required.

Requires Improvement

Are services safe?

- There were arrangements for planning and monitoring the number and mix of staff needed. However, most of the staff we spoke with raised dissatisfaction regarding the staffing levels at the service. The service informed us they had faced challenges in recruiting new staff during the pandemic. The service shared with us during the inspection that they had carried out interviews recently and were in the process of recruiting new staff members.
- There was an effective induction system for staff tailored to their role.
- Staff understood their responsibilities to manage emergencies and to recognise those in need of urgent medical attention. However, most of the non-clinical staff we spoke with were not sure how to identify and manage patients with severe infections, for example, sepsis. Staff we spoke with informed us they had not had to deal with such poorly patients in the time that this service had been opened.
- When there were changes to services or staff the service assessed and monitored the impact on safety.
- There were appropriate indemnity arrangements in place.
- There were suitable medicines and equipment to deal with medical emergencies which were stored appropriately and checked regularly.

Information to deliver safe care and treatment

Staff did not always have the sufficient information they needed to deliver safe care and treatment to patients.

- Individual care records were maintained, but the care records we saw showed that in most cases limited information was recorded in the individual patient's notes. For example, we saw a record, where there was no clinical rationale recorded in the patient's notes. There was no documented evidence of any action plan or follow up required in the patient's notes.
- We noted that most of the individual care records were not accessible to the service as they were kept private by the consultants, which showed that information needed to deliver safe care and treatment was not always available to relevant staff in an accessible way.
- The service had systems for sharing information with staff and other agencies to enable them to deliver safe care and treatment.
- The service had a system in place to retain medical records in line with Department of Health and Social Care (DHSC) guidance in the event that they ceased trading.
- The service was registered with the Information Commissioner's Office.
- Clinicians made appropriate and timely referrals in line with protocols and up to date evidence-based guidance.

Safe and appropriate use of medicines

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

- The service offered ophthalmology (the diagnosis and treatment of eye disorders) and dermatology (the diagnosis and treatment ofskin conditions) related healthcare services. The service was open to adults and children. There were 32 Ophthalmologists and one Dermatologist was working at the service. The service was undergoing a transition from a mixed speciality private clinic to one which would only provide private patient services for ophthalmology by the end of 2022.
- The service did not carry out regular medicines audits to ensure prescribing was in line with best practice guidelines for safe prescribing. The service was unable to provide any prescribing data on the day of the inspection. The service was unable to provide documentary evidence to demonstrate whether the doctors were following the antibiotic prescribing protocol.
- The service had an on-site pharmacy which was managed and monitored by the pharmacist, permanently employed by the service. Patients had a choice to use an on-site pharmacy or an external pharmacy of their choice. All prescriptions dispensed by the on-site pharmacy were reviewed by the in-house pharmacist and records were securely

kept. However, the pharmacist did not have access to the patient's consultation notes, but they were able to raise queries with the prescribing doctors if required. The service informed us that they were planning to introduce an electronic patient record system from October 2022. The service informed us a few days after the inspection that they had created a mailbox for all doctors across the service to provide all relevant clinical information about all of their patients seen within the service.

- The service informed us they did not store any controlled drugs on the premises and the pharmacist was able to order the controlled drugs if required. The doctors were able to prescribe any controlled drugs or high risk medicines as required. The service had appropriate systems, arrangements and a risk assessment in place for managing and handling controlled drugs at the premises. However, the service had not always had access to the consultation notes and was not always aware of which controlled drug or high risk medicine was prescribed and how much quantity or dosage was prescribed, especially if the patient decided to use an external pharmacy. Processes were not in place for checking and monitoring whether these medicines were prescribed in line with legal requirements and current national guidance. However, these medicines were only prescribed by qualified doctors who were authorised by the service and granted practising privileges to work at the service.
- All medicines were prescribed based on the clinical need on an acute basis. The service informed us that the doctors were providing care and treatment to patients with long term conditions.
- The private prescriptions were printed on the letterhead which included a company name, logo and other necessary information. These paper prescriptions were prescribed and signed by the doctor with their GMC number.
- The systems and arrangements for managing emergency medicines and equipment minimised risks.
- Vaccines were appropriately stored in both the fridges and fridge temperatures were monitored regularly.

Track record on safety and incidents

The service had a good safety record.

- There were comprehensive risk assessments in relation to safety issues.
- The service had an up to date fire risk assessment (2 February 2021) in place and they were carrying out regular fire safety checks.
- The service had up to date legionella risk assessment in place and regular water temperature checks had been carried out. (Legionella is a term for a particular bacterium which can contaminate water systems in buildings).
- All clinical equipment was checked and calibrated to ensure clinical equipment was safe to use and was in good working order.
- We noted that the safety of electrical portable equipment was assessed at the premises to ensure they were safe to use.
- The service monitored and reviewed activity. This helped it to understand risks and gave a clear, accurate and current picture that led to safety improvements.
- The electrical installation condition checks of the premises had been carried out on 19 June 2019.

Lessons learned and improvements made

The service learned and made improvements when things went wrong.

- There was a system for recording and acting on significant events. Staff we spoke with demonstrated their understanding to raise concerns and report incidents and near misses.
- 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. For example, a pathology sample was sent to the wrong laboratory. The service had investigated the incident and reminded all staff to follow the correct procedure when sending pathology samples to the laboratory.

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.

When there were unexpected or unintended safety incidents:

- The service gave affected people reasonable support, truthful information and a verbal and written apology
- They kept written records of verbal interactions as well as written correspondence.
- The service acted on and learned from external safety events as well as patient and medicine safety alerts. The service had an effective mechanism in place to disseminate alerts to all members of the team.

Requires Improvement

Are services effective?

We rated effective as Requires improvement because:

- The service was unable to provide evidence that the consultations of all doctors were undertaken in line with relevant national UK guidelines or had a documented rationale for the treatment provided.
- Prescribing was not audited or reviewed to identify areas for quality improvement.

Effective needs assessment, care and treatment

The service told us their doctors were expected to work within current evidence based guidance and standards such as the National Institute for Health and Care Excellence (NICE) best practice guidelines and the Royal College of Ophthalmologists guidelines.

- The service was unable to provide satisfactory evidence that the work of all its doctors was undertaken in line with relevant national UK guidelines.
- All patients completed a registration questionnaire at their first visit which included information about their past medical history, personal details, date of birth and NHS GP details (plus consent to update NHS GP of all consultations details). This questionnaire was scanned and uploaded into the attachments section of the clinical record system.
- Most of the consultation notes were not accessible as they were kept securely and privately by the doctors. Some consultation notes were stored on the service clinical system. We reviewed eight consultation notes and found that the outcomes of each assessment were not always clearly recorded and presented with explanations to make their meaning clear, which included a discussion on the treatment options. The consultation notes had not included appropriate information regarding the initial assessment (to explain why the blood tests were carried out) and no clear information was documented regarding any follow up actions required. Some consultation notes had a letter attached which was sent to the NHS GP.
- The service offered an advanced eye scan to assess eye health in detail, and detect sight-threatening conditions, for clinical diagnostic purposes. The service had comprehensive protocols in place to ensure the effective management and handling of scans to ensure the delivery of safe and effective care.
- All clinicians who conduct the scan were appropriately trained to operate the equipment and analyse the scan results. The scan results were saved in the service's online clinical system.
- We saw no evidence of discrimination when making care and treatment decisions.

Monitoring care and treatment

The service was involved in a quality improvement activity. However, improvements were required.

- The service had not always carried out the consultation notes audits and medicines audits to ensure effective monitoring and assessment of the quality of the service.
- There were no prescribing audits to monitor the individual prescribing decisions, for example, to monitor their antibiotic prescribing, but individual patients on prescribed medicines were monitored to identify the appropriateness of their medicines. The doctors advised patients what to do if their condition got worse and where to seek further help and support.
- There was no evidence to support the provider undertaking a systematic review of prescribing patterns against best practice standards and did not have a process in place for identifying improvements.
- There was evidence of quality improvement activity. For example, the service had carried out data analysis and compared the visual outcomes of the clinic with the national data. The audit identified that the visual outcomes of the service patients were superior compared to those of the NHS patients across the UK.
- The service had carried out a diabetic retinal screening (a test to check for eye problems caused by high blood sugar levels) reporting audit and identified that the report was sent to the NHS GP within the agreed timescale.

Requires Improvement

Are services effective?

- The service had carried out a pain management checklist compliance audit and achieved 100% outcomes.
- The service had carried out an infection control audit of intravitreal injection (the inside of the eye is filled with a jelly-like fluid) suite.
- The service had carried out a consent form audit of a sample of forms to check the accuracy and record keeping of patients' details and the treatment agreed upon and to ensure all consent forms were legible, signed and dated by the patients and the doctors.
- In addition, the service had carried out an allergy audit, covid controls audit, General Data Protection Regulation (GDPR) audit, hand hygiene audit and wait time audit.
- We found the service was following up on pathology results and had an effective monitoring system in place to ensure that all abnormal results were managed in a timely manner and saved in the patient's records.

Effective staffing

Staff had the skills, knowledge and experience to carry out their roles. However, some improvements were required.

- All staff were appropriately qualified. The service had an induction programme for all newly appointed staff.
- The doctors were registered with the General Medical Council (GMC) the medical professionals' regulatory body with a license to practice.
- The service had kept evidence of doctors' professional qualifications in their staff files.
- The doctors had a current responsible officer. (All doctors working in the United Kingdom are required to have a responsible officer in place and required to follow a process of appraisal and revalidation to ensure their fitness to practice). The doctors were following the required appraisal and revalidation processes. Most doctors had received a formal internal appraisal within the last 12 months.
- The service understood the learning needs of staff and provided protected learning time and training to meet them. Up to date records of skills, qualifications and training were maintained. Staff were encouraged and given opportunities to develop.
- Most staff had received training relevant to their role, with the exception of child safeguarding training.
- All non-clinical staff and technicians had received an appraisal within the last 12 months.

Coordinating patient care and information sharing

Staff worked together, and worked well with other organisations, to deliver effective care and treatment. However, some improvements were required.

- Patients received coordinated and person-centred care. If a patient needed further examination they were directed to an appropriate agency; signposted to their own GP or to their nearest A&E department.
- Before providing treatment, doctors at the service ensured they had adequate knowledge of the patient's health, any relevant test results and their medical history.
- When a patient contacted the service, they were asked if the details of their consultation could be shared with their NHS GP. If the patient did not agree to the service of sharing information with their GP, then in case of an emergency the provider discussed this again with the patient to seek their consent. Where patients agreed to share their information, we saw evidence of letters sent to their registered GP in line with GMC guidance.
- The information needed to plan and deliver care and treatment was not always available to the service in a timely and accessible way.
- The service monitored the process of seeking consent appropriately.
- We were told that any treatment including fees was fully explained to the patient prior to the procedure and that people then made informed decisions about their care.

Requires Improvement

Are services effective?

- There was information on the service's website with regards to how the service worked and what costs applied. The website had details on how the patient could contact them with any enquiries.

Supporting patients to live healthier lives

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

- Where appropriate, staff gave patients advice so they could self-care.
- Risk factors were identified, highlighted to patients and where appropriate highlighted to their normal care provider for additional support. For example, we saw a diabetes eye screening information leaflet for patients which explained the complete procedure and risk factors.
- Where patients' needs could not be met by the service, staff redirected them to the appropriate service for their needs.

Consent to care and treatment

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

- Staff understood the requirements of legislation and guidance when considering consent and decision making.
- Staff supported patients to make decisions. Where appropriate, they assessed and recorded a patient's mental capacity to make a decision.

Good

Are services caring?

We rated caring as Good because:

Kindness, respect and compassion

Staff treated patients with kindness, respect and compassion.

- For reasons of safety and infection prevention and control related to the COVID-19 pandemic, we did not commission patient feedback with CQC comment cards. We did not speak to any patients during this inspection.
- The service had carried out regular quarterly patient surveys. We reviewed patient satisfaction survey results since April 2021 and noted feedback from patients was positive about the way staff treat patients. The service sought feedback on the quality of consultation and procedure. During a recent patient satisfaction survey, 100% of the patients rated their overall experience of visiting the clinic as excellent or good.
- 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.
- Interpretation services were available for patients who did not have English as a first language. We saw notices in the reception areas, including in languages other than English, informing patients that this service was available. Patients were also told about multi-lingual staff who might be able to support them. Information leaflets were available in easy read formats, to help patients be involved in decisions about their care.
- The service told that patients had sufficient time during consultations to make an informed decision about the choice of treatment available to them.
- For patients with learning disabilities or complex social needs family, carers or social workers were appropriately involved.
- Staff communicated with people in a way that they could understand, for example, communication aids and easy read materials were available.
- The service had comprehensive patient information leaflets available explaining various clinical procedures. Leaflets included information regarding the time duration, benefits, the treatment procedure, aftercare, possible side effects and success rate.
- The service had developed an easy read information leaflet regarding 'what to expect when you visit the clinic'. This included information about the premises, team members, assessment procedures, eye drops, diagnostic tests, treatments and what to bring with you.

Involvement in decisions about care and treatment

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

- The service gave patients clear information to help them make informed choices including details of the scope of services offered and information on fees.

Privacy and Dignity

The service respected patients' privacy and dignity.

- Staff recognised the importance of people's dignity and respect.
- Staff knew that if patients wanted to discuss sensitive issues or appeared distressed they could offer them a private room to discuss their needs.

Good

Are services responsive to people's needs?

We rated responsive as Good because:

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.

- Patients' individual needs and preferences were central to the planning and delivery of tailored services. Services were flexible, provided choice and ensured continuity of care, for example, late evening appointments were available for patients who were unable to attend the practice during normal working hours.
- The facilities and premises were appropriate for the services delivered. The premises was accessible for patients with mobility issues. The services were offered on three floors. There was a lift available in the premises.
- The service informed us they had acquired the lease of the adjacent building and construction work was commenced in January 2022 to refurbish both properties. Both buildings were going to be interconnected at the lower level. The service was planning to expand what it currently offered.
- The service made reasonable adjustments when patients found it hard to access services.
- The provider offered services for adults and children. The service ensured that all patients were seen face to face for their consultation.
- The service offered consultations to anyone who requested and paid the appropriate fee and did not discriminate against anyone.
- The service website was well designed, clear and simple to use featuring regularly updated information. The website included information regarding access to the service, consultation and treatment fees.
- There was a patients' leaflet which included arrangements for dealing with complaints, information regarding access to the service, consultation and treatment fees, terms and conditions, and cancellation policy.
- They provided services to patients with an ethos of providing individualised care and treatment, considering and respecting the wishes of its patients.

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.
- Patients with the most urgent needs had their care and treatment prioritised.
- Patients could access the service in a timely way by making their appointment over the telephone or in person.
- During this transition period whilst the building works were undergoing, the clinic was open three days per week, Monday to Wednesday. Consultations were available between 8.30am to 8pm Monday to Wednesday. At the time of the inspection, the service was providing reduced hours due to ongoing building renovations. The service was flexible to accommodate consultations for working patients who could not attend during normal opening hours.
- This service was not an emergency service. Patients who had a medical emergency were advised to ask for immediate medical help via 999 or if more appropriate to contact their own GP or NHS 111.

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.

Good

Are services responsive to people's needs?

- Information about how to make a complaint or raise concerns was available. Staff treated patients who made complaints compassionately.
- The service had a complaint policy and procedures in place. The policy contained appropriate timescales for dealing with the complaint. There was a designated responsible person to handle all complaints.
- 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 complaints policy included information of the complainant's right to escalate the complaint to the Independent Sector Complaints Adjudication Services (ISCAS).
- The service had received four complaints in the last 12 months. The service learned lessons from individual concerns, complaints and from analysis of trends. It acted as a result to improve the quality of care. For example, the service had reviewed the new staff induction process to ensure the correct pathway was followed going forward.
- We looked at two complaints received in the last 12 months and found that complaints had been addressed in a professional manner and patients received a timely response. There was evidence that the service had provided an apology when required. However, complaint responses did not always include information of the complainant's right to escalate the complaint if dissatisfied with the response.

Requires Improvement

Are services well-led?

We rated well-led as Requires improvement because:

- There was a lack of good governance in some areas.
- Leaders at all levels were visible and approachable. They worked closely with staff and others to make sure they prioritised compassionate and inclusive leadership.
- The provider had effective processes to develop leadership capacity and skills, including planning for the future leadership of the service.
- The London Claremont Clinic (LCC) was established in 2013 and acquired by Moorfields Eye Hospital NHS Foundation Trust in December 2020. Moorfields had elected to keep LCC as a separate commercial entity, which was a wholly owned subsidiary of Moorfields.
- The CQC registered manager was the senior consultant ophthalmologist, who was a lead consultant for Moorfields private and a board member. He was the LCC clinical lead and had been a founding member and director of LCC prior to Moorfield's acquisition.

Leadership capacity and capability;

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

- Leaders were knowledgeable about issues and priorities relating to the quality and future of services. They understood the challenges and were addressing them.

Vision and strategy

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

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

Culture

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

- Staff felt respected, supported and valued. They were proud to work for the service.
- The service focused on the needs of patients.
- Leaders and managers acted on behaviour and performance inconsistent with the vision and values.
- Openness, honesty and transparency were demonstrated when responding to incidents and complaints. For example, the service had implemented an appointment booking letters audit to ensure letters were sent by the consultants to the patients confirming the fees and time of the appointment. The provider wasaware 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.

Requires Improvement

Are services well-led?

- There were processes for providing all staff with the development they need. This included appraisal and career development conversations. All non-clinical staff and technicians received regular annual appraisals in the last year. Staff were supported to meet the requirements of professional revalidation where necessary. Clinical staff, including technicians, were considered valued members of the team. They were given protected time for professional development and evaluation of their clinical work.
- There was a strong emphasis on the safety and well-being of all staff.
- The service actively promoted equality and diversity. It identified and addressed the causes of any workforce inequality. Staff had received equality and diversity training. Staff felt they were treated equally.
- There were positive relationships between staff and teams.
- There were ineffective processes to identify a failure to maintain securely an accurate, complete and contemporaneous record in respect of each patient. This includes a record of the care and treatment provided to the patient and of decisions taken in relation to the care and treatment provided.
- Staff were clear on their roles and accountabilities.
- Leaders had established proper policies and procedures.

Governance arrangements

There was a lack of good governance in some areas and improvements were required.

- LCC governance was overseen by the LCC board, the chair of which was a non-executive director of Moorfields and its members included senior members of the Trust, including the director of Moorfields private care. There was a service level agreement between Moorfields and LCC that sets out how various departments and services of the Trust support LCC.
- LCC had appointed a new clinic manager recently, who was supported by the Moorfields private senior management, specifically the head of nursing, the head of operations and the head of finance. The full time clinic manager was responsible for the day-to-day operational management in the clinic and was the first point of reference for the staff at the clinic.
- There were ineffective systems or processes in place to ensure safe prescribing guidelines were followed. There was no medicine or prescribing audit to monitor the quality of prescribing.

Managing risks, issues and performance

There were some processes in place for managing risks, issues and performance. However, improvements were required.

- There were some arrangements for identifying, recording and managing risks, issues and implementing mitigating actions. However, monitoring of specific areas required improvement, such as the management of medical records.
- The service did not have reliable systems for appropriate and safe handling of medicines to ensure safe prescribing.
- We noted that the service was unable to monitor and review prescribing activity effectively. This did not enable them to understand risks and give a clear, accurate and current picture that led to safety improvements.
- There was insufficient quality monitoring of doctors' performance. Individual prescribing and diagnostic decisions of doctors' were not monitored or reviewed by the service to assure themselves that treatment was given appropriately. There was limited evidence of doctors' regular clinical supervision, mentorship or support. Most doctors had received an internal appraisal within the last 12 months. There was no peer review system in place. We noted that technicians' performance was monitored and reviewed.
- Service leaders had oversight of safety alerts, incidents, and complaints.
- The provider had a formal documented business continuity plan in place.
- The service submitted data or notifications to external organisations as required.

Requires Improvement

Are services well-led?

- There were robust arrangements in line with data security standards for the availability, integrity and confidentiality of patient identifiable data, records and data management systems.
- The service had plans in place and had trained staff for major incidents.

Appropriate and accurate information

The service acted on appropriate and accurate information. However, improvements were required.

- Quality and operational information was used to ensure and improve performance. Performance information was combined with the views of patients.
- Quality and sustainability were discussed in relevant meetings where all staff had sufficient access to information.
- Care and treatment records were securely kept but included limited information or were not accessible. The information needed to deliver safe care and treatment was not always available to the relevant staff in an accessible way in a timely manner.

Engagement with patients, the public, staff and external partners

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

- The service encouraged and heard views and concerns from the patients, staff and external partners and acted on them to shape services and culture. The service had carried out quarterly patients surveys since April 2021. This was highly positive about the quality of service patients received.
- Staff could describe to us the systems in place to give feedback. We saw evidence of feedback opportunities for staff and how the findings were fed back to staff. We also saw staff engagement in responding to these findings. The service had carried out a staff satisfaction survey in March 2021.
- The service had initiated an online networking tool to communicate quickly with staff members. This networking platform was used to share information, staffing matters and monitor the resources.

Continuous improvement and innovation

There were evidence of systems and processes for learning, continuous improvement and innovation. However, improvements were required.

- There was a focus on continuous learning and improvement. However, some improvements were required, such as, to undertake safeguarding children training relevant to the role.
- The service made use of internal and external reviews of incidents and complaints. Learning was shared and used to make improvements.
- Leaders and managers encouraged staff to take time out to review individual and team objectives, processes and performance.

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 Services in slimming clinics Surgical procedures Transport services, triage and medical advice provided remotely Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance **How the regulation was not being met:** The registered person did not have effective governance, assurance and auditing processes to enable 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 was a lack of good governance in some areas. • Information needed to deliver safe care and treatment was not always available to the relevant staff in a timely manner. • The service did not have reliable systems for appropriate and safe handling of medicines. • The service was unable to provide evidence that the consultations of all doctors were undertaken in line with relevant national UK guidelines or had a documented rationale for the treatment provided. • Prescribing was not audited or reviewed to identify areas for quality improvement. • There was insufficient quality monitoring of clinicians' performance. • Some doctors had not received level three safeguarding children training relevant to their role. This was in breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.