London Aesthetics and Regenerative Centre

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

As part of our inspection programme, we carried out an announced comprehensive inspection of London Aesthetics and Regenerative Centre, which trades as Revitalise London (the service), on 25 October 2023. It was the first inspection of the service which was registered by the Care Quality Commission (CQC) on 4 May 2022.

The service provides a range of procedures relating to dermatology, body, hair and facial treatments. It is registered by the CQC under the Health and Social Care Act 2008 in respect of some, but not all, of the procedures it provides. There are some exemptions from regulation by CQC which relate to particular types of activities and services, which are set out in Schedule 2 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The service provides various non-surgical cosmetic interventions which are not within CQC scope of registration. Therefore, we did not inspect nor report on those procedures.

The service did not currently have a registered manager, the previous one having left a few months prior to our inspection. An application process to replace them has commenced. A registered manager is a person who is registered by 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.

No patients were present on the day of our inspection, but we reviewed feedback they had given on a verified review website.

Our key findings were:

- There is limited assurance about safety. We were not shown evidence that all staff had received appropriate training covering their roles and responsibilities and safety aspects of the service, including for example lead roles in relation to safeguarding and infection prevention and control. There were issues relating to emergency drugs and equipment.
- People are at risk of not receiving effective care or treatment. People's outcomes were not always monitored regularly or robustly. The service did not undertake formal clinical auditing or peer reviews to monitor and improve care and treatment. We were not shown complete training records for all staff members to evidence they had the skills, knowledge and experience to carry out their roles.
- People are supported, treated with dignity and respect and are involved as partners in their care.
- People's needs are met through the way services are organised and delivered.

Overall summary

- The leadership, governance and culture do not always support the delivery of high-quality person-centred care. The arrangements for governance and performance management do not always operate effectively. There was limited oversight of governance arrangements and performance. Policy documents had not been sufficiently reviewed and amended to be appropriate and specific to the service; some contained discrepancies and errors. We could not establish if all risks were dealt with appropriately or in a timely way.

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

- It must ensure care and treatment is provided in a safe way to patients.
- It must 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).

Dr Sean O'Kelly BSc MB ChB MSc DCH FRCA

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

Our inspection team

Our inspection team was led by a CQC lead inspector and included a GP specialist advisor.

Background to London Aesthetics and Regenerative Centre

London Aesthetics and Regenerative Centre Ltd (the service), which trades under the name Revitalise London, operates a clinic at 96 Harley Street, London W1G 7HY, premises it shares with other businesses.

The service was registered by the Care Quality Commission (CQC) in May 2022 to provide the regulated activities Treatment of disease, disorder or injury, Surgical procedures and Services in slimming clinics.

It provides a range of procedures and treatments, some of which are outside the scope of CQC regulation. Those which do fall within scope include surgical removal of moles and warts, skin cancers checks and Gynecomastia (male breast tissue) treatment. Staff told us on average up to 20 patients were seen daily in relation to activities regulated by the CQC. Although it is registered to provide the regulated activity Services in slimming clinics, it does not currently prescribe slimming-related medicines. Full details of the procedures and treatments available can be found on the service website - www.revitaliselondon.co.uk The services are provided only to people aged over-18 years.

Consultation appointments can be booked online or by telephone. They are available all week, between 10:00 am and 8:00 pm Monday to Friday and from 10:00 am to 7:00 pm on Saturday and Sunday.

The service is operated by a team comprising the provider company's director, two contracted doctors, a service manager, four healthcare assistants, a patient co-ordinator and a call handler.

How we inspected this service

We reviewed evidence submitted by the provider and carried out a site visit, interviewing various members of staff. These included the service's company director, its lead doctor, the service manager (who was the service's nominated individual) and healthcare assistants. It is a requirement of regulation 6 of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014 that registered providers which are companies have a nominated individual who is responsible for supervising the management of the carrying on of regulated activities by the company.

We carried out a review of a random selection of patients' care records. We looked at a verified feedback and review website.

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:

There is limited assurance about safety.

We were not shown evidence of a recent infection prevention and control audit being conducted, nor that all staff had received appropriate training covering all safety aspects of the service. There was a risk that staff may not recognise or respond appropriately to signs of deteriorating health and medical emergencies. A risk assessment in relation to emergency drugs had not been conducted. Although the service had a small oxygen bottle, we were not assured it was suitable for use in a healthcare-related emergency. Some safety governance documentation required review, amendment and implementation.

SAFETY SYSTEMS AND PROCESSES

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

- The provider had governance policies relating to safeguarding adults and children, although children were not treated, but these had not been reviewed since August and September 2022, respectively. Nor had they been specifically amended and tailored to be appropriate for the service. The safeguarding lead mentioned was the service manager who had been trained only to level 2. We were told they would undertake level 3 training appropriate to their role as responsible lead. Elsewhere, the policies referred to the ex-registered manager. We were not provided with evidence of all staff members' training and could not confirm all were suitably trained in relation to safeguarding issues. However, those we interviewed demonstrated appropriate awareness of safeguarding issues and what action to take in the event of a safeguarding concern. Guidance on raising safeguarding alerts was available to staff.
- The service had a policy relating to chaperones and we saw posters informing patients they could request one at consultations. We were shown evidence confirming some of the Healthcare Assistants (HCAs) had undertaken chaperoning training and those we spoke with could describe their chaperoning duties. We saw evidence that when chaperones were used it was appropriately noted on patient records.
- The service told us it carried out checks, including Disclosure and Barring Service (DBS) checks, at the time of recruitment, and on an ongoing basis where appropriate. We were shown evidence to confirm this was done in respect of some, but not 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 people who may be vulnerable.
- The service had a governance policy relating to infection prevention and control (IPC), but it had not been suitably amended and tailored to relate specifically to the service. It had been reviewed August but referred to the ex-registered manager as being responsible for IPC matters. We were shown two "clinic audits", which covered a range of service aspects, including IPC, but action plans had not been drawn up and we could not identify who conducted them. We saw one of the HCAs had carried out an IPC audit of the service in March 2023. However, we could not establish if they were qualified to the appropriate level, or whether issues identified in the audit had been addressed. We asked for evidence of a more recent IPC audit, carried out by a suitably qualified person and confirming any outstanding issues had been remedied, but this was not provided. We were shown evidence that cleaning of general areas as carried out daily by the landlord's contractor. Clinical areas were cleaned by service staff after each consultation.
- The service had a governance policy relating to Legionella management. Legionella is a bacterium often found in building water systems, which can lead to serious lung infection. We saw that some, but not all, staff had been trained in legionella awareness, and were shown evidence that water temperatures were monitored and logged. The building landlord had facilities management responsibility and we asked the service to send us the current Legionella risk assessment record, but this was not received.

Requires Improvement

Are services safe?

- The service ensured medical instruments and equipment were safe and that the equipment was maintained according to manufacturers' instructions. Medical instruments were single-use and those we checked were within date. There were adequate supplies of personal protective equipment (PPE) and suitable processes for safely managing healthcare waste, including sharps.

RISKS TO PATIENTS

The service did not have fully effective systems to assess, monitor and manage risks to patient safety.

- The service had carried out some risk assessments of safety issues. We were shown two "audits" carried out in December 2022 and June 2023. These were not clinical audits but covered various safety and management aspects of the service. We could not establish whether actions identified during the audit processes had been addressed as the action plans were incomplete. The audit records did not state who the assessor was or whether they were qualified to perform the audit assessments.
- The service had a governance policy relating to Resuscitation and Medical Emergencies, together with one specifically covering Sepsis Awareness. However, staff told us they had not received Sepsis Awareness training. It had a written Emergency Procedure guidance document, and we were told that all staff had Basic Life Support training. We saw evidence to confirm this for some, but not all, staff. The service kept a limited range of recommended emergency drugs but had not carried out a risk assessment in relation to those it did not. It had a small commercially available oxygen bottle, but we were not assured it was suitable for use in healthcare emergencies. There was a shared defibrillator on the premises.
- The building landlord had arranged a fire risk assessment of the location, which was carried out by a qualified contractor in February 2022. Fire risk assessments should be conducted annually, and we asked for evidence of an up to date one. We were sent an assessment of the service clinic area carried out by one of the service's HCAs in April 2023. We did not see the HCA's training records and could not establish whether they were suitably qualified to assess the fire risk. We saw records confirming some, but not all staff, had received fire safety training.
- All but one of the healthcare assistants had been appointed over the past six months. They told us there was an effective induction process, during which they received training in a range of relevant subject areas. We were shown the training records of some staff, but not all. This indicated that appropriate training had been provided but the service did not provide us with complete training records for us to review.
- There were arrangements for planning and monitoring the number and mix of staff needed.
- When there were changes to services or staff the service assessed and monitored the impact on safety.
- There were appropriate indemnity arrangements in place.

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. This included seeking patients' permission to share information, where appropriate, with their NHS GPs.
- 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 systems for appropriate and safe handling of medicines.

Requires Improvement

Are services safe?

- The systems and arrangements for managing medicines and equipment minimised risks. The service kept prescription stationery securely and monitored its use.
- The service maintained a log of all prescribing as a monitoring exercise. We noted no concerning issues over prescribing practice, which was limited mostly to antibiotics, emollients and the like. No controlled drugs were prescribed.
- 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. Where there was a different approach taken from national guidance there was a clear rationale for this that protected patient safety. Although the service is registered to provide the regulated activity Services in slimming clinics, it did not currently prescribe slimming-related medicines.
- There were effective protocols for verifying the identity of patients.

LESSONS LEARNED AND IMPROVEMENTS MADE

The service learned and made improvements when things went wrong.

- The service had a process for recording and acting on significant events. It had a governance policy relating to significant event, which had last been reviewed in August 2023. Staff understood their duty to raise concerns and report incidents and near misses and they were supported to do so. However, there had been no significant events relating to clinical issues since the service began operating. The doctors also worked in NHS practice and were able to raise relevant external safety events for review.
- There were adequate systems for reviewing and investigating when things went wrong. The service learned, shared lessons and took action to improve safety. We saw examples which included a review of procedure and aftercare relating to mole removal, and a review of consultation notes to ensure their legibility.
- The service and staff were aware of and complied with the requirements of the Duty of Candour. There was a governance policy in relation to the Duty of Candour, last revised in July 2023. We noted it referred to the ex-registered manager. The service encouraged a culture of openness and honesty. The service had systems in place for knowing about notifiable safety incidents.
- The service had a system and governance policy guidelines for the actioning of safety alerts, such as those issued by the Medicines and Healthcare products Regulatory Agency (MHRA). However, staff told us there had been no alerts relating to the type of services provided.

Requires Improvement

Are services effective?

We rated Effective as Requires improvement because:

People are at risk of not receiving effective care or treatment.

People's outcomes were not always monitored regularly or robustly. The service did not undertake formal clinical auditing or peer reviews to monitor and improve care and treatment. We were not shown complete training records for all staff members to evidence they had the skills, knowledge and experience to carry out their roles. Some related governance documentation required review, amendment and implementation.

EFFECTIVE NEEDS ASSESSMENT, CARE AND TREATMENT

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

- Staff told us the service 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, receiving updates as part of their NHS work. However, the service's governance documents we saw only referred to NICE guidance on infection prevention and control.
- The service had arrangements with a local laboratory for carrying out necessary tests.
- We reviewed a random sample of 15 sets of patients' medical records and identified no concerning issues. Patients health histories were recorded, appropriate referrals were made, for example for biopsies, and test results were reviewed and actioned daily. Clinicians had enough information to make or confirm a diagnosis.
- Patients' immediate and ongoing needs were assessed. Where appropriate this included their clinical needs and their mental and physical wellbeing.
- We saw no evidence of discrimination when making care and treatment decisions.
- Arrangements were in place to deal with repeat patients.
- Staff assessed and managed patients' pain, where appropriate, using standard assessment tools.

MONITORING CARE AND TREATMENT

The service was involved in limited quality improvement activity.

- The service carried out some limited quality improvement activity. For example, we were shown two "audits" which looked at various aspects of service delivery, such as health and safety and infection prevention and control. However, the effectiveness of these was questionable as we could not establish if they had been conducted by a person with appropriate qualifications or whether suitable action plans had been drawn up and completed.
- The service did not currently undertake formal clinical auditing to monitor and improve the quality of care and treatment provided. We discussed introducing a process and staff told us this would be instigated.
- We asked about arrangements for peer reviewing treatment and advice given to patients. This was not currently practiced, as only two doctors were employed, with one working only a few sessions per month, but staff told us it would be implemented as the service expanded, which was planned.

EFFECTIVE STAFFING

We could not fully assess whether staff had the skills, knowledge and experience to carry out their roles.

- The service told us there were mandatory training requirements, but we were not provided with evidence of training for all staff.

Requires Improvement

Are services effective?

- The provider had a two-week induction programme for all newly appointed staff, who were subject to six months' probation.
- The two contracted doctors were registered with the General Medical Council (GMC) and were up to date with revalidation. Both also held positions in the NHS. The lead doctor was on the GMC's Plastic Surgery Specialist Register.
- Staff told us the service understood the learning needs of staff and provided protected time and training to meet them. Staff were encouraged and given opportunities to develop.
- There was a sufficient number of staff available to meet current service demands. Recruitment was planned as the service intended expanding. The lead doctor worked up to five days a week in the service.

COORDINATING PATIENT CARE AND INFORMATION SHARING

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

- Patients received coordinated and person-centred care. Staff referred to, and communicated effectively with, other services when appropriate.
- Before providing treatment, doctors ensured they had adequate knowledge of the patient's health, any relevant test results and their medicines history. We saw an example of patients being signposted to more suitable sources of treatment where this information was not available to ensure safe care and treatment.
- All patients were asked for consent to share details of their consultation and any medicines prescribed with their registered GP on each occasion they used the service. Where patients agreed to share their information, this was done in line with GMC guidance. This included when patients moved to other professional services such as for laboratory tests, and the information needed to plan and deliver care and treatment was available to relevant staff in a timely and accessible way. There were clear and effective arrangements for following up on people who had been referred to other services.

SUPPORTING PATIENTS TO LIVE HEALTHIER LIVES

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

- Staff gave patients advice on well-being and, where appropriate, advice so they could self-care.
- Risk factors were identified, highlighted to patients and where appropriate highlighted to their GP for additional support.
- Where patients needs could not be met by the service, staff redirected them to the appropriate service for their needs.

CONSENT TO CARE AND TREATMENT

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

- Staff understood the requirements of legislation and guidance when considering consent and decision making and kept appropriate records relating to patients' consent.
- 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:

People are supported, treated with dignity and respect, and are involved as partners in their care.

KINDNESS, RESPECT AND COMPASSION

Staff treated patients with kindness, respect and compassion.

- The service sought feedback on the quality of clinical care patients received. The process involved patients completing a paper questionnaire following their consultation. We reviewed a random sample of ten questionnaires, which were positive regarding caring aspects of the service.
- We reviewed a verified feedback website, which included comments from 165 patients. The service was rated excellent, being awarded 4.8 out of 5 overall.
- Staff understood patients' personal, cultural, social and religious needs. They displayed an understanding and non-judgmental attitude to all patients.
- The service gave patients timely support and information.

INVOLVEMENT IN DECISIONS ABOUT CARE AND TREATMENT

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

- The service employed various multi-lingual staff who could support patients for whom English is an additional language to help them be involved in decisions about their care. An induction loop was available for patients with hearing impairment.
- Patients' comments we reviewed confirmed they felt listened to and supported by staff and had sufficient time during consultations to make an informed decision about the choice of treatment available to them.
- Guidance on consent and patients' mental capacity was set out in the service's safeguarding governance policies.

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:

People's needs are met through the way services are organised and delivered.

RESPONDING TO AND MEETING PEOPLE'S NEEDS

Services were organised and delivered to meet patients' needs and preferences.

- The facilities and premises were appropriate for the services delivered. The service used one consultation room to deliver the regulated activities the CQC regulates. There were two other rooms used for the unregulated services.
- Staff told us on average up to 20 patients were seen daily in relation to activities regulated by the CQC.
- There was a sufficient number of staff available to meet current service demands.
- The provider understood the needs of their patients and improved services in response to those needs. We saw it reviewed feedback provided by patients and had drawn up an improvement action plan.

TIMELY ACCESS TO THE SERVICE

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

- The practice operated between 10:00 am and 8:00 pm Monday to Friday and from 10:00 am to 7:00 pm on Saturday and Sunday.
- Consultation appointments could be booked online or by telephone.
- Patients had timely access to initial assessment, test results, diagnosis and treatment.
- Waiting times, delays and cancellations were minimal and managed appropriately.
- Patients reported that the appointment booking system was easy to use.

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 a governance policy regarding the complaints process, with a named staff member responsible for managing them.
- We saw information about how to make a complaint or raise concerns was available on the service website under a page headed "privacy policy". We discussed with staff making the complaints process guidance more accessible, as well as other changes to the service website.
- Staff treated patients who made complaints compassionately.
- The service informed patients of any further action that may be available to them should they not be satisfied with the response to their complaint.
- The service learned lessons from individual concerns, complaints and from analysis of trends. We reviewed the 14 complaints recorded by the service, noting most related to pricing issues.

Requires Improvement

Are services well-led?

We rated Well-led as Requires improvement because:

The leadership, governance and culture do not always support the delivery of high-quality person-centred care.

The arrangements for governance and performance management do not always operate effectively. There was limited oversight of governance arrangements and performance. Policy documents had not been sufficiently reviewed and amended to be appropriate and specific to the service; some contained discrepancies and errors. We could not establish if all risks were dealt with appropriately or in a timely way.

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.
- 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 service had effective processes to develop leadership capacity and skills.
- The service currently did not have a registered manager, the last one having left a few months previously. However, an application process to appoint a new one had been initiated.

VISION AND STRATEGY

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

- There was a vision and set of values. The service had a realistic strategy and supporting business plans to achieve priorities.
- Staff were aware of and understood the vision, values and strategy and their role in achieving them.
- The service monitored progress against delivery of the strategy.

CULTURE

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

- Staff felt respected, supported and valued. They were proud to work for the service.
- The service focused on the needs of patients.
- Leaders and managers acted on behaviour and performance inconsistent with the vision and values.
- Openness, honesty and transparency were demonstrated when responding to incidents and complaints. The servicer 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.
- Staff told us there were processes for providing all staff with the development they need. This included appraisal and career development conversations. There were arrangements in place for all staff to receive appraisals, but most had been recently appointed and their appraisals were not yet due. Staff were supported to meet the requirements of professional revalidation where necessary.

Requires Improvement

Are services well-led?

- The service actively promoted equality and diversity. It identified and addressed the causes of any workforce inequality. We were told equality and diversity training for staff was mandatory and the records we saw supported this, but not all were available. Staff felt they were treated equally.

GOVERNANCE ARRANGEMENTS

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

- The service had a range of governance policies relating to various aspects of care and the business. These were commercially available generic documents, which we noted had not been fully or consistently adapted to be relevant to the service. Some had not been reviewed in the last 12 months, others contained inaccuracies, for example referring to ex-members of staff as having lead responsibilities. As we were not provided with training records for all staff, we could not establish if those with current lead responsibilities were suitably qualified for the roles.
- We discussed with staff some issues relating to the service's website. For example, we noted the majority of complaints received by the service related to pricing, details of which could be made clearer. The website had no biographies of staff to allow patients an element of choice. The complaints procedure was present but not immediately accessible and there was no information regarding the company. Some pages appeared to be generic, for example the one headed "Privacy policy", which had not been adapted to be relevant to the service.

MANAGING RISKS, ISSUES AND PERFORMANCE

There was little clarity around processes for managing risks, issues and performance.

- There were some processes to identify, understand, monitor and address current and future risks including risks to patient safety, but these were not always effective. Various risk assessments had been undertaken, but we could not establish if the assessors were suitably experience and qualified, nor if actions identified to mitigate risks had been implemented.
- Clinical audits and peer reviews were not carried out, although the service told us these would be introduced.
- The service had a viable business continuity plan in place.

APPROPRIATE AND ACCURATE INFORMATION

The service acted on appropriate and accurate information.

- Some use was made of quality and operational information, including patient feedback and reviews, to ensure and improve performance.
- Quality and sustainability were discussed in relevant meetings where all staff had sufficient access to information.
- The service used performance information, which was reported and monitored, and management and staff were held to account.
- The information used to monitor performance and the delivery of quality care was accurate and useful.
- There were arrangements in line with data security standards for the availability, integrity and confidentiality of patient identifiable data, records and data management systems.

ENGAGEMENT WITH PATIENTS, THE PUBLIC, STAFF AND EXTERNAL PARTNERS

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

Requires Improvement

Are services well-led?

- The service encouraged and heard views and concerns from patients and staff and acted on them to shape services and culture.

CONTINUOUS IMPROVEMENT AND INNOVATION

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

- There was a focus on continuous learning and improvement.
- 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
Treatment of disease, disorder or injury Services in slimming clinics Surgical procedures	Regulation 17 HSCA (RA) Regulations 2014 Good governance Systems and processes must be established and operated effectively to ensure good governance in accordance with the fundamental standards of care. **How the regulation was not being met:** • The arrangements for governance and performance management do not always operate effectively. There was limited oversight of governance arrangements and performance. • People's outcomes were not always monitored regularly or robustly. The service did not undertake formal clinical auditing or peer review to monitor and improve care and treatment. • We were not shown complete training records in respect of all staff members to evidence they had the skills, knowledge and experience to carry out their roles. • We could not establish if all risks were dealt with appropriately or in a timely way. • Governance policy documents had not been sufficiently reviewed and amended to be appropriate and specific to the service. Some contained discrepancies and errors. **This was in beach of Regulation 17 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.**

Regulated activity	Regulation
Treatment of disease, disorder or injury Services in slimming clinics Surgical procedures	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment Care and treatment must be provided in a safe way for all service users.

This section is primarily information for the provider

Requirement notices

How the regulation was not being met:

- We were not shown evidence of a recent infection prevention and control audit being conducted, nor that all staff had received appropriate training covering all safety aspects of the service.
- There is a risk that staff may not recognise or respond appropriately to signs of deteriorating health and medical emergencies. A risk assessment in relation to emergency drugs had not been conducted. Although the service had a small oxygen bottle, we were not assured it was suitable for use in a healthcare-related emergency.
- Governance policy documents had not been sufficiently reviewed and amended to be appropriate and specific to the service. Some contained discrepancies and errors

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