London Dermatology Centre

Inspection report

69 Wimpole Street
London
W1G 8AS
Tel:
www.the-dermatology-centre.co.uk

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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	Inadequate
Are services safe?	Inadequate
Are services effective?	Requires Improvement
Are services caring?	Good
Are services responsive to people's needs?	Good
Are services well-led?	Inadequate

Overall summary

This service is rated as Inadequate overall.

The key questions are rated as:

Are services safe? – Inadequate

Are services effective? – Requires improvement

Are services caring? – Good

Are services responsive? – Good

Are services well-led? – Inadequate

We carried out an announced comprehensive inspection of London Dermatology Centre on 30 June 2022. This was the first CQC inspection of this location under the current CQC inspection methodology, although the service had been inspected under CQCs previous methodology in October 2013 at which time it was compliant with CQC regulations.

The registered manager is the service manager at the location. 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:

- The service did not have systems in place to ensure that risk factors had been adequately analysed and mitigated.
- Some staff that we spoke to at the service were not aware of safety protocols, and were not aware of their requirements regarding safeguarding.
- The service did not have all emergency medicines and equipment required for a service of its type.
- Patients received effective care and treatment that met their needs.
- The services clinical record system did not have an easy to use audit facility, and the service had not completed audits on specific treatments. Clinical oversight of clinicians at the service was unclear. The clinical record system could not flag specific relevant details, such as any patients on the safeguarding register, and patient records were in some cases noted to be incomplete or unclear.
- Staff training was incomplete, and the service did not have sufficient mechanisms in place to assure that the training of any staff was monitored.
- Parent identification was not sought when children were treated, so the service could not be assured that consent could be provided.
- Staff dealt with patients with kindness and respect and involved them in decisions about their care.
- The service organised and delivered services to meet patients' needs. Patients could access care and treatment in a timely way.
- Governance and risk assessment protocols at the service were not well developed.

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

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

Overall summary

- Ensure systems and processes are established and operated effectively to ensure compliance with the requirements of good governance.
- Ensure systems and processes are established and operated effectively to ensure compliance with the requirements of good staffing.

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

- Improve the way complaints are being adequately captured and managed.

I am placing this service in special measures. Services placed in special measures will be inspected again within six months. If insufficient improvements have been made such that there remains a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating the service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve.

The service will be kept under review and if needed could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement we will move to close the service by adopting our proposal to remove this location or cancel the provider's registration.

Special measures will give people who use the service the reassurance that the care they get should improve.

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**.** The team also included a GP specialist advisor.

Background to London Dermatology Centre

London Dermatology Centre is an independent provider of medical services. The service provides a range of dermatological, aesthetic and sexual health services which are within the scope of CQC regulation. It also provides a number of aesthetic procedures that are not regulated by the Care Quality Commission (CQC). This report references only those services that are regulated by CQC.

London Dermatology Centre is based at 69 Wimpole Street, London, W1G 8AS, in the London borough of Westminster. The service is for private fee-paying patients only, the service does not see NHS patients.

The provider is registered with the CQC to deliver the regulated activities of surgical procedures and treatment of disease, disorder or injury.

The provider primarily provides services to patients within the borough of Westminster, and other areas of London. However, the service also sees patients from other areas of the United Kingdom and from other countries. The service is self-contained within a single premises, with all patients checking in at reception. The service has a three consulting rooms and a treatment room.

The service operates on Monday to Friday from 9:30pm until 5:30pm. Administrative staff also take calls from patients from 10am until 1pm on Saturdays. The service does not formally provide a service outside of these hours. Regulated clinical activities at the site are carried out primarily by two consultant dermatologists and a consultant in genitourinary health. Four other clinicians work at the practice under practising privileges. The service employs a service manager and a team of five reception and other administrative staff who oversee appointments and administration for all service users and patients.

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.

Inadequate

Are services safe?

We rated the service as inadequate for providing safe services because.

The service had not completed risk assessments for the location since 2008. These were out of date and had not been reviewed in this time.

- The service had not completed an infection control audit since 2005.
- Non-clinical staff were not aware of safeguarding protocols, who the safeguarding lead was, or where emergency equipment was located.
- There was no effective procedure to monitor prescription usage so that in the event of a blank prescription going missing no-one would be able to track usage..
- Fire procedures at the service were not adequate.
- The service did not have sufficient emergency medicines in place.
- Chaperones at the service had not been trained, which was a requirement of its own chaperoning policy.
- The service did not have systems in place to assure that an adult accompanying a child had parental authority.
- Clinical notes were not sufficient to ensure safe patient care..
- Letters to patients GPs did not always contain sufficient detail.
- Copies of all prescriptions were recorded, but could not easily be searched.

Safety systems and processes

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

- Staff were not regularly provided with either the information or training that they required to undertake their role. When we spoke to non-clinical staff at the service, they were neither able to define what safeguarding was, nor what they needed to do where concerns were indicated.
- The service did not have systems in place to assure that an adult accompanying a child had parental authority.
- The service had a policy which specified which agencies support patients and protect them from neglect and abuse.
- The provider carried out staff checks at the time of recruitment and on an ongoing basis where appropriate. Disclosure and Barring Service (DBS) checks were undertaken where required. (DBS checks identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable).
- The service had policies to safeguard children and vulnerable adults from abuse, but non-clinical staff had not been trained in safeguarding. The service did not have a mechanism for checking what training doctors had received, and on the day of the inspection, no up-to-date safeguarding training records could be provided.
- Staff who acted as chaperones had received a DBS check, but were not trained in undertaking this role. The service's chaperoning policy specified that all chaperones must be trained.
- The service did not have clear systems to ensure that infection protection and control measures were in place. The service appeared clean, but the service was not able to provide details of infection training that staff had completed either on appointment or an ongoing basis. The last infection control audit had taken place in 2005. There was neither a risk assessment for having not completed an audit on an annual basis, nor a schedule detailing when this should be completed.
- The provider ensured that facilities and equipment were safe, and that equipment was maintained according to manufacturers' instructions. There were systems for safely managing healthcare waste.

Risks to patients

There were not systems to assess, monitor and manage risks to patient safety.

Inadequate

Are services safe?

- There were arrangements for planning and monitoring the number and mix of staff needed.
- The service did not have a clear induction system for employed staff. We spoke to a member of staff who had started at the clinic one year ago, and they had not been provided with role specific training.
- There was no fire marshal in place at the service, and the service did not have an overview of the fire procedures implemented by the building owner..
- Staff understood their responsibilities to manage emergencies and to recognise those in need of urgent medical attention. However, one of the members of staff to whom we spoke did not know where emergency equipment was stored.
- The service did not have suitable medicines and equipment to deal with medical emergencies. The only emergency medicines available were two EpiPens. The service did not have access to a medication for the treatment of anaphylaxis, a medication for the treatment of allergies, hydrocortisone (for a variety of conditions) or a medicine for the treatment of bacterial infections. The service had not risk assessed the absence of these medicines.
- Copies of all prescriptions were recorded, but could not easily be searched, specifically batch numbers which might come up in an MHRA alert. This was particularly relevant as the service also had a dispensary on site. It was not possible to determine what had been prescribed and when without reviewing every single record.
- The service was not able to demonstrate that it assessed and monitored the impact on safety when there were changes to services or staff.
- There were appropriate indemnity arrangements in place.

Information to deliver safe care and treatment

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

- The notes that were scanned and uploaded to the database were sometimes handwritten only, and in two cases reviewed were not clearly legible. It would therefore have been very difficult for another clinician to take over care of the care of the patients should this be needed.
- Where the service had written to the GP of the patient, in one case we saw a letter that did not detail medications prescribed by the service to the patient. This could lead to the GP potentially prescribing something contraindicated.
- 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 systems and arrangements for managing medicines, including vaccines, controlled drugs, emergency medicines and equipment minimised risks.
- The service did not have systems to adequately monitor prescribing. The prescription pad at the service was not serialised, so in the event of a lost or stolen pad, it would be impossible to determine exactly what had been taken.
- Staff prescribed, administered or supplied medicines to patients and gave advice on medicines in line with legal requirements and current national guidance.

Track record on safety and incidents

The service did not have a good safety record.

- The provider had not safety risk assessments, with the last premises risk assessment having been conducted in 2008. Safety policies were in place at the service, but review dates were not set, and the service did not adhere to its own policies.
- The service could not demonstrate that it had monitored and reviewed activity.

Inadequate

Are services safe?

Lessons learned and improvements made

- There was a system for recording and acting on significant events. Staff told us that they understood their duty to raise concerns and report incidents and near missed, although the service told us that there had not been any incidents in the last two years.
- 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 including sessional and agency staff.

Requires Improvement

Are services effective?

We rated the service as requires improvement for providing effective services because:

- The service had not completed any audits of specific conditions or prescribing.
- The service had limited clinical oversight of the other clinicians who worked at the service.
- There was no list of mandatory training for staff at the service. None of the employed staff at the service had been appraised.

Effective needs assessment, care and treatment

The provider had systems to keep clinicians up to date with current evidence-based practice. We saw evidence that clinicians assessed needs and delivered care and treatment in line with current legislation, standards and guidance (relevant to their service)

- Patients' immediate and ongoing needs were fully assessed. Where appropriate this included their clinical needs and their mental and physical wellbeing.
- Clinicians had enough information to make or confirm a diagnosis
- We saw no evidence of discrimination when making care and treatment decisions.

Monitoring care and treatment

The service was not actively involved in quality improvement activity.

- The service had undertaken random audits of 10 clinical notes every six months for the past two years.
- The service had not completed any audits of specific conditions or prescribing. Specific searches could not be requested on the database used by the service. On this basis, it would be impossible to review either those patients with similar clinical treatments or those patients who had similar treatments without reviewing each individual record.
- The service had limited clinical oversight of the other clinicians (four dermatologists and a consultant in sexual health) who worked at the service. As only one consultant in sexual health worked at the service, internal peer review was not possible. The service did not have systems to assure itself of the quality of work of these clinicians.

Effective staffing

Staff did not have the skills, knowledge and experience to carry out their roles.

- All clinical staff at the service were appropriately qualified.
- The provider told us that they had an induction programme for all newly appointed staff, but staff were not provided with training relevant to their role at appointment.
- There was no list of training and development for staff at the service. One member of the non-clinical staff had received safeguarding and basic life support training, but more than four years ago. A new starter from one year ago told us that they had received on the job training only, When interviewed the member of staff was unaware of safeguarding requirements at the service. The two members of non-clinical staff that we spoke to had at no stage received infection control, fire safety or information governance training, and one of them had been at the service for more than five years. The service did not have oversight of clinical staff's training and updates to assure themselves that they were able to undertake their roles.
- Relevant professionals (medical and nursing) were registered with the General Medical Council (GMC) and were up to date with their own appraisal and revalidation requirements.
- Staff whose role included immunisation and reviews of patients with long term conditions had received specific training and could demonstrate how they stayed up to date.

Requires Improvement

Are services effective?

Coordinating patient care and information sharing

Staff worked together, and mostly 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 in most cases. However, we saw one incidence of a clinician not including details of a prescription in a letter to a patient's GP. The GP would therefore not have been aware of potential contraindications.
- Before providing treatment, doctors at the service ensured they had adequate knowledge of the patient's health, any relevant test results and their medicines history.
- 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.
- The provider told us that they had risk assessed the treatments they offered, but were not able to demonstrate documentation of this.
- Patient information was shared appropriately (this included when patients moved to other professional services), and the information needed to plan and deliver care and treatment was available to relevant staff in a timely and accessible way.
- The service monitored the process for seeking consent appropriately.

Supporting 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 people advice so they could self-care.
- 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 did not obtain 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.

- The service sought feedback on the quality of clinical care patients received. However, the questionnaires had not been reported on since 2015.
- 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.

- Staff communicated with people in a way that they could understand, for example, communication aids and easy read materials were available.

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.
- Patients medical records were securely stored electronically.

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.

- The facilities and premises were appropriate for the services delivered.
- The waiting area was large enough to accommodate the number of patients who attended on the day of the inspection.
- The website for the service was very clear and easy to understand. In addition, it contained clear information about the procedures offered.

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 consultation and treatment. Patients were told to use out of hours NHS services if the service was closed.
- Waiting times, delays and cancellations were minimal and managed appropriately.
- Patients reported that the appointment system was easy to use.
- Referrals and transfers to other services were undertaken in a timely way.

Listening and learning from concerns and complaints

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

- Information about how to make a complaint or raise concerns was available. 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 had complaint policy and procedures in place, although this was not clearly advertised in either the waiting room or on the service's website. The number of complaints that the service had received had been steady at three or four per year from opening until 2018, although since then only two had been received.

Inadequate

Are services well-led?

We rated the service as inadequate for providing well led services because.

- Clinical and operational governance procedures at the service were not well established. Procedures to ensure that safe and effective care could be monitored and demonstrated were not in place.
- Leaders at the service did not have oversight of the lack of clear and effective governance procedures. We saw that leaders believed that various systems were in place, where in fact they were not.
- The clinical database at the service did not support risk management and clinical governance. Medical records were unclear, and the database did not support the provision of quality improvement activity.
- The service had minimal risk management procedures in place.

Leadership capacity and capability;

Leaders did not have the capacity and skills to deliver high-quality, sustainable care.

- Leaders were unaware of the conversant with the regulatory requirements for the service, and were not always aware of the deficiencies of systems. For example, a senior member of the team indicated that they believed that medication and treatment searched could be completed on the database, when this in fact was not possible,
- Leaders at all levels were visible and approachable. Staff told us that they felt respected.
- The provider did not have effective processes to develop leadership capacity and skills. Training and development was not proactively managed at the service, and key members of staff were not aware of their roles and responsibilities.

Vision and strategy

The service did not have a clear vision and credible strategy to deliver high quality care and promote good outcomes for patients.

- The service appeared to be providing good clinical care to patients on an individual clinician basis , but the organisation had no process to assure themselves that clinicians were providing satisfactory care and there was no review process and and no clear strategy as to how this might be improved in the future.
- Staff were not aware of the vision, values and strategy of the organisation, or their specific role in achieving them

Culture

The service did not have 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.
- Openness, honesty and transparency were demonstrated when responding to incidents and complaints. The provider was aware of and had systems to ensure compliance with the requirements of the duty of candour.
- Staff told us they could raise concerns and were encouraged to do so. They had confidence that these would be addressed.
- There were limited processes for providing all staff with the development they need. Staff had not been appraised and there was neither a list of required training at the service, or monitoring in place.
- There was an 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.

Governance arrangements

Inadequate

Are services well-led?

There was no clear responsibilities, roles and systems of accountability to support good governance and management.

- Structures, processes and systems to support good governance and management were not developed at the service. There were very limited functions in place to monitor whether safe and effective care were being provided.
- The alternative to a clinical database used by the service did not allow for clear record keeping, or auditing of the clinical database either for relevant information, or for demonstrating quality improvement.
- Staff were clear on their roles and accountabilities.
- Leaders had established policies, procedures and activities to ensure safety. However, these policies were not being consistently followed, and the policies were not ensuring safe and effective care.
- The service did not have procedures in place to monitor performance information which could ensure that management and staff were held to account.
- The was limited information to monitor performance and the delivery of quality care.
- The service submitted data or notifications to external organisations as required.

Managing risks, issues and performance

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

- There were limited processes in place to identify, understand, monitor and address current and future risks including risks to patient safety. Risk assessments had not been completed in some cases for up to 17 years, and the service was not able to identify key risks to providing safe and effective care.
- The service had limited processes to manage current and future performance. Performance of clinical staff could not be demonstrated through audit of the overall body of their work, although six monthly notes audits of 10 records were being carried out. There had been low numbers of incidents, and complaints in the past four years, and the organisation's governance procedures could not provide assurance that anything had been missed. There were limited meetings and other processes in place to monitor this. We were told that oversight for this was through an operational governance meeting, but in the last 18 months only three such meetings had taken place.

Appropriate and accurate information

The service did not have appropriate and accurate information.

- Quality and operational information was not readily available.

Engagement with patients, the public, staff and external partners

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

- The service encouraged and heard views and concerns from the public, patients, staff and external partners.

Continuous improvement and innovation

There was no evidence of systems and processes for learning, continuous improvement and innovation.

- The service was not able to provide evidence of processes for continuing development of the service.

This section is primarily information for the provider

Enforcement actions

Action we have told the provider to take

The table below shows the legal requirements that were not being met.

Regulated activity	Regulation
Surgical procedures Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing How the regulation was being breached: (1) Effective staffing – None of the non-clinical staff at the service had been appraised in the last year, nor was there reasonable and considered mitigation provided. Appraisals are required to ensure that staff remain fit for the role, and to ensure that training and development may be provided as required. (2) Effective staffing – There was no list of required training, or frequency for refreshing particular training for staff at the service. Some non-clinical staff had received safeguarding and basic life support training, but more than four years ago. The two members of non-clinical staff that we spoke to had at no stage received infection control, fire safety or information governance training, and one of them had been at the service for more than five years. Clinical staff were asked by the provider to provide details of training undertaken in the NHS, but this had not been followed up, and records were not in place. The only non-clinical member of staff who undertook chaperoning had not been trained in this. When interviewed staff did not have understanding of those areas in which they had not received training. An understanding of safeguarding, infection control, fire safety, basic life support and information governance is required from all patient facing staff at the service. This was in breach of regulation 18(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Regulated activity	Regulation
Treatment of disease, disorder or injury Surgical procedures	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment How the regulation was being breached:

This section is primarily information for the provider

Enforcement actions

(1) Safe systems and processes – The service had not completed risk assessments for the location since 2008. These were out of date and had not been reviewed in this time. Health and safety and policies relating to the premises were therefore outdated and not fit for purpose. Up to date risk assessments are required to assure the provider that they have considered and mitigated all risks relevant to the service.

(2) Safe systems and processes – Non-clinical staff were not aware of safeguarding protocols, who the safeguarding lead was, or where emergency equipment was located. All staff in patient facing roles must be aware of safeguarding protocols, and where emergency equipment is stored.

(3) Safe systems and processes – The prescription pad was not serialised, so in the event of a lost or stolen pad, it would be impossible to determine exactly what had been taken.

(4) Risks to patients – There was no fire marshal in place at the service. This is a requirement in the event of an evacuation of the building. The building managers had tested systems and had conducted mock evacuations.

(5) Risks to patients - The only emergency medicines available at the service were EpiPens. A service of this kind must have a medication for the treatment of anaphylaxis, a medication for the treatment of allergies of allergies, hydrocortisone (for a variety of conditions), benzylpenicillin for bacterial infections. None were in place. The absence of other medicines such as salbutamol and GTN had not been risk assessed.

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

Regulated activity	Regulation
Treatment of disease, disorder or injury Surgical procedures	Regulation 17 HSCA (RA) Regulations 2014 Good governance How the regulation was being breached:

This section is primarily information for the provider

Enforcement actions

(1) Governance – The service did not have an electronic clinical record system in place, although all consultations were scanned and stored online. They had not risk assessed the shortcomings of this system, which are detailed in points 2-6 below.

(2) Governance - The service had not completed any medicines audits. Specific medicines could not be searched for on the alternative to a database that they had in place meant that medicines audits would be difficult to complete, and therefore the service could not show that the care that it was providing was of an adequate standard.

(3) Governance - Prescribing could not easily be searched. Copies of all prescriptions were recorded, but could not be searched for electronically, specifically batch numbers which might come up in an MHRA alert. This was particularly relevant as the service also had a dispensary on site. It was not possible to determine what had been prescribed and when without reviewing every single record. Such audits are needed in the event of medicines alert.

(4) Governance - The clinical notes that were scanned and uploaded were sometimes handwritten only, and in two cases reviewed were not clearly legible. It would therefore have been very difficult for another clinician to take over care of the care of the patients.

(5) Governance - Where the service had written to the GP of the patient, in one case we saw a letter that did not detail details of medications prescribed by the service to the patient. This could lead to the GP potentially prescribing something contraindicated to that medication.

(6) Governance - The service had no mechanism for flagging patient alerts on their files, for example if there were safeguarding concerns. This meant that clinicians treating the patient may be unaware of known safeguarding concerns.

(7) Consent to care and treatment and governance – The service did not ask for identification from parents attending with children to ensure that they had parental authority to consent to treatments.

(8) Governance – The service had limited clinical oversight of the other clinicians (four dermatologists and a consultant in sexual health) who worked at the service.

This section is primarily information for the provider

Enforcement actions

There was no-one at the service who was qualified to audit the work of the sexual health consultant. This meant that the service could not be assured of the quality of work of these clinicians.

(9) Governance and safe systems and processes – Infection control. The service had not completed an infection control audit since 2005. Although the service was evidently clean, and cleaning protocols were in place, the service had not audited the efficacy of its infection control procedures, so could not be satisfied that they were fit for purpose. The organisation had put Covid procedures in place, and although they appeared fit for purpose, it was unclear how the provider had come to this determination, and they had not been tested.

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