London Transgender Clinic Limited

The London Transgender Clinic

Inspection report

54 Wimpole Street
London
W1G 8YJ
Tel: 02074870910
www.thelondontransgenderclinic.uk

Date of inspection visit: 09 December 2021
Date of publication: 30/12/2021

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	Inspected but not rated
Are services well-led?	Insufficient evidence to rate

Summary of findings

Overall summary

The provider had made the required improvements related to staff mandatory training and the incident management process.

Leaders operated effective governance processes throughout the service and with partner organisations. Staff at all levels were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service.

Leaders had made arrangements for the provision of mandatory training in key skills to all staff and made sure everyone completed this training. They had set up suitable systems to have oversight of staff training.

Leaders had established effective systems to capture incidents. Staff used the internal systems to identify and escalate relevant risks and issues, and identified actions to reduce their impact.

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Outpatients	Insufficient evidence to rate	

Summary of findings

Contents

Summary of this inspection

Background to The London Transgender Clinic

The London Transgender Clinic provides a consultation service to transgender and non-binary individuals, offering guidance and support related to primary care; reproductive options, voice and communication therapy and mental health services (assessment, counselling, psychotherapy). They also offer hormonal treatment and make arrangements for surgery at another independent hospital. Some of these services are arranged with individual professionals working external to the provider location under partnership arrangements. There is on-site provision for minor surgical procedures under local anaesthetic.

The service is registered to provide the following regulated activities:

- Treatment of Disease, Disorder and Injury

- Surgical Procedures

- Diagnostic and Screening Procedures

On-site aesthetic procedures including hair removal are available but do not come under the regulated activities and were not part of this inspection.

The registered manager is Mr Christopher Inglefield. Mr Inglefield is a consultant surgeon who has practising privileges at the hospital where surgery is undertaken.

This service had a focused inspection carried out on 28 September 2021 in response to concerns raised with the Care Quality Commission (CQC). Following that inspection we told the provider they must take action to address concerns related to staff mandatory training and the management of incidents. As a result, we served a warning notice under section 31 of the Health and Social Care Act 2008.

We undertook this follow up site visit on 9 December 2021 to check if the provider had addressed the concerns within the expected time frame.

The inspection methodology for outpatients was used for the areas of focus.

How we carried out this inspection

During the site visit we spoke with a practice nurse, the registered manager and the deputy clinical manager.

We reviewed policies and procedures and were shown electronic records.

You can find information about how we carry out our inspections on our website: https://www.cqc.org.uk/what-we-do/how-we-do-our-job/what-we-do-inspection.

Summary of this inspection

Areas for improvement

Action the service MUST take is necessary to comply with its legal obligations. Action a trust SHOULD take is because it was not doing something required by a regulation but it would be disproportionate to find a breach of the regulation overall, to prevent it failing to comply with legal requirements in future, or to improve services.

Action the service SHOULD take to improve:

- The provider should consider formally capturing information discussed in the weekly meetings so that staff not present are aware of this.

Our findings

Overview of ratings

Our ratings for this location are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Outpatients	Not inspected	Not inspected	Not inspected	Not inspected	Insufficient evidence to rate	Insufficient evidence to rate
Overall	Not inspected	Not inspected	Not inspected	Not inspected	Insufficient evidence to rate	Inspected but not rated

Insufficient evidence to rate

Outpatients

Well-led

Insufficient evidence to rate

Are Outpatients well-led?

Insufficient evidence to rate

At the previous inspection we found the provider did not have suitable arrangements for staff to follow with regard to mandatory safety training and there was no monitoring of staffs training.

The provider had developed a detailed policy related to induction and training for staff to follow. This set out information in a clear manner and included details of subjects to be completed and the frequency of training. The policy also stated the levels at which safeguarding training needed to be completed and how often this should be.

To complete training staff now had access to an e-learning system provided by an external company. This was accessed by individual secure login and could be used whilst on site or in a staff members own time. We saw a lengthy list of subjects available to staff, clinical and non-clinical. Subjects included for example; moving and handling, fire safety, principals of health and safety, bullying and harassment, complaints, learning disability awareness and infection control.

At the previous inspection the provider was told to improve the system to monitor the staff's completion of mandated training. During this follow up inspection we were told the e-learning platform issued a certificate on completion of the training. This was said to indicate the length of time the training covered a person for, before they were required to re-take. We were told the training records pulled through to an excel spreadsheet to show what staff needed to complete. This was shown to us. We saw from the information a colour coding system was used to highlight training undertaken and those staff who had yet to complete subjects.

The deputy clinical manager told us they had been leading on a number of the actions and they were tracking start dates of staff, probation meeting dates and annual reviews, which would be used for discussion of training needs alongside the recently set up training matrix. As well as using the staff's current skillsets they were developing their individual roles and were providing opportunities for additional learning.

At the previous inspection we found the provider did not have a suitable system for staff to understand their responsibilities in reporting incidents, accidents and near misses. Information was not routinely collected and considered as part of an effective governance process.

The provider now had a clearly structured Governance and Risk Policy. This set out information on for example; measuring and monitoring risk, types of risks, roles and responsibilities and the governance meeting structure and frequency of meetings. We saw there was a clear system for scoring risks by type, ensuring that higher risks were identified and acted upon.

Staff now had access to the Incident Management Policy and Procedure. We reviewed this and found its contents applied to all employees and contractors. Information included by way of examples, definitions of incidents and staff responsibilities. Where other policies were to be considered alongside the policy, these were stated. The detail enabled staff to know what to do with incidents and the investigation process.

Insufficient evidence to rate

Outpatients

The staff induction was used as an opportunity to inform staff about the procedure for reporting incidents. We were told by the deputy clinical manager that bi-weekly shared learning sessions ("Lunch and Learn") were to commence the week after our inspection, as new staff were joining the service. No documentary evidence to support this was provided and future inspection would need to corroborate this activity.

The provider now had a system for collecting information related to incidents and to investigate such matters. We were shown a copy of the form used electronically to report an incident. This was accessible to all staff via the internal IT system.

We saw the registered manager was responsible for completing investigations within a specified timeframe. Root cause analysis would be carried out for moderate or severe harm. There had not been any incidents reported since our previous inspection, which required such an investigation.

At the previous inspection we found the service lacked a formal process to enable the provider to have oversight of incidents and that such information was reviewed and considered in appropriate risk and governance meetings.

Staff were involved in various meetings held on different week days. A weekly clinical meeting was used to communicate all relevant matters with staff. These were used as an opportunity to share information and would include learning from any incidents. The practice nurse told us they had not seen any minutes from these meetings. The deputy clinical manager told us they kept a log sheets for incidents and complaints and we were shown an electronic version of this. The service now had a risk register and we saw this had one entry, which had been closed.

The registered manager advised us there was no on-site Medical Advisory Committee, but that he joined the committee, which met at the hospital location where surgery was performed. This meeting would be used for discussion of anything relevant to patients who had come through the registered location.