Health & Aesthetic Clinic Limited T/A Health and Aesthetics Clinic

Inspection report

374 Shooter's Hill Road
London
SE18 4LS
Tel:

Date of inspection visit: 21 July to 1 August 2022
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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	Good
Are services safe?	Good
Are services effective?	Good
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 Good overall. (Previous inspection 8 August 2012 where the service was not rated and was found complaint with the relevant regulations)

The key questions are rated as:

Are services safe? – Good

Are services effective? – Good

Are services caring? – Good

Are services responsive? – Good

Are services well-led? – Requires improvement

We carried out an announced comprehensive inspection at Health and Aesthetics Clinic, 374 Shooter's Hill Road, London, to determine a CQC rating of the key questions and overall.

The Clinic is a private doctor-led aesthetic clinic that carries out non-surgical treatments such as skin peels, dermal fillers, laser liposuction, body contouring and a range of other treatments. At the time of the inspection the provider did not offer a slimming clinic.

This service is registered with CQC under the Health and Social Care Act 2008 in respect of some, but not all, of the services it provides. There are some exemptions from regulation by CQC which relate to particular types of regulated activities and services and these are set out in Schedule 1 and Schedule 2 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The Health and Aesthetic clinic provide a range of non-surgical cosmetic interventions, for example Botox, which are not within CQC scope of registration. Therefore, we did not inspect or report on these services.

The clinical lead 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.

The service used online patient reviews to monitor patient feedback. We saw the provider had 229 reviews which rated the service as four point six out of five stars with the majority of reviews being positive about the staff and describing them as professional. The service replied to all of the reviews.

Our key findings were:

- On the day of the inspection the provider was unable to provide evidence that the systems and processes were effective in some areas of the services governance. For example, there was a lack of oversight of training, and the systems to manage significant events, safety alerts, recruitment, and health and safety.
- We found in some areas the policies to assure the service was operating as intended were ineffective and did not reflect the services practices.
- Patients' immediate and ongoing needs were fully assessed. Where appropriate this included their clinical needs and their mental and physical wellbeing.

Overall summary

- The clinic had an infection control policy and procedures were in place to reduce the risk and spread of infection.
- The clinic shared relevant information with other services appropriately and in a timely way.
- The clinic had good facilities and was well equipped to treat patients and meet their needs.
- Patient feedback indicated they found it easy and convenient to make appointments at the clinic.
- The clinic had a comprehensive complaints policy. Patient feedback was encouraged.
- The clinic had a clear vision and strategy to deliver high quality care and promote good outcomes for patients.

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

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

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

- Only supply unlicensed medicines against valid special clinical needs of an individual patient where there is no suitable licensed medicine available.
- Consider carrying out internal audits of the treatments carried out by staff to ensure best practice and the safety of treatments.
- Keep a record of all training for all staff.
- Put a system in place to ensure patient safety when they refuse pathology testing.

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 was supported by a GP specialist adviser.

Background to Health & Aesthetic Clinic Limited T/A Health and Aesthetics Clinic

The provider for Health & Aesthetic Clinic Limited T/A Health and Aesthetics Clinic is Health & Aesthetic Clinic Limited. The provider is registered to provide the regulated activities of diagnostic and screening procedures, family planning, services in slimming clinics and treatment of disease, disorder or injury (At the time of the inspection the provider did not offer a slimming clinic or family planning service) located at:

374 Shooter's Hill Road

London

SE18 4LS

Health & Aesthetic Clinic Ltd was established in 2011. It is a private doctor-led aesthetic clinic that carries out non-surgical treatments such as skin peels, dermal fillers, laser liposuction, body contouring and a range of other treatments.

At Health & Aesthetic Clinic Ltd the aesthetic cosmetic treatments that are provided are exempt by law from CQC regulation. Therefore, we carried out the inspection in relation to medically related treatments only.

Services are available for people over the age of eighteen only.

The staff team comprises of one clinical director who is also the clinical lead for governance, a CQC registered manager, a practice manager, three aesthetician and a part-time private GP.

The clinic operates from converted premises, facilities include disabled parking, entrance ramp, platform lift, five large and fully air-conditioned treatment rooms, two accessible toilets, an off reception waiting area and free guest WIFI.

The clinic's opening times are Monday, 10am-3pm; Tuesday and Thursday, 10am-8pm, Friday, 10am-6pm and Saturday, 9pm-5pm. The clinic is closed on Wednesday and Sundays.

How we inspected this service

We based our judgement of the quality of care at this service on a combination of:

• what we found when we inspected,

• information from the provider, patients, the public and other organisations

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.

Good

Are services safe?

We rated safe as Good because:

Although we identified some safety concerns these were rectified on the day of inspection or soon after our inspection. The likelihood of this happening again in the future is low and therefore our concerns for patients using the service, in terms of the quality and safety of clinical care are minor. (see full details of the action we asked the provider to take in the Requirement Notices at the end of this report).

Safety systems and processes

- The provider was a family business and had carried out some staff checks at the time of recruitment. However, on the day of the inspection we found there were gaps in recruitment records. For example, references. In addition, the service did not have the full immunisation records for all staff as recommended in The Green Book - Information for public health professionals on immunisation.
- 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 did not see people under the age of 18 years. The provider was the safeguarding lead. The service had both adult (reviewed January 2021) and childrens (reviewed May 2022) safeguarding policies in place. The service had systems to safeguard children and vulnerable adults from abuse. All staff received up-to-date safeguarding and safety training appropriate to their role. Staff knew how to identify and report concerns.
- The provider had conducted safety risk assessments. The service had a health and safety risk assessment in place carried out on 23 June 2022, which did not have any outstanding actions. Health and safety training was part of staff induction.
- The practice had a fire risk assessment in place reviewed on the 9 May 2022 and evidence that the fire equipment was regularly checked.
- The service had a legionella water test carried out by a different contractor on 24 April 2022 and a legionella risk assessment carried out by an independent contractor on the 3 June 2022, however the assessment was not dated.
- On the day of the inspection, the premises were clean and tidy, there was an effective system to manage infection prevention and control. The premises were cleaned each day by an external cleaner and other cleaning was carried out by the administrative staff as required and a formal cleaning schedule was in place at the time of the inspection. Single use clinical supplies were used. Staff had completed the prevention and management of infection control training.
- The service had an infection control risk assessment on the 15 April 2022, this was completed every six months. There were systems for safely managing healthcare waste.
- The service had been renovated in 2011, when the electrical fixed wiring was updated, however, the service had not had a check following the renovation. The Electricity at Work Regulations require this to be carried out approximately every five years. Following the inspection, the provider has arranged for this to be carried out.
- The provider had carried out portable appliance testing on the 21 October 2021; however, they did not have evidence that they had carried out the annual calibration checks on the equipment. Following the inspection, the provider had arranged for this to be carried out.
- The provider carried out appropriate environmental disability risk assessments, which took into account the profile of people using the service and those who may be accompanying them.

Risks to patients

- Appropriate indemnity arrangements were in place to cover potential liabilities that may arise.

Good

Are services safe?

- There was an effective approach to managing staff absences and for responding to sickness, holidays and busy periods.
- There was an induction system for staff tailored to their role.
- Resuscitation equipment was readily available and clinical staff were suitably trained in emergency procedures.
- There were medicines and equipment to deal with medical emergencies which were stored appropriately and checked regularly. However, at the time of the inspection the practice did not have a pulse oximeter. Following the inspection, the provider told us they have purchased a pulse oximeter.

Information to deliver safe care and treatment

- Patient records were maintained electronically and were password protected. We were advised that previous paper records were stored securely. The manager said the service had a protocol in place for the retention of medical records in line with Department of Health and Social Care (DHSC) guidance, should they cease trading.
- 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.
- All patients were required to complete a comprehensive registration form prior to their first appointment. This included the patient's personal details, past medical history, GP details and a signature. Patient identification, in the form of a passport or driving licence, was requested in circumstances when the provider was unsure of a patients' age.
- The provider explained that pathology and blood specimens (Such as skin or mole removals) were sent to an NHS Trust for testing, and they would contact the patient with the results and follow up any delayed results. The provider explained that some patients refused to consent to the testing because of the cost. However, the NHS recommends that they should be sent to pathology for testing. In addition, the policy for responding to test results did not include what happened when the patient declined to pay for the test and about the agreed response times from the pathology department to the provider and then to the patient.
- Clinicians made appropriate and timely referrals in line with protocols and up to date evidence-based guidance.
- Patients were required to complete a consent form for each appointment at the clinic, which asked permission to keep their NHS GP informed.

Safe and appropriate use of medicines

- The systems and arrangements for management and storage of medicines, including controlled drugs, emergency medicines and equipment minimised risks.
- The service did not prescribe Schedule 2 and 3 controlled drugs (medicines that have the highest level of control due to their risk of misuse and dependence). They did not prescribe schedule 4 or 5 controlled drugs.
- At the time of the inspection the service did not offer a slimming clinic.

Track record on safety and incidents

- The lead clinician explained they reviewed all The Medicines and Healthcare products Regulatory Agency (MHRA) safety alerts and informed the service manager if they required follow up.
- The clinician provided a policy last reviewed in 2022, which stated that the service did not have a system in place to demonstrate they had reviewed the MHRA alerts.
- The lack of a system was raised with the service at their previous inspection on 8 August 2022. Following the inspection, the service sent an updated policy and process which clearly stated the way safety alerts will be managed in the future.

Lessons learned and improvements made

Good

Are services safe?

- The service did not have a system in place for the management of significant events. The provider had a black book where they would record any issues but did not have any evidence of an investigation.
- The significant event policy was last reviewed in July 2022, this described how to manage an adverse drug reaction, a medicines error and a complaint, however it did not describe the process for the general management of all significant events. Following the inspection, the provider submitted an updated policy which clearly outlined the steps staff had to take if they identified any incident.
- The provider stated they had not had any significant events in the previous 12 months.
- The provider was aware of and complied with the requirements of the Duty of Candour. The provider encouraged a culture of openness and honesty.

Good

Are services effective?

Effective needs assessment, care and treatment

- Patients' immediate and ongoing needs were fully assessed. Where appropriate this included their clinical needs and their mental and physical wellbeing.
- We looked at the care records of five patients who had treatments carried out in the last 12 months and found the care and treatment provided was satisfactory. Clinicians had had enough information to make or confirm a diagnosis. Patients were provided with the costs of the services and provided with time to make the decision about their care and treatment.
- We saw no evidence of discrimination when making care and treatment decisions.
- Staff advised patients what to do if their condition got worse and where to seek further help and support.

Monitoring care and treatment

- At the time of the inspection the lead clinician had carried out annual audits for the British College of Aesthetics, which reviewed the types of procedures carried out by the clinician.
- The most recent internal audit was carried out from December 2019 to January 2020 where 30 patients were reviewed to assess the compliance of follow up appointments. This demonstrated that 73% of patients had follow up appointments.
- The provider carried out patient surveys to identify areas for improvement.

Effective staffing

- The provider had an induction programme for all staff.
- The provider was a member of the British Association for Aesthetic medicine for which they completed an annual appraisal. The annual appraisal reviewed their scope of work, training, and personal development. The clinical lead had completed a postgraduate diploma in clinical education in 2020.
- The aesthetic therapists completed various specific beauty treatments training for their roles, such as in regard to the using the ultrasound, electrotherapy and knowledge of skin and facial massage. They said they had sufficient training for their roles.
- Although, staff had completed training, the system in place to monitor staff training was not always effective. For example, on the day of the inspection they did not have a full training history for the clinicians.

Coordinating patient care and information sharing

- Patients received coordinated and person-centred care. Staff referred to, and communicated effectively with, other services when appropriate.
- 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.

Supporting patients to live healthier lives

- Where appropriate, staff gave people advice so they could self-care.
- Where patient's need could not be met by the service, staff redirected them to the appropriate service for their needs.

Consent to care and treatment

Good

Are services effective?

- Staff understood the requirements of legislation and guidance when considering consent and decision making.
- Staff supported patients to make decisions. Patients were provided with a cooling off period before making a decision about their treatments.

Good

Are services caring?

Kindness, respect and compassion

- The service sought feedback on the quality of clinical care patients received. The service used an online patient feedback service. This had 229 reviews which rated the service as four point six stars, with the majority of reviews being positive about the staff and describing them as professional. The service replied to all the reviews.
- Feedback from patients was positive about the way staff treat people.
- The service gave patients timely support and information.

Involvement in decisions about care and treatment

- The clinic was offered on a private, fee-paying basis only and was accessible to people who chose to use it.
- The service used an online patient feedback service. The comments made were positive about patients' involvement in decisions about their care.
- Patients were involved in decisions about their care and treatment.
- Clinicians understood the relevant consent and decision-making requirements of legislation and guidance, including the Mental Capacity Act 2005.

Privacy and Dignity

- Conversations with doctors could not be overheard by patients in the waiting room.
- Privacy screens were available when required.
- A copy of the clinic's Privacy Policy was available on their website.

Good

Are services responsive to people's needs?

Responding to and meeting people's needs

- The provider understood the needs of their patients and improved services in response to those needs.
- The facilities and premises were appropriate for the services delivered. The service had carried out a premise's disability risk assessment.
- The clinic's website contained a range of information for patients relating to the clinical experience and included skincare tips.

Timely access to the service

- The service was open outside of core working hours.
- The clinic's opening times are Monday, 10am-3pm; Tuesday and Thursday, 10am-8pm, Friday, 10am-6pm and Saturday, 9pm-5pm. The clinic is closed on Wednesday and Sundays.
- Patients accessed the service by telephone or through the providers website.
- The inspection did not highlight any concerns relating to the admission, or discharge of patients from the clinic. Waiting times, delays and cancellations were minimal and managed appropriately.
- Feedback from patients showed that they felt the appointment system was easy to use.

Listening and learning from concerns and complaints

- 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 a complaint policy and procedure in place, which was last reviewed in April 2022.
- The complaints policy and procedures were in line with recognised guidance. The policy included details of information for the Parliamentary and Health Service Ombudsman (PHSO). However, this was raised at the previous inspection because the PHSO is only appropriate in relation to the handling NHS complaints.
- The practice had not received any complaints.

Requires Improvement

Are services well-led?

We rated well-led as Requires improvement because:

- On the day of the inspection the provider was unable to provide evidence that the systems and processes were effective in some areas of the services governance. For example, there was a lack of oversight of training, and the systems to manage significant events, safety alerts, recruitment, and health and safety.
- We found in some areas the policies to assure the service was operating as intended were ineffective and did not reflect the services practices.
- 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 plan for the future leadership of the service.

Leadership capacity and capability

- 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

- There was a clear vision and set of values.
- Staff were aware of and understood the vision, values and strategy and their role in achieving them.

Culture

- Staff felt respected, supported and valued and they worked well as a team.
- The service focused on the needs of patients.
- 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 processes for providing all staff with the development they need. This included appraisal and career development conversations. All staff received regular annual appraisals in the last year.
- There were positive relationships between staff and teams.

Governance arrangements

- The service had changes to the leadership team during the pandemic and on the day of the inspection the provider was unable to provide evidence that the systems and processes were effective in some areas of the services governance. For example, there was a lack of oversight of training, and the systems to manage significant events, safety alerts, recruitment, and health and safety.
- We found in some areas the policies to assure the service was operating as intended were ineffective and did not reflect the services practices. For example, the significant events policy, the business continuity plan which had details of contacts from the primary care trust, which no longer exists.
- Staff were clear on their roles and accountabilities.
- Although, the provider had carried out some health and safety risk assessments, on the day of the inspection we found gaps.
- The service had a legionella risk assessment carried out by an independent contractor on the 3 June 2022, but the assessment was not dated,

Requires Improvement

Are services well-led?

- The service had been renovated in 2011, when the electrical fixed wiring was updated, however the service had not had a check following the renovation.
- The provider did not have evidence that they had carried out the annual calibration checks on the equipment.
- The provider had plans in place and had trained staff for major incidents.
- The provider had a managing quality assurance policy in place. This stated the management would monitor and measure the progress of every process or employee to find if there are any failures or inadequacies.

Managing risks, issues and performance

- The practice had not carried out any internal clinical audit at the time of the inspection since 2020.

Appropriate and accurate information

- The service used performance information, which was reported and monitored, and management and staff were held to account.
- 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.

Engagement with patients, the public, staff and external partners

- The service encouraged and heard views and concerns from the public, patients, staff and external partners and acted on them to shape services and culture. The service used an online patient feedback service. This had 229 reviews which rated the service as four point six stars, with the majority of reviews being positive about the staff and describing them as professional. The service replied to all of the reviews.
- Staff could describe to us the systems in place to give feedback. They had monthly meetings and access to a text group.
- The service was transparent, collaborative and open with stakeholders about performance.

Continuous improvement and innovation

- The lead clinician was a member of Ethics and regulatory committee of British College of Aesthetic Medicine (BCAM). Where they had Initiated a sustainability project.
- The provider was awarded highly commended in aesthetic awards 2022 for the professional initiative of the year.
- The provider was on the advisory board for skincare products.

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 Family planning services Treatment of disease, disorder or injury Services in slimming clinics	Regulation 17 HSCA (RA) Regulations 2014 Good governance The registered person had systems or processes in place that operated ineffectively in that they failed to enable the registered person to assess, monitor and improve the quality and safety of the services being provided. In particular: • The policies and procedures did not always reflect staff practices. • The service did not have an effective system in place for the management of MHRA safety alerts. • The system for the management of significant events was not effective. • The system for staff recruitment did not include staff interviews, evidence of staff immunisations.