Sk:n - Leeds Street Lane

Inspection report

52 Street Lane
Roundhay
Leeds
LS8 2ET
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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?	Good
Are services well-led?	Good

Overall summary

This service is rated as Good overall.

We carried out an announced comprehensive inspection at Sk:n - Leeds Street on the 25 February 2020, as part of our inspection programme. We visited their site at 52 Street Lane, Roundhay, Leeds, LS8 2ET, West Yorkshire, LS20 8EB. The previous inspection in November 2013 was unrated; we found it met the five standards we inspected.

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? – Good

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the service was meeting the legal requirements and regulations associated with the Health and Social Care Act 2008.

Sk:n - Leeds Street is situated in the Roundhay area of Leeds, West Yorkshire. The provider operates as a doctor-led service which specialises in the combination of medical aesthetic treatments and anti-ageing medicine, as well as offering rejuvenation and dermatology treatments.

This service provides independent dermatology services, offering a mix of regulated skin treatments and minor operations as well as other non-regulated aesthetic treatments. There are some exemptions from regulation by CQC which relate to particular types of regulated activities and services and these are set out in and of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We only inspected and reported on the services which are within the scope of registration with the CQC.

This service is registered with the Care Quality Commission (CQC) under the Health and Social Care Act 2008 in respect of some, but not all, of the services it provides.

This service is registered with the CQC under the Health and Social Care Act 2008 to provide treatment of disease, disorder or injury, surgical procedures and diagnostic and screening services as regulated activities, and this was the focus of our inspection.

The clinic manager is the registered manager for the service. 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.

We received ten completed CQC comment cards during our visit, all of which were positive. They described the service and staff as being friendly, professional and non judgemental. The premises were described as clean and welcoming.

During the inspection we reviewed a range of systems and processes relating to governance, service delivery and customer care.

Our key findings were:

• There were clear systems in place to manage risk so that safety incidents were less likely to happen.

• The service was offered on a private, fee-paying basis and was accessible to people who chose to use it.

• Procedures were safely managed and there were effective levels of client support and aftercare.

• There were systems and processes in place to safeguard people from abuse. All clinical staff had a documented record of safeguarding training.

• The service encouraged and valued feedback from patients. Feedback was positive regarding the services. They commented on the caring attitude of staff and the cleanliness of the clinic.

• There was a leadership and managerial structure in place with clear responsibilities, roles and accountability to support good governance.

• Staff were aware of their own roles and responsibilities. They said they felt supported by leaders and managers who were accessible and visible. Communication between staff was effective.

• There was a clear commitment to regulation and using this as a framework to ensure a high and safe standard of care for patients.

Dr Rosie Benneyworth BM BS BMedSci MRCGP

Overall summary

Chief Inspector of Primary Medical Services and Integrated Care

Our inspection team

Our inspection team was led by a CQC lead inspector who was accompanied by a GP specialist advisor.

Background to Sk:n - Leeds Street Lane

Sk:n - Leeds Street Lane operates from 52 Street Lane, Roundhay, Leeds, LS8 2ET. The building includes a reception and waiting area and treatment rooms, all of which are located on the first floor. There is no access to a lift; patients with mobility issues are redirected to the Sheffield clinic which is accessible. There is ample parking onsite.

The provider operates as a doctor-led service which specialises in the combination of medical aesthetic treatments and anti-ageing medicine, as well as offering rejuvenation and dermatology treatments.

Services are available to adults only. This service is registered with CQC under the Health and Social Care Act 2008 in respect of the provision of advice or treatment by, or under the supervision of, a medical practitioner, including the prescribing of medicines for the support of cosmetic or medical treatments.

The service is led by the clinic manager who is the managing director of the business. A doctor (male) who is the lead clinical director, two further doctors (one male and one female), one nurse prescriber, two nurse practitioners, one skin practitioners (all female) and one clinical assistant. This clinical team is supported by a receptionist and administration team, led by a clinic manager.

The service operates:

• Monday and Friday – 10am to 8pm

• Saturday – 9am to 6pm

• Sunday – 10am to 5pm

How we inspected this service

Before visiting the clinic, we reviewed a range of information we hold about the service. In addition, we requested that the provider send us information pre-inspection which we also reviewed.

During our inspection we:

• Spoke with the registered manager, the director of medical services, the nominated individual, nurses, a skin practitioner and administrative staff.

• Looked at information the clinic used to deliver care and treatment plans.

• Reviewed ten CQC comment cards and patient feedback received by the clinic.

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:

The service had established safety processes to keep staff and patients safe. This included in relation to safeguarding people from abuse, creating records, minimising the risks to patient safety and reporting incidents.

Safety systems and processes

The service had clear systems to keep people safe and safeguarded from abuse.

- The provider had conducted safety risk assessments. It had appropriate safety policies in place, which were regularly reviewed and communicated to staff. They outlined clearly who to go to for further guidance. Staff received safety information from the service as part of their induction and refresher training. The service had systems to safeguard children and vulnerable adults from abuse.
- Treatment was offered to those aged over 18 years of age. Identification checks were undertaken to verify the identity of patients.
- 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 for all newly appointed staff in accordance with the provider's policy. (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).
- Staff received up-to-date safeguarding and safety training appropriate to their role. They knew how to identify and report concerns.
- Staff who acted as chaperones were trained for the role.
- There was an effective system to manage infection prevention and control (IPC). The most recent IPC audit in October 2019 showed high levels of compliance with an overall score of 86%. We saw evidence to confirm that any issues for improvement were immediately acted upon by the provider. For example foot operated bins had been replaced.
- We reviewed the legionella risk assessment and confirmed that the provider had necessary control measures in place (Legionella is a bacterium which can contaminate water systems in buildings).
- 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.
- The provider carried out appropriate environmental risk assessments, which took into account the profile of people using the service and those who may be accompanying them.

Risks to patients

There were systems to assess, monitor and manage risks to patient safety.

- There was an established process for sending samples for histology and receiving results for review. Staff recorded samples in the histology log and the minor operations book, and all samples were tracked when dispatched. The medical director contacted patients if there was a cause for concern and made referrals for example to facial rejuvenation clinics. If there were no concerns, clinic staff phoned and sent patients' copies of their results.
- There were arrangements for planning and monitoring the number and mix of staff needed.
- There was an effective induction system for permanent and temporary staff tailored to their role. There were staff policies and procedures in place for them to follow.
- The provider had recruitment and occupational health policies in place.
- Staff understood their responsibilities to manage emergencies and to recognise those in need of urgent medical attention.
- Staff received annual basic life training updates and the location had a defibrillator and emergency medicines.
- All the medicines we checked were in date and fit for use.
- When there were changes to services or staff the service assessed and monitored the impact on safety.
- There were appropriate indemnity arrangements in place to cover potential liabilities.

Information to deliver safe care and treatment

Staff had the information they needed to deliver safe care and treatment to patients.

- The service had systems for sharing information with staff and other agencies to enable them to deliver safe care and treatment. The provider had an effective

Good

Are services safe?

system to share information with a patient's GP if appropriate. The provider sought the patient's consent in line with their policy which included provision to decline any treatment the provider felt posed a risk.
- The service had a system in place to retain medical records in line with Department of Health and Social Care (DHSC) guidance in the event that they ceased trading.
- 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 reliable systems for appropriate and safe handling of medicines.

- The systems and arrangements for managing medicines, emergency medicines and equipment minimised risks.
- 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 of medicines. Where there was a different approach taken from national guidance there was a clear rationale for this that protected patient safety.

Track record on safety and incidents

The service had a good safety record.

- There were comprehensive risk assessments in relation to safety issues. Clinicians made appropriate and timely referrals in line with protocols and up to date evidence-based guidance. We saw evidence of an appropriate referral when histology tests had shown that a lesion was cancerous. The patient was advised of this finding and referred promptly for further treatment.
- The service monitored and reviewed activity. This helped it to understand risks and gave a clear, accurate and current picture that led to safety improvements.

Lessons learned and improvements made

The service learned and made improvements when things went wrong.

- There was a system for recording and acting on significant events. We spoke with staff who understood their duty to raise concerns and report incidents and near misses. Leaders and managers supported them when they did so.
- There were effective systems for reviewing and investigating when things went wrong.
- A complaint regarding a clinical outcome had been reviewed and improvements had been made. A presentation was made to all staff to share the learning outcomes.
- The provider was aware of and complied with the requirements of the Duty of Candour. The provider encouraged a culture of openness and honesty. The service had systems in place for knowing about notifiable safety incidents.
- 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 staff.

Good

Are services effective?

We rated effective as Good because:

The provider reviewed and monitored care and treatment to ensure it provided effective services. They carried out audits to assess and improve quality, including those on consent and infection rates.

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).
- Almost all patients self-referred to this service (others were referred by the NHS). The provider 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.
- Patients' immediate and ongoing needs were fully assessed. Where appropriate this included their clinical needs and their mental and physical wellbeing. Arrangements were in place to support patients receiving long-term or repeated treatment. We saw that all treatment options were considered within a clear ethical framework.
- We saw no evidence of discrimination when making care and treatment decisions.
- Staff assessed and managed patients' pain where appropriate.

Monitoring care and treatment

The service was actively involved in quality improvement activity.

- The service used information about care and treatment to make improvements. There was evidence of quality improvement. For example, the quality of clinical records was reviewed on a monthly basis and audits were undertaken to review minor operations and skin treatments.

Effective staffing

Staff had the skills, knowledge and experience to carry out their roles.

- All staff were appropriately qualified. The provider had an induction programme for all newly appointed staff.
- Relevant professionals (medical and nursing) were registered with the General Medical Council (GMC)/ Nursing and Midwifery Council and were up to date with revalidation.
- The provider understood the learning needs of staff and provided protected time and training to meet them. Up to date records of skills, qualifications and professional training were maintained.

Coordinating patient care and information sharing

- Whilst the opportunity for working with other services was limited, the service did so when this was necessary and appropriate. Before providing treatment, clinicians 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 had risk assessed the treatments they offered. They had identified medicines that were not suitable for prescribing if the patient did not give their consent to share information with their GP, or they were not registered with a GP. For example, medicines liable to abuse or misuse.
- Care and treatment for patients in vulnerable circumstances was coordinated with other services. For example, the service had an NHS contract to provide transgender patients with hair removal 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 people written and verbal advice to help them keep them safe, for example in relation to wound care post treatment.
- Risk factors were identified and highlighted to patients before undergoing treatment.
- Where clients 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 .

Good

Are services effective?

- Staff understood the requirements of legislation and guidance when considering consent and decision making. Staff had completed training in the Mental Capacity Act 2005 and the Deprivation of Liberty Safeguards.
- 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.
- The service monitored the process for seeking consent appropriately.

Good

Are services caring?

We rated caring as Good because:

Staff treated patients with kindness and compassion and involved them in decisions about their care. Staff protected patients' privacy and dignity.

Kindness, respect and compassion

Staff treated clients with kindness, respect and compassion.

- Feedback from patients was positive about the way staff treated people.
- Staff understood patients' personal, cultural and social needs. They displayed an understanding and non-judgmental attitude to all clients.
- The service gave patients timely support and information.

Involvement in decisions about care and treatment

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

- Patients told us through comment cards, that 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.
- The service had a policy regarding translation services and could offer patients who did not have English as a first language a translator if required. Interpreters signed to confirm they interpreted questions and information and responded in line with the patient's wishes.

Privacy and Dignity

The service respected patients' privacy and dignity.

- There were no privacy curtains installed within the clinical rooms, as a result of a safety risk assessment associated with the use of lasers. They offered patients gowns if this was appropriate. The doors were kept locked during consultations and we observed staff knock on the doors.
- Staff recognised the importance of people's dignity and respect.
- Staff provided patients with a private room to discuss their needs if required.

Good

Are services responsive to people's needs?

We rated responsive as Good because:

The service organised and delivered services to meet patients' needs. There were short waiting times for dermatology and minor surgery appointments, patients were advised of treatment prices in advance. Staff made patients aware of their complaints policy.

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 provider understood the needs of their patients and improved services in response to those needs. The provider prioritised creating a hygienic and welcoming environment.
- The facilities and premises were appropriate for the services delivered. Patients with restricted mobility could be seen at an alternative clinic in Sheffield.
- The provider undertook feedback and satisfaction surveys with their patients. They valued feedback, reflected this across the whole staff team. We saw that patient feedback was consistently positive.

Timely access to the service

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

- Patients had timely access to initial assessment, test results, diagnosis and treatment.
- Patients reported that the appointment system was easy to use and praised the professionalism of all staff.

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.
- 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.
- The service acted quickly to address any concerns raised by patients. We saw that no complaints had been received within the last year for treatments that fell within the scope of CQC regulations.
- We examined the complaints processes and found them to be satisfactory. The service informed patients of any further action they could take should they not be satisfied with the response to their complaint. The provider's complaints guidance included information on how to contact the Independent Sector Adjudication Service.
- Referrals and transfers to other services were undertaken in a timely way. For example, when test results indicated cancerous tissue, the patient was immediately referred to their GP for treatment.

Good

Are services well-led?

We rated safe as Good because:

Leaders and managers understood the needs of the service and patients using the service. They created positive relationships in line with the provider's values and supported staff with their career development.

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 provider had effective processes to develop leadership capacity and skills, including planning for the future leadership of the service.

Vision and strategy

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

• There was a clear vision and set of values.

• The service had a realistic strategy and supporting business plans to achieve priorities.

• 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. It carried out annual 'mock CQC' audits to assess quality of care against the CQC standards of care.

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 behavior and performance inconsistent with the vision and values.

• 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 processes for providing all staff with the development they needed. This included appraisal and career development conversations.

• All staff had received an appraisal in the last year.

• Staff were supported to meet the requirements of professional revalidation where necessary.

• Clinical staff, including nurses, were considered valued members of the team. They were given protected time for professional development and evaluation of their clinical work.

• 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.

Governance arrangements

There were clear responsibilities, roles and systems of accountability to support good governance and management.

• Structures, processes and systems to support good governance and management were clearly set out, understood and effective. The governance arrangements promoted interactive and co-ordinated person-centred care.

• Staff were clear on their roles and accountabilities

• Leaders had established proper policies, procedures and activities to ensure safety and assured themselves that they were operating as intended.

Managing risks, issues and performance

There were clear and effective clarity around processes for managing risks, issues and performance.

• There was an effective, process to identify, understand, monitor and address current and future risks including risks to patient safety.

Good

Are services well-led?

• The service had processes to manage current and future performance.

• Performance of clinical staff could be demonstrated through audit of their consultations, prescribing and referral decisions.

• Leaders had oversight of safety alerts, incidents, and complaints.

• Clinical audit had a positive impact on quality of care and outcomes for patients. There was clear evidence of action to change services to improve quality.

• The provider had plans in place and had trained staff for major incidents. The clinic held an emergency 'grab box', which contained a wide range of items including emergency contact details.

Appropriate and accurate information

The service acted on appropriate and accurate information.

• 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. All patients were allocated a unique identifier code and this was used on any paperwork that was at risk of being seen, such as treatment lists.

• Quality and operational information was used to ensure and improve performance.

• Performance information was combined with the views of patients.

• The service used performance information which was reported and monitored; 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 effective 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, the public, staff and external partners to support high-quality sustainable services.

• The service encouraged and heard views and concerns from patients and staff.

• Staff said they had regular meetings with the clinic manager and they could use these to make suggestions or raise concerns.

• The service was transparent, collaborative and open with stakeholders about performance.

Continuous improvement and innovation

There was evidence of systems and processes for learning, continuous improvement and innovation.

• The provider carried out detailed audits of the practice annually. This consisted of reviewing the service following the CQC key lines of enquiry and highlighting a score, rating and areas for improvement.

• The director of medical services had written the premises standards for an external body in 2018. This document had been shared across the cosmetic practitoners industry.

• Clinical staff were actively involved with ongoing awareness via clinical courses and discussions with fellow colleagues.

• The service had developed a clinical governance summary board. They ran a mock CQC inspection every six months. We saw a copy of the report from February 2020 where actions had been addressed. For example replacing light bulbs in corridors.