Skin Excellence Clinics (Wells)

Inspection report

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This report describes our judgement of the quality of care at this service. It is based on a combination of what we found when we inspected, information from our ongoing monitoring of data about services and information given to us from the provider, patients, the public and other organisations.

Ratings

Overall rating for this location	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?	Good

Overall summary

This service is rated as Good overall. Skin Excellence Clinics (Wells) was registered to provide regulated activities in July 2021. This was the first inspection of this location since registration.

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 an announced comprehensive inspection at Skin Excellence Clinics (Wells) on 15 March 2023 as part of our planned inspection programme.

Skin Excellence Clinics (Wells) 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.

Skin Excellence Clinics (Wells) provides a range of non-surgical cosmetic interventions, for example wrinkle reduction injections by botulinum toxin injections (Botox), skin and lip filler treatments, platelet rich plasma (PRP) skin treatments for cosmetic purposes which are not within CQC scope of registration. Therefore, we did not inspect or report on these services. PRP is a type of therapy that uses injection of a concentration of patients own platelets. We only inspected element of the service which fell under our scope of regulated activities, for example thread lifts (a non-surgical procedure that aims to lift and sculpt the face), minor skin surgeries, hormone replacement therapy (HRT), PRP treatments for the purpose of treating medical conditions such as urinary stress incontinence and erectile dysfunction.

The provider has 2 locations, 1 which is at the address above and a second clinic located in Plymouth. The service manager 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 provider's Nominated individual and Clinical Lead is a Member of the British College of Aesthetic Medicine and Member of the American Cellular Medicine Association and registered with the General Medical Council.

We reviewed patient feedback which had been collated by the service.

Our key findings were:

- The service had embedded systems, processes and operating procedures to keep patients safe, to manage incidents and safeguard patients from abuse.

Overall summary

- The service monitored and reviewed the effectiveness of the care provided. Staff held appropriate qualifications and knowledge to provide quality patient care.
- Patients were treated with compassion, kindness, dignity and respect.
- The service organised and delivered services to meet patient's needs. Patients were well informed about the service provided.
- The service took feedback seriously and responded to concerns appropriately.
- Managers had the skills and capacity to deliver quality care. There were clear roles, responsibilities and systems to support governance and management. There were effective processes to managing risk, learning from incidents or concerns and continuous improvement.

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

- Review recruitment and training systems to make sure all recruitment checks are carried out; and staff receive appropriate training to provide care and treatment.
- Embed new systems to make sure all staff have vaccinations records in line with guidance.
- Review accessibility arrangements for patients and consider improvement to enable those patients with hearing loss or translations needs are supported to access the service.

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

Our inspection team

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

Background to Skin Excellence Clinics (Wells)

- Skin Excellence Clinic Wells is operated by the provider Skin Excellence Clinics Ltd and is registered with CQC to provide the regulated activities: Surgical Procedures and Treatment of disease, disorder or injury. During the inspection we found they were providing treatment to approximately 2 patients a year, which saw them send samples to the hospital for testing and required them to be registered for the Regulated activity of Diagnostic and screening. The provider has now submitted the required documentation to correct this.
- Skin Excellence Clinic Wells is registered to provide services to patients over the age of 18.
- The provider Skin Excellence Clinic Ltd has a second location known as Skin Excellence Clinics. This is situated in the area of Plymouth and did not form part of this inspection.
- The service offers an appointment only service between the core hours of 9am to 3pm on Mondays and Tuesdays and 10am to 6:30pm on Thursdays and Fridays. The service occasionally offers Saturday appointments between 10am and 5pm.
- Outside of these hours patients can contact them by phone for post procedure concerns. Any concerns will be managed by the service where appropriate or signposted to the relevant service.
- The service is run by the lead clinician and a clinic manager. They are supported by a nurse, doctor with GP background and administration staff. Administration staff are shared with the second location.
- The provider serves approximately 2500 patients a year across 2 locations.

How we inspected this service

Prior to the inspection, we reviewed a range of information provided from the pre-inspection information request and any notifications we had received from the service.

During our visit:

- We spoke with the registered manager, clinical lead and staff.
- We reviewed documentation and records including clinical records.
- We reviewed patient feedback collated by the service.
- Observed patient and staff interactions whist they were waiting for appointments.
- We made observations of the premises and facilities where the service was provided.

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 embedded systems and processes to keep patients safe, to monitor the environment and safeguard patients from abuse.
- Infection prevention and control (IPC) systems and processes were effective.
- There was an effective system in place for reporting, recording and learning from incidents and significant events.
- Although we found gaps in staff files including vaccination history in line with guidance and training, the provider responded to this in the days post inspection to rectify it. New systems had been put in place to minimise the risk of this reoccurring. We have not been able to check this, as it happened after our inspection.

Safety systems and processes

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

- The provider had contracted an external company to undertake safety risk assessments. It had appropriate safety policies, which were regularly reviewed and communicated to staff. They outlined clearly who to go to for further guidance. We reviewed the health and safety risk assessments and found outstanding actions were documented and acted on. Safety policies were in line with the service's needs. 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. All staff had the required safeguarding training in line with current guidance and safeguarding policies detailed how to escalate concerns. Staff knew how to identify, report and manage safeguarding concerns. Staff who acted as chaperones were trained for the role and had received a DBS check. Patients were offered chaperone's prior to consultation.
- The provider carried out staff checks, including checks of professional registration where relevant, on recruitment and on an ongoing basis. 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). We reviewed 3 staff files and found 1 did not have a DBS check. The provider was aware of this and had instructed a new DBS check to be carried out. Although a risk assessment had not been carried out, leaders told us this staff member was employed in an administrative role that did not involve having direct patient contact at the time of inspection.
- The service had a practising privileges agreement with a doctor who regularly worked at the service. For their own assurances they held documentation for the doctor in line with their recruitment policy.
- There was an effective system to manage infection prevention and control, which included daily checks for cleanliness. The IPC lead had completed Legionella training and the service complied with testing and prevention.
- The service had contracted an external company to carry out an IPC audit. The results of this audit included that there were gaps in staffs vaccination records. Although action was taken, at the time of inspection the staff vaccination history was not in line with The Green Book guidance. We raised this with the provider who sent evidence post inspection that they had begun actioning this. Where staff were unable to provide evidence of recommended vaccines, this would be risk assessed.
- 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 systems to assess, monitor and manage risks to patient safety.

Good

Are services safe?

- There were arrangements for planning and monitoring the number and mix of staff needed. Patients using the service attended on an appointment only basis to ensure the correct staff were available.
- Staff understood their responsibilities to manage emergencies and to recognise those in need of urgent medical attention. They knew how to identify and manage patients with severe infections, for example sepsis.
- When there were changes to services or staff the service assessed and monitored the impact on safety. For example, where staff raised the idea of new treatment options or medicines, this was assessed by senior leaders before a decision was made on whether to provide it.
- There were appropriate indemnity arrangements in place.
- There were suitable medicines and equipment to deal with medical emergencies which were stored appropriately and checked regularly. This included oxygen, a defibrillator, resuscitation equipment and medicines appropriate to the service needs.

Information to deliver safe care and treatment

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

- Individual care records were written and managed in a way that kept patients safe. The care records we saw showed that information needed to deliver safe care and treatment was available to relevant staff in an accessible way. Patients were required to review the options and consent for treatment each time they attended.
- The service had systems for sharing information with staff and other agencies to enable them to deliver safe care and treatment. We were told that for approximately 2 patients per year, samples from minor surgical procedures were sent to a hospital for testing. This was sent and returned to the service in a secure way, however the service did not currently hold a service level agreement with the hospital for their own records. We raised this with leaders, and they told us this would be reviewed.
- Patients were assessed by clinical staff at the service. Clinicians would only liaise with a patient's general practitioner where appropriate and with the patients consent.
- The service had a process for receiving and responding to medical alerts.
- Clinicians made appropriate and timely referrals in line with protocols and up to date evidence-based guidance. Due to most procedures falling outside of National Institute of Clinical Excellence (NICE) guidance, the service followed processes and guidance dictated by the license of the treatment. They subscribed to appropriate associations and participated in seminars and discussion.

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 and equipment minimised risks. The service kept prescription stationery securely and monitored its use. Where prescriptions were used, the prescription identification number was placed onto the patient record.
- 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.
- The service does not prescribe Schedule 2 and 3 controlled drugs (medicines that have the highest level of control due to their risk of misuse and dependence). Neither did they prescribe schedule 4 or 5 controlled drugs.

Good

Are services safe?

(Some of) the medicines this service prescribes are unlicensed. Treating patients with unlicensed medicines is higher risk than treating patients with licensed medicines, because unlicensed medicines may not have been assessed for safety, quality and efficacy. These medicines are not recommended by the National Institute for Health and Care Excellence (NICE) or the British Menopause Society. NICE Guidance NG23 states that clinicians must explain to women that the efficacy and safety of unregulated hormones are unknown.

Track record on safety and incidents

The service had a good safety record.

- There were comprehensive risk assessments in relation to safety issues including the environment and clinical practice.
- 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.
- There was a system for receiving and acting on safety alerts. The service had system in place for receiving alerts from relevant bodies including the Medicines and Healthcare Products Regulatory Agency (MHRA).

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. Staff understood their duty to raise concerns and report incidents and near misses. Leaders and managers supported them when they did so.
- There were adequate systems for reviewing and investigating when things went wrong. The service had no incidents relating to CQC regulated activities, however we were provided an example of how they managed an incident which involved a delay in the identification of a complication. The service implemented a checklist for staff to use when completing post procedure calls, which would assist in the identification of the complication that occurred. This was applied to all patients, to minimise the risk of this reoccurring. The service learned and shared lessons identified themes and took action to improve safety in the service.
- Significant events were on the agenda to be discussed at team meetings. Due to the joint leaders across 2 locations, learning was shared across the sites. Following the incident, the changes to post treatment calls were applied to all patients that attended both sites.
- Leaders at the service attended and contributed to external safety events to learn and improve the service provided, including complications panels.
- 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 and took appropriate action when needed.
- All patient interactions were documented in patient notes.

Good

Are services effective?

We rated effective as Good because:

- The provider maintained their knowledge and skills. They reviewed and monitored care and treatment to ensure treatments were effective.
- Staff were supported to learn and develop their knowledge.

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.
- The provider had systems to keep clinicians up to date with current evidence based practice. Where treatments fell outside of the guidance provided by the National Institute of Health and Care Excellence (NICE), staff followed manufacturer guidance and training.
- Clinicians had enough information to make or confirm a diagnosis. We were told, if pathology results returned were abnormal, patients would be advised how to follow this up.
- We saw no evidence of discrimination when making care and treatment decisions.
- Arrangements were in place to deal with repeat patients. Those patients who required a course of treatment would have this arranged or patients could recontact the service at a time to suit them.
- Staff assessed and managed patients' pain where appropriate.

Monitoring care and treatment

The service was actively involved in quality improvement activity.

- The service provided evidence they had completed an audit into outcomes of treatments in scope of CQC regulation. This audit included if they had followed their processes, dates, type of complication if any and how it was managed. We also viewed further clinical audits that were in progress which included complications of minor surgery and thread lifts.
- The service actively sought feedback for all visits, where feedback included areas to improve on, it was discussed and where appropriate changes were made. For example, feedback had identified that a clinic room was not completely private. The service had bought a further privacy screen as a result.

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.
- Internal appraisals had not always taken place, however we were provided with evidence that such conversations had taken place through variation of contracts. Staff told us they could raise concerns or ask for support freely. Post inspection, formal appraisals were organised.

Good

Are services effective?

- Staff maintained their knowledge by maintaining their professional registration and knowledge, participating and contributing to conferences. The clinical lead had become a trainer for thread lifts.
- The provider understood the learning needs of staff and provided protected time and training to meet them. We reviewed staff training records and found some staff had not completed all the training in line with the services policies, for example fire safety awareness. We raised this with leaders and post inspection was sent evidence that they had developed an improved oversight of mandatory training. This included, how they will monitor this training in line with their policy and staff were completing the required learning.
- We found staff were supported to learn and develop knowledge that improved patient experience. For example; the service were involved in research for combined treatments and were encouraged to present new treatments they felt would benefit patients.

Coordinating patient care and information sharing

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

- Patients received coordinated and person-centred care. Where staff felt at consultation the proposed treatment was inappropriate, patients would be told this and signposted to other services.
- 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, including those who attended regularly received a consultation prior to any new treatments being agreed. Patients were required to consent before each treatment. Whilst information was not routinely shared with the patients GP, the service would do so if required and the patient consented. If the patient did not wish to consent, the clinicians would respect their wishes and continue to make their own clinical decision.
- The provider had risk assessed the treatments they offered. The provider did not provide or prescribe high risk medicines.
- The service provided an example of how care and treatment for patients in vulnerable circumstances were treated in a sensitive way. They would allow extra time at the appointment or more communication prior to the appointment to ensure it was safe.
- Patients self referred to this service. There was not a system to accept or refer patients onto other services, however staff would advise patients what treatment to seek elsewhere where appropriate.
- Where required, the service would request samples be reviewed by the local hospital.
- Patients were unable to receive same day treatment following consultation, with the exception of treatments deemed low risk or as part of a course. Treatment was arranged for approximately 2 weeks after the initial consultation. This allowed a patient to change their mind about whether to have the treatment.

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. This was recorded in patients records and appropriate leaflets were handed out.
- All patients treated were given a follow up phone call the day following treatment. This may be carried out by a clinician or administrative staff depending on the nature of the procedure. Where the administrative staff completed this, they were given a form to complete to gain the required information. If this raised concerns, it would be escalated to a clinician to review.

Good

Are services effective?

- Risk factors were identified, highlighted to patients and where appropriate highlighted to their normal care provider for additional support. Patients could recontact the service post procedure including out of hours for advice is they were concerned or experienced a complication.
- Where patients needs could not be met by the service, staff redirected them to the appropriate service for their needs.

Consent to care and treatment

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

- Staff understood the requirements of legislation and guidance when considering consent and decision making. Consent forms were completed before each treatment and recorded in patient notes.
- Staff supported patients to make decisions. Where appropriate, they assessed and recorded a patient's mental capacity to make a decision. Due to the nature of the service, they did not undertake treatments for any patients who could not independently and safely consent to treatment.

Good

Are services caring?

We rated caring as Good because:

- Staff treated patients with kindness, treated them respectfully and involved them in decisions about their treatment.

Kindness, respect and compassion

Staff treated patients with kindness, respect and compassion.

- The service sought feedback on the quality of clinical care patients received. They had received 97% return rate of their feedback.
- Feedback from patients was positive about the way staff treat people.
- 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. Due to the introduction of a new way to document patients' journey, which included taking photos via 3D mapping equipment, the service was in discussion about extending appointment times so the addition of these photos did not impact the time for clinical assessment.

Involvement in decisions about care and treatment

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

- The service did not have access to interpretation services. We raised this with the provider who told us that they had not experienced any patients who required this. Where they had treated patients who experience hearing loss, they allowed extra time for appointments and communicated via email in advance where appropriate. Post inspection, the provider told us this would be added to their next team meeting to discuss how the service could improve in this area.
- Positive feedback included that patients 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 did not provide consultations over the phone or virtually. The clinician would discuss the risks and benefits of any treatment and gave time to answer any questions. The clinician would also discuss realistic outcomes and costs during this consultation. Guidelines for costs are available on the services website, however a patients could not book in for a treatment without a consultation.

Privacy and Dignity

The service respected patients' privacy and dignity.

- Staff recognised the importance of people's dignity and respect. The service had responded where it had been identified privacy could be compromised when someone was in the waiting room by purchasing an additional blind.
- Staff knew that if patients wanted to discuss sensitive issues or appeared distressed they could offer them a private room to discuss their needs.

Good

Are services responsive to people's needs?

We rated responsive as Good because:

- The service took complaints and feedback seriously and responded to them appropriately.
- The service would make reasonable adjustments to meet patients' needs, where the service could not meet the needs of a patient they were transparent about this.

Responding to and meeting people's needs

The service organised and delivered 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. While most appointments were during normal working hours, appointments on a Saturday were available some of the weekends each month.
- We found staff respected patients views and as a result of feedback had made changes. For example:
  - The service had put up a further privacy screen after it was highlighted that the privacy glass had some gaps.
  - The service offers patients the option to take payments in the private setting of the consultation room, following feedback that a patient did not want this to be overheard by others.
- The facilities and premises were appropriate for the services delivered.
- Reasonable adjustments had been made so that people in vulnerable circumstances could access and use services on an equal basis to others. Where the service could not meet a patients needs, they were transparent about this when booking the appointment. For example, the clinic rooms were on the same floor as the car park, however the toilet was down a small set of stairs. Where patients had accessibility concerns, they were told this.
- The service did not have access to translation services. When we raised this with leaders, they put it on their next staff meeting agenda to discuss this improvement.

Timely access to the service

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

- The service did not provide any urgent services. Patients accessed appointments via telephone and were advised of time to appointment on calling the service.
- Patients were not provided with same day treatments in most cases. The exceptions were deemed low risk treatments or patients who were receiving a course of treatment.
- Where patients were awaiting results from a sample, they were told when the results were returned to the service in a secure way. Staff told us they put time in their diary to remind them to chase any results that had not been returned in a timely way.
- We were told if a patient did experience a complication, they would be prioritised. Patients could access advice from the clinic doctor out of hours.
- Waiting times, delays and cancellations were minimal and managed appropriately.

Listening and learning from concerns and complaints

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

- The service had a complaints policy and procedures in place. Although staff told us they had not received any complaints, they had actively sought feedback from patients, which reflected the positive experience of the service.

Good

Are services responsive to people's needs?

Where concerns were highlighted in feedback, leaders reviewed these and provided a response to patients and sought opportunity to make changes to the service when needed. For example, following feedback the service had increased the number of reminders it had given to patients to attend their appointment, from 2 to 3. Further feedback from patients following this included that they were contacting them too much and therefore it was reviewed again and reduced back to the original reminder system.

Good

Are services well-led?

We rated well-led as Good because:

- Management of the service had the capacity and skills to deliver quality, sustainable care.
- The positive culture allowed leaders and staff to work together to ensure continuity and meet patient expectations.
- There were clear and effective processes for managing risk, issues and performance.
- There were clear roles and responsibilities to support governance and management. Some areas of governance required further review such as staff recruitment and training, however the leaders were aware of this and were able to provide evidence of the changes being made shortly after the day of inspection.

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 held a business plan to support their aims including how they would safeguard and develop the service.
- Leaders at all levels were visible and approachable. They worked closely with staff to make sure they prioritised compassionate and inclusive leadership. Conversations with staff were often held informally and were not routinely documented. This had been recognised by leaders who planned to put a system in place.
- The provider had effective processes to develop leadership capacity and skills, including planning for the future leadership of the service. They had recently employed a new member of staff to support leaders with some clinical administrative tasks such as clinical audits.
- During this inspection we identified that the service provided a CQC regulated activity to a small number of patients a year that they were not registered for. We raised this with the provider who responded promptly and now has the correct applications in to rectify this.

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 developed a business plan annually to monitor themselves against these.
- Staff were aware of and understood the vision, values and strategy and their role in achieving them.

Culture

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

- Staff felt respected, supported and valued. They were proud to work for the service.
- The service focused on the needs of patients.
- Leaders and managers acted on behaviour and performance inconsistent with the vision and values.
- Openness, honesty and transparency were demonstrated when responding to incidents and complaints. For example, in the absence of an incident in scope of CQC regulation, the service shared another incident they had managed. The leaders welcomed feedback and were quick to make required changes. 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.

Good

Are services well-led?

- There were processes for providing all staff with the development they need. Where the service could not evidence a formal appraisal for staff they could demonstrate how they had supported staff to learn, develop and assured themselves of staff competencies. For example, they had employed a receptionist who had previous been a registered nurse. They supported them to regain their registration and supporting further learning.
- There were positive relationships between leaders and staff. All staff were considered valued members of the team. One role had been adapted to support a member of staff to work from home to better meet their personal needs.
- There was a strong emphasis on the safety and well-being of all staff. For example, leaders had paid for staff to attend an awards ceremony the service was nominated for. Staff were actively supported to seek support for their mental well-being where needed. In some circumstances leaders would fund this.
- The service actively promoted equality and diversity. It identified and addressed the causes of any workforce inequality. Staff were required to complete equality and diversity training as mandatory training. On the day of inspection, not all staff had completed this, however it had been allocated to staff to complete. Post inspection, we were sent evidence of how leaders had improved oversight of staff training to be in line with their own policy. 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 and management of partnerships, joint working arrangements and shared services promoted interactive and co-ordinated person-centred care. For example:
  - Team meetings were documented.
  - Although some staff appraisals had not been formally recorded, the service could demonstrate a trail of staff development and change of contract being in place to reflect this. Formal staff appraisals had been booked in post inspection to record staff progress.
- Staff were clear on their roles and accountabilities. Some staff had taken on further accountabilities since starting this service, but all staff were still clear on who to go to.
- Leaders had established proper policies, procedures and activities to ensure safety. Where we found areas of improvement such as staff training that was not in line with their policy, they were responsive to rectify this. Leaders recognised areas of administrative tasks they could continue to improve on.

Managing risks, issues and performance

There were clear and effective 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.
- The service had processes to manage current and future performance. Performance of clinical staff could be demonstrated through audit of their clinical outcomes. Leaders had oversight of safety alerts including MHRA alerts, incidents, complaints and patients' feedback.
- 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 contingency plans in place for major incidents. The service had appropriate risk assessments and had actioned them appropriately.

Good

Are services well-led?

Appropriate and accurate information

The service acted on appropriate and accurate information.

- Quality and operational information was used to ensure and improve performance. Performance information was combined with the views of patients.
- Quality and sustainability were discussed in relevant meetings where all staff had sufficient access to information. Staff and leaders had open and transparent conversations about the future of the service.

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, staff and external partners and acted on them to shape services and culture. All patient feedback was reviewed by the clinic manager and where patients raised areas of improvement, these were discussed and responded to. Clinical staff attended appropriate conferences to keep up to date with latest guidance and have discussions with peers.
- There were systems to support improvement and innovation work. Examples include:
- Staff could describe to us the systems in place to give feedback. These included patients being sent a feedback form post appointment and advising patients to leave google reviews. We saw evidence of feedback opportunities for staff and how the findings were fed back to staff.
- For specific treatments the service was registered with the American Medical Cellular Association where they engaged with seminars and discussion to enable best practice.

Continuous improvement and innovation

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

- There was a focus on continuous learning and improvement. The service was open
- The service made use of reviews of incidents and complaints. Learning was shared and used to make improvements.
- Leaders told us that audits of procedures, complications and case reviews were shared with clinical peers in line with the British College of Aesthetic Medicine guidance.
- The service culture allowed open conversations between staff and leaders. Leaders listened to staff opinions where improvements could be made.
- There were systems to support improvement and innovation work. Examples include:
  - Due to positive feedback around initial consultations they identified this was an important part of a patient journey so have expanded this to provide imaging to give patients and objective view of their outcomes. As a result, they were looking to increase the consultation time by 15 minutes to give each patient a 60 minute appointment,
  - The provider frequently attended worldwide conferences where they contributed and took away learning from these.
  - Participation in a research project that focused on the combination of two treatments.