A New You (Brighton) Limited

Inspection report

78 Trafalgar Street
Brighton
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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	Requires Improvement
Are services safe?	Requires Improvement
Are services effective?	Requires Improvement
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 Requires improvement overall.

The key questions are rated as:

Are services safe? – Requires improvement

Are services effective? – Requires improvement

Are services caring? – Good

Are services responsive? – Good

Are services well-led? – Requires improvement

We carried out this announced comprehensive inspection of A New You (Brighton) Ltd on 4 August 2022 under Section 60 of the Health and Social Care Act 2008. 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.

The service was previously inspected on 5 July 2021. We identified breaches of regulation and took enforcement action against the provider in relation to Regulation 12(1) Safe care and treatment and Regulation 17(1) Good governance. We issued a Notice of Decision under Section 18 of the Health and Social Care Act 2008 to suspend the provider's registration as a provider, in respect of all regulated activities, for a period of three months. The notice to suspend the provider's registration was issued because we believed that a person would or may be exposed to a risk of harm if we did not take this action. We also issued a requirement notice in relation to Regulation 18(1) Staffing.

Following our inspection on 5 July 2021, the service was rated as inadequate overall and inadequate for providing safe, effective and well-led services. It was rated as requires improvement for providing caring services and good for providing responsive services. The service was placed into special measures.

We carried out a focused inspection of the service on 9 February 2022. We found that sufficient improvements had been made to lift the suspension of the provider's registration. However, we identified continuing breaches of regulation and issued a warning notice in relation to Regulation 17(1) Good governance. We carried out a further review on 19 April 2022, to confirm that the provider had taken sufficient action to comply with the regulations.

Throughout the COVID-19 pandemic CQC has continued to regulate and respond to risk. However, taking into account the circumstances arising as a result of the pandemic, and in order to reduce risk, we have conducted our inspections differently.

This inspection was carried out in a way which enabled us to spend a minimum amount of time on site. This was with consent from the provider and in line with all data protection and information governance requirements.

This included:

- Speaking with staff in person and on the telephone.
- Requesting documentary evidence from the provider.
- A site visit.

Overall summary

We carried out an announced site visit to the service on 4 August 2022. Prior to our visit we requested documentary evidence electronically from the provider. We spoke to staff on the telephone prior to our site visit.

A New You (Brighton) Ltd is an independent provider of consultations and treatment for dermatological conditions, including acne and rosacea, prescription skincare, and the screening and treatment of skin lesions. Botox (Botulinum toxin) injections are provided for the treatment of excessive sweating. The service also provides nurse-led pre-assessment consultations, for patients seeking surgical procedures outside of the service.

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. A New You (Brighton) Ltd also provides a wide range of non-surgical aesthetic interventions. This includes cosmetic Botox injections, dermal fillers and facial thread vein treatments, which are not within CQC scope of registration. Therefore, we did not inspect or report on these services.

A New You (Brighton) Ltd is registered with the Care Quality Commission to provide the following regulated activities: Treatment of disease, disorder or injury; Diagnostic and screening procedures. Prior to our inspection in July 2021, we identified that the provider was carrying out the excision of moles and other skin lesions without being registered to provide the required regulated activity Surgical procedures. The provider continues not to be registered for this regulated activity and currently provides only non-regulated treatment of skin lesions, such as non-invasive plasma fibroblast therapy, a technique used to stimulate production of collagen in the skin.

The service director 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.

Our key findings were:

- There were improved safeguarding systems and processes to keep people safe. Staff had received training in the safeguarding of children and vulnerable adults.
- Arrangements for chaperoning were effectively managed. Staff had received chaperone training and had been subject to Disclosure and Barring Scheme (DBS) checks.
- Arrangements to manage medical emergencies had been adequately risk assessed. Staff had received training in basic life support.
- There were improved systems for the safe and appropriate use of medicines. However, some recent risks associated with the storage of medicines requiring refrigeration had not been promptly addressed.
- There were improved systems and processes to assess the risk of, and prevent, detect and control the spread of infections. This included processes to maintain and monitor staff immunisations.
- There was a lack of records to demonstrate that recruitment checks had been carried out in accordance with regulations for some staff employed on a trial basis.
- There were improved arrangements to ensure training for staff in key areas. However, there had been insufficient monitoring to ensure update training was received in a timely manner.
- There were improved processes for performance review and staff appraisal.
- There were improved risk monitoring processes which resulted in more accurate assessment of potential risks in some areas. However, there had been insufficient action taken to monitor some fire safety risks.

Overall summary

- Prescribing practices had been recently monitored. There was some auditing of clinical and prescribing processes which required further embedding.
- Governance and monitoring processes were improved but required further embedding to provide assurance to leaders that systems were operating as intended.
- Some steps had been taken to ensure best practice guidance was now followed in providing treatment to patients. There were improved arrangements to ensure the safe delivery of dermatology services.
- There were improvements to ensure consistency in clinical record keeping and the collation of key records and documents.
- Policies had been revised to provide updated, relevant and sufficient information, to provide effective guidance to staff.
- Staff dealt with patients with kindness and respect.
- Patients were routinely asked to provide feedback on the service they had received. Complaints were managed appropriately.

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

- Ensure care and treatment is provided in a safe way to patients.
- Establish effective systems and processes to ensure good governance in accordance with the fundamental standards of care

(Please see the specific details on action required at the end of this report).

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

- Provide information for patients on the service's website about how to make a complaint.
- Continue to embed and review governance, monitoring and auditing processes to provide assurance they are operating as intended.

We found that sufficient improvements had been made to remove the service from special measures.

Dr Sean O'Kelly BSc MB ChB MSc DCH FRCA

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 included a GP specialist advisor.

Background to A New You (Brighton) Limited

A New You (Brighton) Ltd is an independent provider of consultations and treatment for dermatological conditions, including acne and rosacea, prescription skincare and mole screening. Botox (Botulinum toxin) injections are provided for the treatment of excessive sweating. The service also provides nurse-led pre-assessment consultations, for patients seeking surgical procedures outside of the service. The service offers consultations and treatments to people over the age of 18.

The Registered Provider is A New You (Brighton) Ltd.

A New You (Brighton) Ltd is located at 78 Trafalgar Street, Brighton, East Sussex, BN1 4EB.

The service is open from 10am to 6pm on Mondays, Wednesdays and Fridays, 10am to 8pm on Tuesdays and Thursdays and 10am to 5pm on Saturdays.

The service is run from self-contained ground floor premises which are leased by the provider. The service has a suite of consultation and treatment rooms, a waiting room and administration area. Patients are able to access toilet facilities on the ground floor. Access to the premises at street level is available to patients with limited mobility.

Services are currently managed by the service director who is a registered nurse and carries out pre-assessment consultations for patients seeking dermatological review or surgical procedures. The service director is supported by nurses and administrators, and also aesthetic practitioners who are not involved in the delivery of regulated activities. At the time of our inspection, one consultant dermatologist provided remote review of patients' lesions under a service level agreement. There were no other doctors employed by the service who were involved in the delivery of regulated activities.

How we inspected this service

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.

Requires Improvement

Are services safe?

Safety systems and processes

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

- The service had improved systems to safeguard children and vulnerable adults from abuse. At our inspection in July 2021, we found that staff were unclear as to who the safeguarding lead within the service was. There was a lack of guidance for staff on how to raise safeguarding concerns about a patient. Some staff had not received training in safeguarding vulnerable adults or children. At this inspection we found that the safeguarding lead within the service had been clearly identified. There was improved guidance for staff as to how they would raise a safeguarding concern or referral. Staff had access to contact information for local safeguarding teams. The provider had developed safeguarding policies which provided comprehensive guidance to staff on both vulnerable adult and child safeguarding processes. Staff had received training in the safeguarding of vulnerable adults and children.
- At our inspection in July 2021 we found that the provider was unable to demonstrate that required recruitment checks had been carried out for all staff employed by the service. At this inspection we found that the provider had made improvements to recruitment processes and had developed a recruitment checklist which set out their approach to monitoring staff at the point of recruitment. However, there remained some inconsistencies in the provider's approach to ensure that all required recruitment checks were completed. The provider told us of two staff members who had not yet confirmed their employment with the service but who were working on a trial basis whilst waiting to agree their contractual terms. We found that both staff had undertaken some limited tasks within the service prior to our inspection, such as supervised reception duties and involvement in premises audit and risk assessment processes. There were no personnel records available for either staff member. The provider told us that recruitment checks were underway for one staff member and had not begun for the other.
- We reviewed personnel files of five other staff employed by the service and found that some recruitment and monitoring checks were insufficient. For example, DBS checks for two clinical staff members were copies of checks undertaken by previous employers and were not transferrable. (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). Immediately following our inspection, the provider confirmed they had applied to undertake a DBS check for those staff members.
- At our inspection in July 2021, we found there was a lack of a documented chaperone policy and no signage on display which prompted patients to request a chaperone. Staff had not undergone chaperone training. At this inspection, we found there was a chaperone policy and appropriate signage in place. Staff who undertook the role had completed appropriate training.
- The service had some systems to manage health and safety risks within the premises. Legionella risk assessments were carried out and resulting actions had been completed. (Legionella is a particular bacterium which can contaminate water systems in buildings). There was guidance and information, including risk assessments and safety data sheets, available to staff to support the control of substances hazardous to health (COSHH). There were documented risk assessments in place to manage risks associated with the premises and general environment.
- The provider had employed an external agency to conduct a fire safety risk assessment of the premises on 2 August 2022. The assessment had indicated some remedial actions were required to be undertaken, such as the replacement of some internal doors with fire doors. There was no fire alarm within the service due to the small nature of the premises. Staff told us that they would shout 'fire' to raise the alarm. There were smoke detectors located within the premises, however, we noted that these were not regularly checked to ensure their safe working. There were fire extinguishers located within the premises which were regularly serviced and maintained. The service had designated staff who were trained as fire marshals and staff had undertaken some fire safety training. Records confirmed that staff had participated in a fire drill in April 2021. Staff told us that another drill had been undertaken immediately prior to our inspection but this had not been documented, timed or assessed for its effectiveness.

Requires Improvement

Are services safe?

- The provider ensured that facilities and equipment were safe, and that equipment was maintained according to manufacturers' instructions. We reviewed records to confirm that electrical equipment had undergone portable appliance testing in September 2021.
- At our inspection in July 2021, we found there was a lack effective systems to manage infection prevention and control within the service. We found the provider's infection, prevention and control policy did not provide sufficient detail or guidance for staff. Staff were unclear as to who was the lead for infection control within the service. Staff had not received training in infection prevention and control and the provider had not undertaken an audit of their infection prevention and control processes.
- At this inspection we found the provider had implemented a newly developed policy which provided clear and comprehensive guidance for staff on infection prevention and control processes. The provider had undertaken an audit and risk assessment of their infection control processes in July 2022 and areas requiring remedial action, identified by the audit process, had been noted and the actions taken recorded. The lead staff member for infection prevention and control had been clearly identified and staff had in the main, received appropriate training. However, records held by the provider indicated that two staff members, including the lead staff member for infection prevention and control, had not undertaken updated training required in June and July 2022 respectively.
- At our previous inspection the provider was unable to demonstrate that they held appropriate records relating to staff immunisations. There was no written staff immunisation policy in place and no record which documented the monitoring of staff immunisations. At this inspection we found that the provider had revised their policy and approach to monitoring staff immunisations. The provider demonstrated they had appropriately monitored the immunisation status of staff involved in the delivery of regulated activities, in line with current guidance.
- At our inspection in July 2021, we found the refrigerator used to store medicines was unclean. We found multiple items which had expired, stored in cupboards within treatment rooms. At this inspection, we found that the refrigerator used to store medicines had been replaced and was clean, and there were improved processes for stock control and monitoring. The premises were clean and well maintained. There were cleaning schedules in place.
- There were systems for safely managing healthcare waste, including sharps items. We saw that clinical waste disposal was available in clinical rooms. We saw there were bins used to dispose of sharps items that were signed, dated and not over-filled. External, lockable bins were used to store healthcare waste awaiting collection by a waste management company.

Risks to patients

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

- There were arrangements for planning and monitoring the number and mix of staff required to meet patient needs. Clinical staff working on a sessional basis were scheduled according to individual patient need.
- There were some planned induction processes in place. Staff told us induction processes included shadowing other staff and the development of a clear understanding of the patient journey. There was a plan of required training for staff to complete as part of the induction process.
- We reviewed arrangements within the service to respond to medical emergencies. We found there were appropriate supplies of emergency medicines available to staff in the event of a medical emergency, for example anaphylaxis (a severe, potentially life-threatening allergic reaction). At our inspection in July 2021, we found the service did not have oxygen or a defibrillator on site and no documented risk assessment in place to assess how a medical emergency would be managed in the absence of emergency equipment. At this inspection we found there were comprehensive risk assessments in place to assess the level of risk to patients in the event of a medical emergency, which included rationale for the emergency medicines and equipment held. The provider had installed an oxygen supply within the service in order to support the management of a medical emergency.

Requires Improvement

Are services safe?

- At our inspection in July 2021, our review of training records confirmed that non-clinical staff had not received training in basic life support. Since our previous inspection, the provider had ensured that all non-clinical staff had completed training in basic life support.
- The service had a first aid kit in place which was appropriately stocked, and we saw evidence that the contents were regularly checked.
- The provider had in place a public and employer's liability insurance policy effective from August 2021.

Information to deliver safe care and treatment

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

- At our inspection in July 2021, we found that clinical records were not always clear, comprehensive and legible. We found there was an inconsistent approach to clinical record keeping, with varying forms and documents missing from individual records. The records did not always include evidence that risks to the patient had been discussed or documented. There was a lack of evidence of treatment plans for some patients.
- At this inspection we found that a combination of hand-written and electronic records continued to be held. Clinical records were stored on a secure, password-protected, electronic system. Staff told us that hand-written records were stored securely in locked cupboards until they were scanned onto the electronic system.
- Since our previous inspection the service had provided limited services which fell into scope of CQC regulation. We noted the service no longer provided the prescribing of weight management medicines and had suspended their service to provide excision of moles and other skin lesions, until they registered for the correct regulated activity. Services provided since our previous inspection, included nurse-led pre-assessment consultations for patients seeking dermatological review or cosmetic surgical procedures outside of the service, and prescribing for acne and excessive sweating.
- We reviewed clinical records relating to 15 patients who had received treatment within the service. We found that standards of clinical record keeping had improved since our previous inspection. Records included sufficient and appropriate information. We saw that risks of treatment had been discussed with patients and were documented. Patients were required to complete a medical questionnaire prior to their consultation which included their past medical history, allergies and existing medical conditions. We noted that the provider had recently undertaken an audit of clinical records which was planned to be repeated on a quarterly basis.
- Patients previously attended the service for assessment and treatment of skin lesions such as moles, lipomas and cysts, including excision of the lesion. The provider had stopped providing excision of lesions since our inspection in July 2021. At our previous inspection we found that clinical staff providing dermatology screening services had not received specialist dermatology training and were not following best practice guidance such as that provided by the British Association of Dermatologists (BAD). For example, screening of moles and other lesions did not include the use of a dermatoscope, and we found no instances where removed lesions had been sent for histology. (A dermatoscope is a hand-held visual aid device used to examine and diagnose skin lesions and diseases).
- At this inspection, we found the provider had reviewed their approach to the provision of dermatology services and was able to demonstrate the improvements made. The service director provided nurse-led pre-assessment of a lesion which included determining the reason for the consultation, recording a medical history and taking images of the lesion using a dermatoscope. The service director had recently received training in the use of the dermatoscope. The service held an agreement with a consultant dermatologist who provided remote assessment of those images, remote consultation and diagnosis, to determine if the lesion required excision and histological analysis. Patients requiring excision of their lesion were either advised to seek that excision from another service or were placed on a waiting list with the provider.
- Patients' NHS GP details were routinely recorded. Staff told us they would share information with the registered GP where this was appropriate and when they had patient consent to do so.

Requires Improvement

Are services safe?

- Staff told us if a lesion appeared suspicious, they would refer the patient back to their registered GP or directly onto a secondary care pathway.

Safe and appropriate use of medicines

The service had some systems for the appropriate and safe handling of medicines.

- At our inspection in July 2021 we found there was a lack of systems and arrangements for managing the safe handling of medicines and prescribing practices in a way which minimised risks to patients. Medicines requiring refrigeration were not appropriately stored or monitored; prescribing processes did not support the easy tracking of patient prescriptions; there was a lack of processes to ensure the security of arrangements for online prescription ordering; there was no audit or clinical oversight of prescribing practices within the service.
- At this inspection we found appropriate processes were in place for the ordering, receipt and monitoring of stock medicines held and staff kept accurate records of those medicines. There were improved security arrangements for authorised staff to access online ordering and prescribing sites.
- Medicines requiring refrigeration were stored in a refrigerator which was monitored to ensure it maintained the correct temperature range for safe storage. We found the service had recorded a maximum temperature which exceeded the maximum recommended temperature of eight degrees centigrade, for a period of four weeks prior to our inspection. Staff told us they had sought advice from an engineer who had concluded that the fridge mechanism to reset the daily temperature range, had developed a fault. However, this had not been rectified at the time of our inspection. All actual temperatures recorded were within the required range.
- Emergency medicines were readily available and in date and supplies were regularly checked. There were documented records of those checks.
- At this inspection we reviewed patient prescription records and prescribing processes. There was limited prescribing within the service, however, the provider had recently introduced some auditing of prescribing practices which was scheduled to be repeated on a quarterly basis. Our review of clinical records confirmed that staff prescribed and administered medicines to patients, and gave advice on medicines, in line with legal requirements and current national guidance.

Track record on safety and incidents

- There were some risk assessments in place to support the management of health and safety within the premises.
- There was improved monitoring and review of activities to support the provider in identifying potential risks within the service. There was a risk register in place. The provider had introduced a series of risk assessment and audit processes which provided more comprehensive monitoring information and provided a clear, accurate and current picture which led to safety improvements. For example, the provider had identified lone working as a potential risk and had developed a lone working policy and improved processes for staff to raise an alarm.

Lessons learned and improvements made

The service had improved systems to ensure they learned when things went wrong.

- At our previous inspection we reviewed the provider's significant event policy and significant event log. We found there was a lack of guidance available to staff within the policy on how to report an incident. Staff we spoke with were unable to give examples of when they had raised concerns or reported an incident or a near miss. At this inspection we found the provider had developed an incident management and reporting policy which provided improved guidance for staff. This included an incident reporting template for staff to use. We noted that two incidents had been reported since our previous inspection. The incidents had been discussed and the learning shared amongst the team.

Requires Improvement

Are services safe?

- At our previous inspection we found that the service had registered to receive patient safety alerts via the Central Alerting System immediately prior to our inspection. We saw no evidence that patient and medicine safety alerts had previously been responded to, acted upon or learned from. At this inspection we found that the service continued to be registered to receive medicines and safety alerts and was able to demonstrate their review and response to such alerts.

Requires Improvement

Are services effective?

Effective needs assessment, care and treatment

The provider had improved systems to keep clinicians up to date with current evidence-based practice.

- At our previous inspection we found that clinical staff employed by the service did not always have the knowledge and experience to deliver the care and treatment offered by the service. Staff involved in the delivery of dermatology services, such as the screening and excision of moles and other lesions, had not received any specialist training. At this inspection, we found the provider had revised their approach to the delivery of dermatology services and had made some changes to personnel involved in those services. For example, the service now held an agreement with a consultant dermatologist who provided remote assessment of lesions, remote consultation and diagnosis, to determine if the lesion required excision and histological analysis.
- We found that improvements had been made to ensure care and treatment was delivered in line with relevant current legislation, standards and guidance. For example, a dermatoscope was now utilised in the assessment of moles and other skin lesions, in line with the British Association of Dermatologists (BAD) best practice guidance. The service director had undergone dermatology training and had received training in the use of the dermatoscope.
- The service no longer prescribed weight loss treatments such as Saxenda, which we found at our previous inspection, were not managed in line with prescribing and monitoring requirements guidance, as set out by the manufacturer.
- At this inspection we reviewed clinical records relating to 15 patients who had received treatment within the service. We saw that the service used a template to record information about each patient. This included their previous medical history, medicines being taken and known allergies. Treatment planning and risks of treatment had been discussed with patients and documented. We found improvements in the consistency of clinical record keeping within the service.
- We saw no evidence of discrimination when making care and treatment decisions.

Monitoring care and treatment

The service was able to demonstrate some quality improvement activity.

- The service had implemented processes to begin to gather and use information about care and treatment to make improvements.
- At our inspection in July 2021, we found no evidence of clinical auditing or quality improvement activity within the service. There was no audit or clinical oversight of prescribing practices and no clinical supervision for staff who were prescribers or for those providing dermatology services. There had been no auditing of infection prevention and control or clinical record keeping processes.
- At this inspection we found the provider had begun to implement a programme of quality improvement activity within the service. The provider had recently introduced auditing of prescribing practices and clinical record keeping processes which were scheduled to be repeated on a quarterly basis.
- The provider had undertaken an audit and risk assessment of their infection control processes in July 2022. Risk assessment activities had been undertaken relating to, for example, emergency medicines and equipment, the environment, health and safety and safeguarding processes.

Effective staffing

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

- There were some planned induction processes in place. Staff told us induction processes included shadowing other staff and the development of a clear understanding of the patient journey.

Requires Improvement

Are services effective?

- At our previous inspection we found that staff did not always have the appropriate skills and training to carry out their roles. There was no policy in place which outlined the provider's training requirements for staff and no documented monitoring of staff training. Staff employed within the service, had not completed training in, for example: vulnerable adult and child safeguarding, infection control, information governance, basic life support, confidentiality, mental capacity act and chaperoning. Staff employed on a sessional basis were not required to provide evidence of training completed elsewhere. Staff involved in the delivery of dermatology services, such as the screening and excision of moles and other lesions, had not received any specialist training.
- At this inspection we found the provider had developed a planned programme of training for staff. Staff employed on a sessional basis were required to provide evidence of training completed externally or to complete training within the service. We saw records which confirmed that since our previous inspection, staff had completed training not previously undertaken, for example, child safeguarding, infection control, information governance and basic life support training.
- However, we noted the provider had not ensured timely monitoring of their records to assure themselves that training which required updating after a given period, was repeated. For example, the provider held records for several areas of training dated July 2021, for one clinical staff member who was employed on a sessional basis. The provider held no evidence to confirm that the training had been updated following the required time period of 12 months, as indicated by the training provider. We saw that the lead for infection prevention and control within the service had completed infection control training in June 2021 which was valid for a 12-month period. The provider held no records to confirm the training had been updated in a timely manner.
- There was an improved approach to staff appraisal. We reviewed staff files and saw evidence of recent appraisal and one-to-one meetings with line-managers.
- The provider told us they checked the professional registration status of nurses and doctors employed within the service, at the start of their employment. We reviewed staff files and found evidence of monitoring of professional registration. There were records held which confirmed doctors were registered with the General Medical Council (GMC) and that nurses were registered with the Nursing and Midwifery Council (NMC) and were up to date with revalidation.

Coordinating patient care and information sharing

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

- Staff referred to and communicated effectively with other services. At the time of our previous inspection, sessional consultants provided pre- and post-operative consultations and care for surgical cosmetic treatments carried out at hospitals independent of the service. At this inspection we found the provider now offered only nurse-led pre-assessment consultations, for patients seeking surgical procedures outside of the service. The service director undertook those consultations prior to referral to a specialist surgical consultant within an independent hospital setting.
- The service had developed links with a local psychotherapy service and referred patients directly where such support was required, prior to surgical treatment.
- Patients were asked for consent to share details of their consultation with their registered GP. There were improved processes to ensure patients' GP details were consistently recorded and where a patient had declined to share their GP information, there was documented evidence to state this. Staff told us they would share treatment information with a patient's GP if this was deemed necessary and they had the patient's consent.

Supporting patients to live healthier lives

Staff empowered patients and supported them to manage their own health and maximise their independence.

Requires Improvement

Are services effective?

- Patients were provided with information about procedures, including the benefits and risks of treatments provided. The service provided advice and support to patients who underwent surgical cosmetic treatments at other locations independent of the service.
- Where patients' needs could not be met by the service, staff told us they redirected them to the appropriate service for their needs. For example, if staff were concerned about a suspicious lesion, they would refer the patient back to their NHS GP.

Consent to care and treatment

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

- Staff we spoke with understood the requirements of legislation and guidance when considering consent and decision making. Staff described processes for the assessment of patients' suitability for treatment which included their psychological well-being, mental capacity and vulnerability. Staff told us they would not agree to treat patients about whom they had any concerns.
- However, at our inspection in July 2021 we found there was no documented consent policy within the service. Consent processes were inconsistently applied and consent records were missing for five out of the six patient records we reviewed. The consent form template for minor procedures was not fit for purpose and did not clearly document the consent process and discussions between the clinician and patient. There was no field for the clinician to sign and no date field on the form.
- At this inspection we found the provider had developed a more comprehensive consent form which clearly documented the consent process and discussions between the patient and practitioner. The provider's clinical governance policy set out their intentions to monitor the quality and completeness of clinical record keeping as part of their clinical auditing processes.
- Our review of clinical records and the provider's recent audit of clinical record keeping processes confirmed that consent processes were more consistently and comprehensively recorded.

Good

Are services caring?

Kindness, respect and compassion

Staff treated patients with kindness, respect and compassion.

- The service gave patients timely support and information in relation to their care and treatment.
- Staff understood patients' personal, cultural, social and religious needs. They displayed an understanding and non-judgmental attitude to all patients.
- The service actively invited feedback on the quality of care patients received via a satisfaction survey sent out to patients, via a third party following their appointment. Patients were also able to complete the survey whilst at the service, by scanning an electronic code into a hand-held device. The survey provided patients with the opportunity to provide feedback and make suggestions for improvements to services.
- The service received weekly survey summary results which were monitored to ensure required actions were taken promptly. This enabled the service to identify areas for improvement and feedback which required a direct response to the patient.
- However, the provider had recently identified that they had achieved only a nine per cent return rate from 2,408 surveys sent out. In response, the provider had introduced an additional paper-based survey which patients were invited to complete immediately following their appointment.
- The service also invited patients to complete reviews on Google, the feedback from which was available to be viewed on the service's website.
- We observed some staff interactions with patients on the day of our site visit, both in person and on the telephone. We found that staff treated patients with kindness, respect and professionalism.

Involvement in decisions about care and treatment

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

- The service ensured that patients were provided with all the information they required to make decisions about their treatment prior to treatment commencing.
- Information about pricing was available to patients on the service's website and within the service. Patients were provided with individual quotations for their treatment following their first consultation.
- Interpretation services were available for patients who did not have English as a first language. Staff within the service were able to speak several languages.

Privacy and Dignity

The service respected patients' privacy and dignity.

- Staff recognised the importance of people's dignity and respect. Consultations and treatments took place behind closed doors and conversations could not be overheard.
- Patients were collected from the waiting area by the clinician and escorted into the consultation room.
- Reception staff were aware that if patients wanted to discuss sensitive issues or appeared distressed, they could offer them a private room to discuss their needs.
- Chaperones were available should a patient choose to have one. There were signs on display within the service to encourage patients to request a chaperone. Staff who provided chaperoning services had undergone required employment checks and had received training to carry out the role.
- Improvements had been made to information governance arrangements within the service since our inspection in July 2021, which ensured that confidential information was held securely. Staff had received information governance

Good

Are services caring?

training and there was an information governance policy to provide guidance to staff. Processes now ensured that all confidential electronic information was stored securely. For example, improvements had been made to ensure the security of access arrangements for online prescription ordering processes. Technical errors which had previously resulted in some patient records being lost during electronic transfer had been resolved.

- Staff working in the reception area of the service told us that they operated a clear desk policy and hard copy documents were scanned electronically or promptly shredded.

Good

Are services responsive to people's needs?

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 arranged services in response to those needs. For example, there was a flexible approach to arranging consultations for patients who were seeking surgical cosmetic treatments.
- The facilities and premises were maintained to a high standard and were appropriate for the services and treatments delivered. All rooms were located on the ground floor. Patients with limited mobility were able to access the premises at street level.
- Reasonable adjustments had been made so that people in vulnerable circumstances could access and use services on an equal basis to others. For example, the service had arranged longer appointments for patients who were needle phobic.

Timely access to the service

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

- Appointments could be booked in person or by telephone. Patients usually had appointments within a short time from their request. Evening and weekend appointments were available.
- Waiting times, delays and cancellations were minimal and managed appropriately.
- Referrals to other services were undertaken in a timely way and were managed appropriately. For example, the service director liaised directly with external consultants where patients had undergone a pre-assessment consultation within the service for dermatological review or cosmetic surgical procedures.

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 within the service. We noted that there was no information available about how to make a complaint on the provider's website. The provider had identified this at the time of our inspection and told us they had plans to update their website to include information about their complaints procedure.
- Staff treated patients who made complaints compassionately.
- The service had recorded one complaint within the previous 12 months and was able to demonstrate how appropriate and timely actions were taken in response to the complaint.
- There were some arrangements in place to signpost patients who may not be satisfied with the response to a complaint. The service's written complaints policy included information to support patients should their complaint remain unresolved.
- There was some evidence to demonstrate that complaints had been discussed and the learning shared amongst the team. We were able to see documented evidence of one staff meeting where complaints were discussed.

Requires Improvement

Are services well-led?

Leadership capacity and capability

Leaders had demonstrated some capacity and skills to deliver high-quality, sustainable care.

- Leaders had demonstrated improved capacity to implement systems and processes to support the delivery of high-quality care.
- Leaders had some awareness and understanding of the issues and priorities relating to the quality and future of the service.
- Leaders within the service were visible and approachable. They worked closely with the small team of staff and others and told us they prioritised compassionate and inclusive leadership.
- There was a staffing structure in place across the service and staff were aware of their individual roles and responsibilities. The provider was in the process of recruiting a new manager within the service in order to further develop quality and governance processes.
- There were open lines of communication between staff based within the service and also those employed by the service on a sessional basis. Staff we spoke with felt well supported and described leaders within the service as approachable. Staff told us they had regular one-to-one interaction with managers due to the small nature of the service. Staff spoke of some team meetings they had attended, and we saw records of those meetings. Clinical staff employed on a sessional basis were subject to some clinical observation by leaders and we saw some brief records of those observations.

Vision and strategy

- The provider had a vision and desire to provide a high-quality service that put caring at its heart, and which promoted good outcomes for patients.
- Staff were aware of and understood the vision, values and strategy and their role in achieving them.

Culture

There were improved systems and processes to support a culture of high-quality sustainable care.

- The service was focused upon the needs of patients. The provider had begun to develop systems and processes which required further embedding, to support a culture of high-quality, sustainable care.
- Openness, honesty and transparency were demonstrated when responding to incidents and complaints. There had been no serious incidents in the past 12 months relating to regulated activities carried out by the service. However, the provider was aware of and had systems to ensure compliance with the requirements of the duty of candour.
- Since our inspection in July 2021, the provider had begun to develop processes to ensure staff received regular review of their performance and assessment of their training and professional development needs. We reviewed staff files and saw evidence of recent appraisal and one-to-one meetings with line-managers. There were improved processes for monitoring and evaluation of the clinical decision making and prescribing practices undertaken by clinical staff employed on a sessional basis. However, evidence of this was limited due to the nature of current services provided and the reduction in the number of staff involved in the delivery of regulated activities at the time of our inspection.
- There were positive relationships between staff and regular informal and formal communications within the team. Staff told us they felt respected, supported and valued.
- Staff told us they could raise concerns and suggestions for improvement and were encouraged to do so.
- There was a strong emphasis on the safety and well-being of all staff. There was a lone working policy and risk assessment. Staff told us that external counselling support was available to them if required.

Governance arrangements

Requires Improvement

Are services well-led?

There were improvements in establishing responsibilities, roles and systems of accountability to support good governance and management.

- Structures, processes and systems to support good governance and management had been more clearly set out, understood and established since our previous inspection. The provider had developed more awareness of some of the issues and priorities relating to the quality and governance of the service.
- Staff understood their individual roles and responsibilities. The provider had identified individual members of staff to assume lead roles in key areas such as safeguarding and infection prevention and control, since our previous inspection. We noted that at the time of our inspection, the provider was in the process of recruiting a new manager within the service.
- At our inspection in July 2021, we found that the provider had not established appropriate policies, procedures and systems to ensure services were delivered safely. Policies did not always contain sufficient or up to date information to provide adequate guidance to staff, in order to ensure the safety of staff and patients. At this inspection we found that policies had been revised to provide updated, relevant and sufficient information and accurate guidance for staff. For example, the provider's medicines management and prescribing policy had been revised to remove extensive references to the management of medicines which did not apply to the service. Policies which previously did not reflect best practice guidance, for example with regard to the monitoring of staff immunisations and arrangements for the management of medical emergencies, had been appropriately revised.
- At our inspection in July 2021 we found there was a lack of defined and documented processes and systems for the management of some key areas. For example, there were no documented policies which provided guidance to staff on the consent process, chaperoning or clinical governance processes. At this inspection we found the provider had developed clear policies to support the management of those processes.
- However, there remained some areas where, despite setting out clear policies and processes, the provider had not assured themselves that those processes were always operating as intended. For example, the provider had not ensured that staff recruitment processes were consistently followed. The provider had not applied a sufficiently rigorous approach to the monitoring of staff training to ensure that requirements for updated training were met in a timely manner.
- Staff told us they had regular one-to-one interaction with managers. Staff spoke of some team meetings they had attended, and we saw records of those meetings. Although there were limited examples, we saw evidence that organisational updates, incidents and complaints were discussed and shared with staff.
- The provider utilised the services of an external organisation to provide some support with human resource processes and health and safety management.

Managing risks, issues and performance

There were improved processes for managing risks, issues and performance.

- There were improved governance processes to ensure leaders were able to identify, understand, monitor and address current and future risks, including risks to patient safety. However, these were limited due to the nature of services provided and required further embedding to promote continuous improvement.
- There were improved processes to ensure safety alerts were acted upon. Patient safety alerts were received and monitored by the service.
- We reviewed the provider's significant event policy and significant event log and found there was improved guidance available to staff within the policy on how to report an incident. We noted that examples of incidents recorded within the last 12 months included a needlestick injury to a staff member and a loss of power within the premises. There was some evidence that incidents had been discussed and the learning shared amongst the team. We were able to see some evidence of staff meetings where incidents were discussed.

Requires Improvement

Are services well-led?

- The service had made improvements to processes to manage current and future performance. However, there were further improvements required to ensure consistency in the application of processes for undertaking recruitment checks, and the ongoing review of staff training requirements. There had been some improvements made to ensure the provider had oversight of clinical staff, including auditing of clinical decision making, prescribing practices and clinical record keeping. There was an improved approach to staff appraisal.
- The provider had a business continuity plan in place.

Appropriate and accurate information

There was appropriate and accurate information available.

- There were improvements in quality, governance and operational information to monitor performance and drive improvement.
- The provider had established appropriate policies, procedures and systems to ensure appropriate guidance for staff and to ensure services were delivered safely.
- There was an improved approach to clinical record keeping. Records we reviewed were complete and contained sufficient and accurate information.
- Staff told us they had attended some staff meetings. We saw documented evidence of staff meetings, where for example, updates, incidents and complaints had been discussed and outcomes from the meetings cascaded to staff.
- Improvements to information governance arrangements ensured that confidential information was held securely. There were improved processes to ensure the security of access arrangements for online prescription ordering.

Engagement with patients, the public, staff and external partners

The service involved patients, staff and external partners to support sustainable services.

- The service encouraged and valued feedback from patients, the public and staff. Feedback was closely monitored and acted upon to shape services.
- Staff could describe to us the systems in place for them to give feedback.
- The service was transparent and open with stakeholders about the feedback received. Feedback was available to be viewed on the service's website.

Continuous improvement and innovation

- There was evidence of improvements made to the service as a result of feedback received. For example, longer appointments were facilitated for needle phobic patients.
- Leaders and managers encouraged staff to review individual and team objectives, processes and performance.
- There was evidence of some quality improvement activity.

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 Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance The provider was unable to demonstrate that systems and processes were implemented effectively to assess, monitor and improve the quality and safety of the services provided in the carrying on of the regulated activities. In particular: • To ensure timely monitoring of training updates required for all staff employed within the service. This was in breach of regulation 17(1)(2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Regulated activity	Regulation
Treatment of disease, disorder or injury Diagnostic and screening procedures	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment The provider had not done all that was reasonably practicable to ensure care and treatment was provided in a safe way for service users. In particular: • To ensure adequate processes to monitor and address fire safety arrangements within the premises. • To ensure required recruitment checks are carried out for all staff. • To implement fridge temperature monitoring processes and timely interventions which ensure the correct temperature range for the safe storage of medicines. This was in breach of regulation 12(1)(2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.