Sk:n - Manchester Albert Square

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.

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 Sk:n Manchester Albert Square on 18 May 2022 under Section 60 of the Health and Social Care Act 2008. The inspection was planned to check whether the service was meeting the legal requirements and regulations associated with the Health and Social Care Act 2008. This was the first rated inspection of the service. The service was previously inspected in September 2013, when it was not rated but was found to be meeting all standards that were inspected.

Throughout the Covid-19 pandemic the Care Quality Commission (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.
- Additional communications for clarification.

We carried out an announced site visit to the service on 18 May 2022. Prior to our visit we requested documentary evidence electronically from the provider. We spoke to staff in person on 18 May 2022 and via a video call on 16 May 2022.

The provider specialises in a combination of medical aesthetic treatments and anti-ageing medicine, as well as offering skin rejuvenation and a range of dermatology treatments. This service provides independent doctor-led dermatology services, offering a mix of regulated skin treatments and minor surgical procedures, as well as other non-regulated aesthetic treatments.

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

Overall summary

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. Sk:n Manchester Albert Square provides a wide range of non-surgical aesthetic interventions, for example, cosmetic Botox injections and dermal fillers which are not within the CQC scope of registration. Therefore, we did not inspect or report on these services.

Sk:n Manchester Albert Square is registered with the Care Quality Commission to provide the following regulated activities: Treatment of disease, disorder or injury, Diagnostic and screening procedures and Surgical Procedures.

The service did not have a registered manager. The provider informed us that another registered manager within the group had been asked to apply to add the location Sk:n Manchester Albert Square to their existing registration on an interim basis, pending the return to work of the substantive clinic manager post holder. We were assured that the substantive post holder would be requested to re-apply upon their return to work.

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 a 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:

- Leaders and staff engaged positively in the inspection process and were open and transparent regarding the challenges they had experienced with the management of the service.
- The provider had established governance and monitoring processes to provide assurance to leaders that systems were operating as intended. Plans were in place to address outstanding action plans and to ensure continuous improvement in the service.
- There were safeguarding systems and processes to keep people safe.
- Clinical record keeping lacked detail in some areas.
- There were appropriate arrangements in place to manage medical emergencies. Risk assessments had been completed for any recommended medicines not stocked and suitable emergency equipment was in place.
- Recruitment checks had been carried out in accordance with regulations.
- There were comprehensive health and safety risk assessments and processes in place.
- The service routinely sought feedback from patients and used this information to monitor and improve the service.
- The provider had a comprehensive complaints procedure however documented evidence of resolutions had not always been maintained.

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

- The provider should ensure clinical records contain sufficient detail and information to provide appropriate audit trails of actions taken and by whom.
- Patients referred to other services should be followed up where appropriate, to ensure appropriate treatment plans have been put in place to safeguard patient safety.
- The provider should continue to embed their plans to improve the management of complaints records and staff awareness of the required processes.
- The provider should continue to support the management of the service to ensure consistent leadership and continuous improvement.

Dr Rosie Benneyworth BM BS BMedSci MRCGP
Chief Inspector of Primary Medical Services and Integrated Care

Our inspection team

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

Background to Sk:n - Manchester Albert Square

Sk:n Manchester Albert Square provides independent doctor-led dermatology services, offering skin treatments such as prescribing for acne and other skin conditions, and minor surgical procedures, including the excision of moles and other skin lesions. The service also provides non-regulated aesthetic treatments, for example, cosmetic Botox injections, laser hair removal, skin peels and hydrafacial procedures which are not within the CQC scope of registration.

The Registered Provider is Lasercare Clinics (Harrogate) Limited, who provide services from more than 50 locations across England.

Sk:n – Manchester Albert Square is located at 1 Albert Square, Manchester, M2 3FU

The clinic opening times are:

- Monday to Friday – 10:00 am – 8:00 pm
- Saturday – 9:00 am – 6:00 pm
- Sunday – 10:00 – 5:00 pm

The staff team is comprised of a clinic manager, supported by aesthetic practitioners who all provide only non-regulated aesthetic treatments. Doctors who specialise in dermatology, provide dermatology consultations and treatments at the clinic subject to client's individual needs and appointment bookings. Staff are supported by the provider's regional and national management and governance teams.

The service is located on the second floor and lift access is not available for clients of the clinic (only goods and services). The premises includes an office / refreshment area, five treatment rooms and a reception and waiting area. Patients are able to access toilet facilities within the building. Patients with limited mobility are diverted via the contact centre to more suitable locations such as the Sk:n Chester Vicars Lane.

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 Safe because:

The provider had developed safeguarding policies and procedures which provided appropriate guidance to staff. There were systems to assess, monitor and manage risks to patient safety. Staff had the information they needed to deliver safe care and treatment to patients. The service had systems in place to learn and make improvements should things go wrong.

Safety systems and processes

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

- The service had policies in place to safeguard children and vulnerable adults from abuse. Staff were supported to complete safeguarding training at a level appropriate for their role.
- We were informed that the Sk:n Manchester Albert Square Clinic did not offer treatment to patients under 18 years of age. Where there was doubt, staff asked patients to confirm they were 18 years of age or over. Clear guidance was provided to patients that children should not attend unless chaperoned by another adult in addition to the patient.
- The provider carried out all required staff checks at the time of recruitment. Disclosure and Barring Service (DBS) checks were undertaken for all staff. (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). All staff who acted as chaperones were trained for the role and had undergone a DBS check.
- We reviewed processes for the monitoring of staff immunisations. Records provided contained evidence of Hepatitis B status and other immunisation records where available. We noted that in response to inspection findings of other services, the organisation had developed a new policy on immunisations and was reviewing their approach to ensure staff immunisations were undertaken and monitored on an ongoing basis in partnership with occupational health.
- There were effective systems to manage infection prevention and control within the service. Cleaning and monitoring schedules were in place and all cleaning was carried out by staff employed within the service. Auditing of infection control was last undertaken in April 2022 following which the audit percentage score was 96%. Any areas requiring attention had been clearly highlighted for action and progress was routinely monitored.
- There were systems for safely managing healthcare waste, including sharp items. We saw that clinical waste disposal was available in clinical rooms and the clinic had a contract with a company for the disposal of clinical waste.
- There were sufficient stocks of personal protective equipment, including aprons and gloves. The service performed minor surgical procedures for which they used single-use, disposable items.
- There was a documented generic risk assessment in place to manage risk within the premises that was reviewed on a monthly basis. We were informed that the most recent version of the legionella (a bacterium which can contaminate water systems in buildings) risk assessment dated June 2017 related to a different layout of the building and therefore another legionella risk assessment had been commissioned. This was not available for inspection at the time of our visit; however, we were provided with a copy of the job sheet to confirm the risk assessment had been completed on 09 May 2022. We noted that there was a certificate of registration with the Legionella Control Association which was due to expire in August 2022 and evidence of water testing for the premises.
- The provider had carried out fire safety risk assessments. We noted that the building owner had completed a fire risk assessment on 19 March 21. The provider had also completed their own risk assessment on 23 June 2021 and no outstanding actions were noted. There was appropriate fire-safety equipment located within the service such as fire extinguishers and emergency lighting which had been regularly serviced and maintained.
- 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 wiring and portable appliances had undergone testing in March 2022.

Risks to patients

Good

Are services safe?

There were 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 patient demand.
- There were planned induction processes in place and a plan of required training for staff to complete as part of their induction process. The service was supported by the provider's central human resources team in this regard. Additionally, the provider had produced an e-learning policy which outlined the required training for staff to complete which included safeguarding training.
- Staff understood their responsibilities to manage emergencies and had received basic life support training which was routinely updated.
- There were appropriate professional indemnity arrangements in place for clinical staff.
- The provider had in place public and employer's liability insurance policies.
- The organisation's national contact centre was open from 09:00 am until 08:00 pm Monday to Saturday to offer help and support to patients. Outside of these hours patients were advised to seek emergency assistance.
- We reviewed arrangements within the service to respond to medical emergencies. There were suitable medicines and equipment to deal with medical emergencies which were stored appropriately and checked regularly. There was a risk assessment in place for emergency drugs to inform the rationale for any recommended drugs not being held at the clinic.
- There was a defibrillator and oxygen available on the premises which were subject to regular checks.

Information to deliver safe care and treatment

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

- Clinical records were stored on a secure, password-protected, electronic system. Hand-written active clinical records were stored securely in locked cabinets within a secure room.
- Patients attended the clinic for assessment and treatment of a variety of dermatological conditions such as mole, wart, verrucae and skin tag removals, facial thread veins and treatment of acne specialising in Roaccutane (a medicine used to treat acne). Clinical staff providing dermatological services had received specialist dermatology training and followed best practice guidance such as those provided by the British Association of Dermatologists (BAD).
- The service had systems for sharing information with staff and other agencies when necessary, for example the patient's NHS GP, to enable them to deliver safe care and treatment.
- The service had a system in place to retain medical records in line with Department of Health and Social Care (DHSC) guidance in the event that they cease trading.
- Clinicians made appropriate and timely referrals in line with protocols and up to date evidence-based guidance.

Safe and appropriate use of medicines

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

- The systems and arrangements for managing medicines, including emergency medicines and equipment minimised risks. The service kept prescription stationery securely and monitored its use.
- Staff prescribed medicines to patients and gave advice on medicines in line with legal requirements and current national guidance.

Track record on safety and incidents

The service had a good safety record.

Good

Are services safe?

- There were comprehensive risk assessments in relation to safety issues and to support the management of health and safety within the premises.
- The provider had developed monitoring processes which provided a clear, accurate and current picture to local and national leaders which led to safety improvements. A Medical Standards and Clinical Governance Committee ensured local and group oversight, and prompt intervention when required.
- The provider had produced an audit schedule to ensure ongoing monitoring and auditing of the service at specific intervals and to provide assurance to leaders that systems were operating as intended. Some of those process were implemented by regional and national support roles who worked closely with local managers to identify risks and implement improvements. For example, regional audit staff worked with local managers to undertake six-monthly auditing of all aspects of service delivery, including for example, a review of health and safety and premises safety, medicines management and infection, prevention and control. The last clinical audit was completed in May 2022 and the audit percentage score was 78%. Areas in need of review had been highlighted within the report and clear action plans had been produced

Lessons learned and improvements made

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

- There were systems for recording and acting on significant events. Staff understood their duty to raise concerns and report incidents and near misses via the provider's electronic reporting system. Local and national leaders supported them when they did so. There had been no significant events recorded within the past 12 months.
- There were appropriate systems for reviewing and investigating when things went wrong. The service learned, shared lessons across the organisation and took action to improve safety in the service.
- 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. Safety alert information and other organisational messaging such as medical team updates were cascaded to staff within local services via update bulletins issued by central teams and reinforced by local managers. The service acted on and learned from external safety events as well as patient and medicine safety alerts.

Good

Are services effective?

We rated effective as Good because:

The provider assessed needs and delivered care in line with current legislation and evidence-based guidance. The service was actively involved in quality monitoring activity. The provider obtained consent to care and treatment in line with legislation and guidance.

However, the provider should ensure clinical records contain sufficient detail and information to provide appropriate audit trails of actions taken and by whom.

The provider should also review the arrangements for following up patients referred to other services where appropriate, to ensure appropriate treatment plans have been put in place to safeguard patient safety.

Effective needs assessment, care and treatment

The provider had systems to keep clinicians up to date with current evidence-based practice however the management and maintenance of clinical records was in need of review.

- Clinicians employed by the service had high levels of skills, knowledge and experience to deliver the care and treatment offered by the service.
- Clinicians kept up-to-date with current evidence-based practice. Clinicians assessed needs and delivered care and treatment in line with relevant current legislation, standards and guidance. These included the National Institute for Health and Care Excellence (NICE) and British Association of Dermatologists (BAD) best practice guidelines.
- The service ensured they provided information to support patients' understanding of their treatment, including pre- and post-treatment advice and support. Staff within the service provided a telephone call prior to and following treatment to set expectations and follow-up any post-treatment advice. Patients were also able to access post treatment support via follow up appointments and on the telephone.
- We saw no evidence of discrimination when making care and treatment decisions.
- We reviewed clinical records relating to 10 patients who had received treatment within the service. We found variations in the quality of records completed by clinicians. For example, five out of 10 patient notes viewed were difficult to decipher and the name of the clinician was not clearly printed. Furthermore 2 out of 10 records viewed did not have an identifier number recorded on notes.
- We found one histology in the histology folder and only a verbal entry of referral to the patient's GP could be located in the records. We asked the provider to follow this matter up and were informed that the patient was referred to the care of the NHS by the Clinic and were seen very promptly, to a positive outcome on treatment. A letter was also sent by Sk:n to the patient's GP. The provider confirmed that they had requested a copy of the letter back from the GP to complete their records.

Monitoring care and treatment

The service was able to demonstrate quality improvement activity.

- The service used information about care and treatment to assess the need to make improvements.
- Medical Standards and Clinical Governance Committee provided a central structure under which patient treatment outcomes were monitored.
- Staff employed on a sessional basis were subject to review of their performance within the service and monitoring of their clinical decision making and patient treatment outcomes.

Good

Are services effective?

- Regional audit staff worked with local managers to undertake six-monthly auditing of all aspects of service delivery, including for example premises safety, policy and procedural management, infection prevention and control and medicines management.
- Auditing processes included staff interviews to confirm their level of knowledge and understanding. Service locations received a score and rating which reflected the level of risk identified by the audit. We found that the last clinical audit and the clinic manager CQC checklist audit of the service (both carried out on 17 May 2022) had identified several areas for improvement. Action points arising from the audit had been identified and systems were in place to ensure these were monitored and acted upon.

Effective staffing

Staff had the skills, knowledge and experience to carry out their roles however evidence of additional training completed by some Doctors was in need of review.

- The provider understood the learning needs of staff and provided protected time and training to meet them. Records of training completed by Doctors were in need of review as some gaps were identified. We received assurance from the provider that up-to-date certificates had been requested from Doctors where necessary.
- There were planned induction processes in place and a plan of required training for staff to complete as part of the induction process.
- Clinical staff employed on a sessional basis provided evidence of their professional external appraisal summary to the provider and participated in weekly meetings.

Coordinating patient care and information sharing

Staff worked with other organisations when necessary, to deliver effective care and treatment however some aspects of patient follow-up needed review.

- Patients who used the service received coordinated and person-centred care. Staff referred to other services where appropriate however the arrangements for following up patients referred to other services, for example with a malignant histology, was in need of review.
- Before providing treatment, doctors at the service ensured they had adequate knowledge of the patient's health, previous medical and their medicines history.
- All patients were asked for consent to share details of their consultation and any medicines prescribed, with their registered GP when they registered with the service.
- Patient information was shared appropriately, and the information needed to plan and deliver care and treatment was available to relevant staff in a timely and accessible way.
- There was a documented consent policy. Clinical records reviewed confirmed the consent process had been followed and discussions between the practitioner and patient had taken place.

Supporting patients to live healthier lives

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

- Patients were provided with information about procedures, including the benefits and risks of treatments provided.
- The service provided pre- and post-treatment advice and support to patients, for example about wound care.
- Patients were sent an email post treatment from the service to obtain feedback on the service provided.
- Where patients presented with concerns or complications post treatment, staff had access to nurses from across the organisation as well as a group medical standards team for advice, triage and support.

Good

Are services effective?

- If patients' needs could not be met by the service, staff would redirect them to the most appropriate service for their needs.
- Risk factors were identified, highlighted to patients and where appropriate highlighted to their normal care provider for additional support.

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. Staff were encouraged by the provider to complete training in the Mental Capacity Act 2005 however gaps were noted for this topic.

Good

Are services caring?

We rated caring as Good because:

Staff helped patients to be involved in decisions about their care and treatment. Staff understood the needs of patients and respected their privacy and dignity.

Kindness, respect and compassion

Staff treated patients with kindness, respect and compassion.

- Staff were supported to complete equality and diversity training to help them understand patients' personal, cultural, social and religious needs. They displayed a welcoming, understanding and non-judgmental attitude to patients.
- The service gave patients timely support and information in relation to their care and treatment.
- The service actively invited feedback on the quality of care patients received. The provider had partnered with Trustpilot and Reputation to collect, collate and publish reviews from patients and to help use the feedback to continually improve the services provided.

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. During the first contact with a patient, the provider's national contact centre gathered information to ensure all the patients' needs could be met.
- Information about procedures and pricing was available to patients on the service's website and within the clinic. Patients were provided with individual quotations for their treatment following their first consultation.
- The service had developed a patient information folder located within the waiting area. This provided information which included the provider's registration certificate, health care information, guidance on cosmetic procedures, data security information, a price guide, statement of purpose, complaints policy, terms of business, client selection and acceptable behaviour policy, and information on childrens' access to the clinic.
- Contact centre staff asked prospective patients about their accessibility needs, including whether they required interpretation or British Sign Language services. Clients requiring translation services were requested to arrange their own translation services from suggested companies or bring somebody to translate for them. The provider informed us that they were reviewing companies to set up a contract to provide telephone and in-person translation services for all clinics, to include British Sign Language. The provider informed us that they could also provide documents in large print or Braille if required and notified in advance.
- The clinic had a hearing loop installed.

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.
- Staff knew that if patients wanted to discuss sensitive issues, they could offer them a private room to discuss their needs.
- Chaperones were available should a patient choose to have one. The provider's chaperone policy was on display in the waiting area. All staff who provided chaperoning services had undergone required employment checks and received training to carry out the role.

Good

Are services caring?

- Staff complied with the service's information governance arrangements. Processes ensured that all confidential electronic information was stored securely on computers. All patient records and information kept as hard copies was stored in locked cabinets within a locked room. Staff working in the reception area operated a clear desk policy and hard copy documents were promptly locked away.

Good

Are services responsive to people's needs?

We rated responsive as Good because:

The service organised and delivered services to meet patients' needs. Feedback was routinely sought from patients to monitor their experience and to improve the service. Patients were able to access care and treatment from the service within an appropriate timescale for their needs.

However, the provider should continue to embed its plans to improve the management of complaint records and develop staff knowledge and skills in relation to complaint management.

Responding to and meeting people's needs

The service organised and delivered services to meet patients' needs. It took account of patient needs and preferences.

- The provider understood the needs of their patients and improved services in response to those needs. Doctor-led dermatology services were provided according to patient need.
- The facilities and premises were appropriate for the services delivered however they were not accessible for people with limited mobility, as the clinic was located on the second floor of the building. Patients with limited mobility were diverted to access a more suitable clinic for their needs.
- 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 provider had an account with an independent provider, to offer British Sign Language support services to patients.
- We reviewed publicly available information regarding patient experiences at the service. The service encouraged patients to use Trustpilot to review and rate their experience. The provider's website included a direct link to all Trustpilot reviews. At the time of our review Trustpilot showed the service was rated 4.8 out of 5 based on 241 mainly positive reviews.
- The provider also provided us with the results of their Reputation feedback results for the period 17 February 2022 to 17 May 2022. This indicated that 61 reviews had been received via surveys and 10 reviews via Google. 57 patients provided positive reviews, one patient provided a neutral score and 13 patients provided negative reviews. The reputation score was 471 and rated fair. The provider monitored feedback, trends and performance closely, to identify areas to improve performance.

Timely access to the service

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

- Patients had timely access to initial assessment, test results, diagnosis and treatment.
- Waiting times, delays and cancellations were minimal and managed appropriately.
- Patients were able to register their interest in booking an appointment via the provider's website and this was followed up by the national contact centre.
- Appointments could be booked in person or by telephone. Evening and weekend appointments were available.
- Referrals and transfers to other services were undertaken in a timely way.

Listening and learning from concerns and complaints

The service did not consistently respond to complaints appropriately.

Good

Are services responsive to people's needs?

- The service had a complaints policy in place and information about how to make a complaint or raise concerns was available for patients to read in the reception area and on the provider's website.
- The service clearly informed patients of any further action that may be available to them should they not be satisfied with the response to their complaint. The service's written complaints policy included up-to-date information to support patients should their complaint remain unresolved. For example, there was reference within the policy to the Independent Sector Complaints Adjudication Service (ICAS) from whom additional advice and support may be sought.
- Records indicated that the clinic had received four complaints within the previous 12 months which pertained to regulatory activities. A complaints summary report had been produced which included an analysis of trends and timelines. The provider indicated that they had been unable to locate any documented evidence of the resolution provided in relation to three of the complaints although some actions had been recorded.
- The provider informed us that the management of complaints had been impacted by the Covid-19 pandemic, clinic closures and changes in staff and management. Furthermore, the ability to evidence that complaints had been managed in accordance with the provider's policies and procedures was not available in its entirety. The provider had identified the shortfalls and in response had established a new complaints department in September 2021. The new department was working to provide guidance, resource and future training in complaints management.

Good

Are services well-led?

We rated well-led as Choose a rating because:

The provider had established clear responsibilities, roles and systems of accountability to support good governance. Processes were in place for monitoring and managing risks, issues and performance concerns within the service.

However, the provider should continue to support the management of the service to ensure consistent leadership and continuous improvement

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 and were open and transparent regarding factors that had impacted upon the operation of the clinic. For example, the provider informed us of difficulties they had experienced due to a number of changes in the management of the clinic and in managing the performance of a previous manager following the acquisition of another brand that was co-located within the same building. We were informed that the provider had arranged for an exit audit to be undertaken following which several concerns were identified. For example, a lack of team meetings, missing bulletin and policy sign off sheets, missing cleaning checklists and mandatory training not being up-to-standard. We were assured that in response to the findings, the provider had identified additional resources to support the ongoing development of the clinic, address the findings of audit action plans and to improve and sustain standards.
- The provider had effective processes to develop leadership capacity and skills, including planning for the future leadership of the service. At the time of our inspection, the service did not have a registered manager. The provider informed us that another registered manager within the group had been asked to apply to add the location Sk:n Manchester Albert Square to their existing registration on an interim basis, pending the return to work of the substantive clinic manager. We were assured that the substantive post holder would be requested to re-apply to become the registered manager upon their return to work.
- Leaders at all levels within the service were visible and approachable. They worked closely with staff to make sure they prioritised compassionate and inclusive leadership. For example, on the day of our site visit, the inspection team was supported by the director of governance and risk management, the CQC nominated individual, the audit lead and the audit manager.
- There was a local, regional and national staffing structure in place across the organisation and staff were aware of their individual roles and responsibilities. The provider had identified individual members of staff to assume lead roles in key areas.
- Leaders demonstrated the capacity to implement systems and processes to support the delivery of high-quality care. They understood the challenges and had developed strategies focused upon key areas including clinical governance, risk management and the use of technology.

Vision and strategy

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

- There was a clear vision and set of values. The service had a realistic strategy and supporting business plans to achieve their priorities.
- Staff were aware of and understood the vision, values and strategy and their role in achieving them.

Good

Are services well-led?

- The provider had set out clear brand values which were to be accessible, approachable, expert and responsible. The organisation's values focused upon brand reputation, customer experience and customer loyalty. The organisation's mission statement was "Inspiring greater confidence through better skin."
- The service monitored progress against delivery of the strategy. It periodically carried out 'mock' CQC audits to assess and monitor the quality of care provided.

Culture

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

- Leaders and managers acted on behaviour and performance inconsistent with the vision and values.
- The provider informed us that there had been no significant events in the past 12 months relating to the regulated activities carried out by the service.
- The provider was aware of and had systems in place to ensure compliance with the requirements of the duty of candour.
- Staff felt respected, supported and valued. The service focused on the needs of patients.
- There was a culture of promoting positive relationships and prompt and effective communications between staff. However, the most recent clinical audit (undertaken the day before our inspection) indicated that there was no evidence of regular team meetings or one to one meetings for staff. We saw documentary evidence that a staff meeting had been coordinated in January 2022 and organisational communications were shared across the organisation. For example, in the form of bulletins which staff within local services were required to sign to confirm their receipt and understanding.
- There was an emphasis on the safety and well-being of all staff.
- The service actively promoted equality and diversity and staff were supported to complete equality and diversity training.

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 and understood.
- Regional and national structures implemented by the provider, for example, clinical governance and central medical committees ensured appropriate levels of oversight and support to local teams, to ensure consistent and effective governance arrangements.
- Staff understood their individual roles and responsibilities. The provider used performance information, which was reported and monitored, and management and staff were held to account.
- Leaders had established appropriate policies, procedures and activities to ensure safety and assure themselves that they were operating as intended.
- Leaders had regular update meetings with the medical director, to highlight any changes and to discuss patients' specific needs. Leaders understood the need to submit data or notifications to external organisations when required.
- There was a system for cascading information within the organisation.
- There were arrangements in line with data security standards for the availability, integrity and confidentiality of patient identifiable data, records and data management systems. Correspondence sent from the service was emailed through an encryption service to ensure confidentiality.
- The information used to monitor performance and the delivery of quality care was accurate and useful. There were plans to address any identified weaknesses.

Good

Are services well-led?

- Confidential electronic information was stored securely on computers. All active patient information kept as hard copies was stored in locked cabinets within a locked room. Staff demonstrated a good understanding of information governance processes.
- The provider ensured document management processes were followed, which included version control, author and review dates.

Managing risks, issues and performance

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

- There were mainly effective governance processes to ensure leaders were able to identify, understand, monitor and address current and future risks including risks to patient safety.
- Leaders had oversight of safety alerts, incidents and complaints. There was a system for recording and acting upon significant events. Staff understood their duty to raise concerns and report incidents and near misses. Leaders and managers supported them when they did so.
- 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 service had processes to manage current and future performance. Performance of clinical staff was subject to review via audit of their consultations and patient treatment outcomes.

Appropriate and accurate information

The service did not always maintain appropriate and accurate information.

- Quality and operational information was used to ensure and improve performance. The service used feedback from patients combined with performance information to drive improvement.
- The provider carried out all required staff checks at the time of recruitment and all required ongoing monitoring, such as professional registration status and medical indemnity confirmation.
- Individual care records were documented within clinical notes although we found variations in the quality of records completed by clinicians.

Engagement with patients, the public, staff and external partners

- The service encouraged and heard views and concerns from the public, patients, staff and external partners but could not always demonstrate it had acted appropriately on complaints from patients.
- Patients were asked to provide feedback following their treatment at the service.
- The service was transparent, collaborative and open with stakeholders about performance.
- Staff felt confident in providing feedback to managers. The provider had identified a freedom to speak up guardian to provide additional support to staff.

Continuous improvement and innovation

There was evidence of systems and processes for learning, continuous improvement and innovation however some training records needed review to evidence the full range of training completed by Doctors.

- There was a focus on continuous improvement.
- The service made use of internal and external reviews of incidents and complaints. Learning was shared and used to make improvements.

Good

Are services well-led?

- Leaders and managers encouraged staff to take time out to review individual and team objectives, processes and performance.

There were systems to support improvement and innovation, including a focus on the use of digital technology to drive improvement and share information across the organisation.