A New You (Brighton) Limited

Inspection report

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Brighton
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Date of inspection visit: 05/07/2021 to 12/07/2021
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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	Inadequate
Are services safe?	Inadequate
Are services effective?	Inadequate
Are services caring?	Requires Improvement
Are services responsive to people's needs?	Good
Are services well-led?	Inadequate

Overall summary

This service is rated as Inadequate overall.

The key questions are rated as:

Are services safe? – Inadequate

Are services effective? – Inadequate

Are services caring? – Requires improvement

Are services responsive? – Good

Are services well-led? – Inadequate

We carried out an announced comprehensive inspection at A New You (Brighton) Ltd on 5 July 2021 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. This was the provider's first inspection of the service since it registered with the Care Quality Commission (CQC).

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 using video conferencing.
- Requesting documentary evidence from the provider.
- A site visit.

We carried out an announced site visit to the service on 5 July 2021. Prior to our visit we requested documentary evidence electronically from the provider. We spoke to staff using video conferencing following our site visit, between 6 and 12 July 2021.

A New You (Brighton) Ltd is an independent provider of consultations and treatment for dermatological conditions, including acne and rosacea, prescription skincare, and mole removal and screening. Botox (Botulinum toxin) injections are provided for the treatment of excessive sweating. The service also provides pre- and post-operative consultations for surgical cosmetic treatments and follow up care post-surgery. Surgery is carried out at other locations that are independent of this 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

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. A New You (Brighton) Ltd also provides a wide range of non-surgical aesthetic interventions. This included 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 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. Immediately prior to our site visit, the provider submitted an application to provide Surgical procedures as a regulated activity.

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 was a lack of monitoring of training undertaken by staff and those employed on a sessional basis. There was a lack of training for staff in some key areas.
- There was a lack of performance review, clinical supervision and monitoring of clinical staff employed on a sessional basis. Staff employed by the service had not recently undergone appraisal.
- Systems for the safe and appropriate use of medicines were not in place. Medicines requiring refrigeration were not stored or monitored to ensure they remained safe and effective.
- Prescribing practices were not adequately monitored to identify risks to patients. There was a lack of auditing of clinical and prescribing processes.
- There was a lack of effective 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 vaccination.
- There was a lack of safeguarding systems and processes to keep people safe. Some staff had not received training in the safeguarding of adults or children.
- Arrangements for chaperoning were not effectively managed. Staff had not received chaperone training and had not been subject to Disclosure and Barring Scheme (DBS) checks.
- Although there were suitable emergency medicines in place, arrangements to manage medical emergencies had not been risk assessed.
- Patient safety alerts had not been received or monitored by the service.
- Fire safety processes were in place. Staff had participated in fire drills and had received fire safety training.
- There were general health and safety risk assessments in place.
- There was a lack of governance and monitoring processes to provide assurance to leaders that systems were operating as intended.
- Best practice guidance was not always followed in providing treatment to patients. For example, in the assessment and removal of lesions and weight management prescribing requirements.
- There was an inconsistent approach to clinical record keeping and a lack of information governance processes. Key records and documents were missing for some patients.
- There were no records to demonstrate that recruitment checks had been carried out in accordance with regulations, including for clinical staff employed on a sessional basis.
- Policies and procedures were not monitored, reviewed and kept up to date. Policies failed to provide relevant and sufficient information.

Overall summary

- Staff found leaders approachable and supportive and felt they provided an individual service to patients.
- 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
- Ensure persons employed in the provision of the regulated activity receive the appropriate support, training, professional development, supervision and appraisal necessary to enable them to carry out their duties.

We 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 Proposal under Section 18 of the Health and Social Care Act 2008 to suspend the provider's registration. The provider submitted written representations to us which were not upheld. 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. This notice to suspend the provider's registration was issued because we believed that a person will or may be exposed to a risk of harm if we did not take this action. The provider had the right to make an appeal to the First-tier Tribunal. The period of suspension became effective on 18 November 2021. The provider will be inspected again prior to the expiry of the suspension to assess whether sufficient improvements have been made.

We also issued a Requirement notice in relation to Regulation 18(1)(2) Staffing.

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

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

- Develop the service's complaints policy to include information to support patients should their complaint remain unresolved.

I am placing this service into special measures. Services placed in special measures will be inspected again within six months. If insufficient improvements have been made such that there remains a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating the service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve.

The service will be kept under review and if needed could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement, we will move to close the service by adopting our proposal to remove this location or cancel the provider's registration.

Special measures will give people who use the service the reassurance that the care they get should improve.

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**.** The team included a national clinical advisor and a second CQC inspector.

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 pre and post-operative consultations for surgical cosmetic treatments and follow up care post-surgery. Surgery is carried out at other locations that are independent of this 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.

There were eight members of staff employed by A New You (Brighton) Limited involved in the delivery of regulated activities and five consultant surgeons provided pre- and post-operative consultation services to patients on an ad-hoc, sessional basis.

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.

Inadequate

Are services safe?

Safety systems and processes

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

- The service had a lack of systems to safeguard children and vulnerable adults from abuse. We reviewed the provider's safeguarding and safety policy. We found that this did not provide sufficient detail or guidance for staff. For example, there was a lack of guidance for staff on how to raise safeguarding concerns about a patient. Staff we spoke with were unclear as to who the safeguarding lead within the service was and this was not stated within the policy. There was no reference to local safeguarding arrangements or contact details of local safeguarding teams within the policy or on display within the service. The policy contained a link to a national newspaper article on children's services dated 2003 which was not relevant to the policy. Staff we spoke with demonstrated an understanding of what would constitute a safeguarding concern. However, staff we spoke with were unclear as to how they would raise a safeguarding concern. Some staff had not received training in safeguarding adults or children. We reviewed training records and found a record of adult and child safeguarding training for only one staff member. The provider told us they did not hold records of safeguarding training completed by staff employed on a sessional basis.
- Prior to our inspection the provider sent us their employee handbook and told us that this represented their recruitment policy. We noted that the handbook had last been reviewed in August 2017. We found the staff handbook did not outline what recruitment checks would be completed prior to a staff member commencing their employment. During our inspection the provider told us they would require details of history of employment in the form of a CV and that staff were required to attend two interviews, an off-site meeting and a trial day, prior to any offer of employment. They told us that verbal or written references would always be obtained from a previous employer and that details of professional registration and medical indemnity would be obtained where applicable.
- At our inspection on 5 July 2021 we reviewed four personnel files of six that were available to us. Staff told us there were no files available for two staff members and no records available relating to the consultant surgeons who provided services on a sessional basis. Our review of personnel files found one CV in one file and one reference in another file. We found that proof of identity was held for two staff members. We saw no evidence that professional registration, professional qualifications or evidence of medical indemnity had been checked for any staff at the point of recruitment. We viewed two references on a personal electronic device for one staff member for whom there was no personnel file available. The provider was unable to provide any further evidence that required recruitment checks had been carried out.
- Disclosure and Barring Service (DBS) checks had not been undertaken for any staff members. (DBS checks identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable).We reviewed four personnel files of six that were available to us and found no evidence of DBS checks. There was no evidence of DBS checks for consultant surgeons who provided consultations within the service. There had been no assessment of the risks associated with permitting staff and consultants to provide services without a DBS check. The registered manager told us they had recently submitted their own application for an updated DBS check.
- Staff we spoke with told us that patients were routinely offered a chaperone and that either a nurse or a member of administration staff would undertake that role. We saw no evidence of a documented chaperone policy and no signage on display which prompted patients to request a chaperone. We found that those staff had not undergone chaperone training and had not been subject to a DBS check or an associated risk assessment.
- 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, 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. An annual health and safety review was undertaken and had last been documented on 12 October 2020. Resulting actions such as display screen equipment assessments for administration staff had been completed.

- The provider had carried out regular fire safety risk assessments. Staff had last participated in a fire drill on 20 April 2021. There was appropriate fire-fighting equipment located within the premises which was regularly serviced and maintained. The service had designated staff who were trained as fire marshals and staff had undertaken fire safety training.
- 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 October 2020.
- There was a lack of effective systems to manage infection prevention and control within the service. Cleaning and monitoring schedules were in place for individual treatment rooms. The premises were generally well maintained, and all floors were uncarpeted. However, the provider had not undertaken an audit of their infection prevention and control processes.
- At our inspection on 5 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. For example, syringes and antiseptic skin cleaning solutions. We reviewed the provider's infection, prevention and control policy which was sent to us prior to our inspection visit but was not dated. We found that this did not provide sufficient detail or guidance for staff. For example, the policy did not include specific guidance on handwashing, use of personal protective equipment, staff training or specimen handling. There was no specific reference to COVID-19 in the policy. There was a brief, documented risk assessment in place which identified the measures the provider had taken to minimise the risks associated with COVID-19. Staff were unclear as to who was the lead for infection control within the service and this was not stated within the policy. Staff had not received training in infection prevention and control. The provider told us they did not hold records of infection prevention and control training completed by staff who worked on a sessional basis.
- 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. During our inspection on 5 July 2021 we reviewed four personnel files of six that were available. Our review of personnel files identified one Hepatitis B status record for one staff member. There were no other vaccination records available for the remaining staff members. The provider confirmed they were unaware of Public Health England guidance (PHE) which outlines the recommended programme of vaccination for frontline healthcare staff (varicella, tetanus, polio, diphtheria and MMR (measles, mumps, rubella). The provider was unable to provide any further assurances that staff had received the required vaccinations.
- 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 was a lack of 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.

Inadequate

Are services safe?

- 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. Our review of four staff files identified induction records for two staff members. However, there was no 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). The service did not have oxygen or a defibrillator on site and no documented risk assessment in place to assess the level of risk to patients in the event of a medical emergency or the need for emergency equipment. There was no risk assessment relating to how a medical emergency would be managed in the absence of emergency equipment. For example, a supply of oxygen to support patients who developed anaphylaxis. We found that not all sessional clinical staff were aware that oxygen was not held on site.
- Prior to our inspection the provider sent us a policy document entitled 'medical emergency'. This document provided some brief information about notifications required to be made to the Care Quality Commission. There was no guidance provided to staff within the document on how they should respond in a medical emergency. We reviewed the provider's record of employee training, dated 1 July 2021, and looked at staff personnel files. We found evidence that one staff member had completed basic life support training. There were no records held regarding life support training completed by sessional staff.
- 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 2020. However, there was a lack of monitoring to ensure appropriate professional indemnity arrangements were in place for sessional clinical staff.

Information to deliver safe care and treatment

Staff did not have the information they needed to deliver safe care and treatment to patients.

- At our inspection on 5 July 2021, we found that a combination of hand-written and electronic records were 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. We reviewed clinical records relating to six patients who had received treatment within the service. The records we saw did not always contain information we would expect to see, for example the patient's date of birth. 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 evidence that risks to the patients had been discussed or documented. There was a lack of evidence of treatment plans for some patients. We found a lack of recording of batch numbers of medicines used and a lack of recording of suture material and type, within some records. Staff told us there had been technical errors which occurred when some records were completed electronically, on a hand-held device, and then failed to upload onto the provider's clinical records system. Staff told us this resulted in the record being permanently lost from the system. We were not provided with evidence to demonstrate that this had been reviewed or treated as a significant event.
- Patient GP details were not always recorded and where a patient had declined to share their GP information, there was no documented evidence to state this. Staff told us they would share information with the registered GP where this was appropriate, and when they had patient consent to do so. However, there was no evidence that information had ever been shared with a GP and staff we spoke with were unable to provide an example.
- Patients attended the clinic for assessment and treatment of skin lesions such as moles, lipomas and cysts. 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). The provider told us they did not send specimens for histological examination in line with BAD guidance but were unable to provide research-based evidence to support this decision. Staff told us if a lesion appeared suspicious, they would refer the patient back to their registered GP. In such an instance, the service relied upon the patient to contact their GP and did not share their concerns directly with the GP.

- Protocols for the prescribing of weight management medicines (Saxenda) were unclear and did not follow prescribing and monitoring requirements. We reviewed the clinical records of one patient who had been prescribed Saxenda. We noted the patient had not undergone blood pressure monitoring as part of their initial consultation prior to treatment and subsequent follow up consultation notes were incomplete.

Safe and appropriate use of medicines

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

- 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.
- At our inspection visit on 5 July 2021, we looked at the arrangements in place for the safe storage of medicines. We saw that medicines requiring refrigeration were stored within a lockable refrigerator. Within the refrigerator we found multiple items which had expired. The refrigerator had a freezer compartment, which meant it was unsuitable for the purpose of storing medicines. We found medicines stored directly beneath the freezer compartment had partially frozen. Medicines requiring refrigeration should be stored according to the manufacturer's summary of product characteristics, which is usually between +2 ° C and +8 ° C, to ensure they remain safe and effective. Temperature monitoring records confirmed twice daily checks of the fridge temperature. However, neither the fridge nor the thermometer enabled the temperature range to be recorded for a given period and so only the actual temperatures had been recorded. We noted that in one 36-hour period the temperatures recorded exceeded the required range, but no action had been taken to ensure the safety of medicines stored within the fridge or to provide a reason for the high temperatures.
- On 5 July 2021 we reviewed patient prescription records and prescribing processes. We found that prescribing processes did not support the easy tracking of patient prescriptions. The security of access arrangements for online prescription ordering processes was unclear and the provider did not demonstrate that individual prescribers log-in details were kept safe. For example, we found that administration staff had access to one prescriber's log-in details for an online ordering and prescribing site. Staff told us this was an oversight due to the staff sharing computers.
- We identified an example of significant overprescribing of an injectable local anaesthetic for one patient. We found the excess medicines for that patient stored within the medicines' fridge. The medicines had reached their expiry date for safe usage in December 2020. The provider was unable to explain why those medicines had been prescribed in such volumes and why the excess medicines had been retained.
- There was no audit or clinical oversight of prescribing practices within the service. Staff who were prescribers confirmed there were no arrangements in place for clinical supervision of their prescribing practices.

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 a lack of monitoring and review of activities to support the provider in identifying potential risks within the service. The provider did not have sufficient monitoring information to provide a clear, accurate and current picture which led to safety improvements.

Lessons learned and improvements made

The service had a lack of systems to ensure they learned when things went wrong.

Inadequate

Are services safe?

- 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. The significant event log sent to us by the provider listed two events which had occurred between December 2020 and May 2021. During our inspection we identified incidents that we would expect to be considered as significant events. We reviewed health and safety records and found that minor accidents had been reported using an accident form. There was no evidence that incidents had been discussed and the learning shared amongst the team. We were not shown documented evidence of staff meetings where incidents may have been discussed.
- We reviewed the provider's patient safety alert policy and found that this did not provide sufficient detail or guidance for staff. For example, the policy did not confirm who the lead was within the service for monitoring patient safety and medicines alerts and how action would be taken to ensure alerts were responded to appropriately. 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. The provider told us they intended to establish systems to ensure that alerts would be disseminated to all members of the team and acted upon appropriately going forward.

Inadequate

Are services effective?

Effective needs assessment, care and treatment

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

- Clinical staff employed by the service did not always have the knowledge and experience to deliver the care and treatment offered by the service. For example, staff involved in the delivery of dermatology services, such as the screening and excision of moles and other lesions, confirmed they had not received any specialist training.
- We found that care and treatment was not always delivered in line with relevant current legislation, standards and guidance. For example, the British Association of Dermatologists (BAD) best practice guidance had not been implemented in the screening and treatment of moles and other lesions. The provider was unable to provide research-based evidence to support this decision.
- Our review of clinical records confirmed that patients prescribed weight loss treatments such as Saxenda were not managed in line with prescribing and monitoring requirements guidance, as set out by the manufacturer.
- We reviewed clinical records relating to six patients who had received treatment within the service. We saw that the service used a template to record information about the patient. This included their previous medical history, medicines being taken and known allergies. We found this was not consistently completed for each patient and was not always legible.
- Staff assessed and managed patients' pain where appropriate. Patients were prescribed local anaesthetic medicines prior to some procedures, where appropriate.
- We saw no evidence of discrimination when making care and treatment decisions.

Monitoring care and treatment

The service was unable to demonstrate quality improvement activity.

- The service was unable to demonstrate that it gathered and used information about care and treatment to make improvements.
- 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 prescribing clinical supervision for staff who were prescribers. There were no auditing or clinical supervision arrangements in place for staff providing dermatology services. There had been no auditing of infection prevention and control processes. There were no audits of clinical records to monitor compliance against the provider's expected standards of record keeping and to ensure completeness.
- Staff employed on a sessional basis were not subject to a structured review of their performance within the service and there had been no auditing of their clinical decision making or patient treatment outcomes.

Effective staffing

Staff did not always have 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. Our review of four staff files identified induction records for two staff members.
- 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. Some staff had completed training in fire safety, health and safety, first aid and legionella awareness in the days preceding our site visit. There were no training records which reflected training completed prior to that time. Staff employed within the service, including the registered manager, had not completed training in, for example: 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. There were no records held of skills and qualifications required to support a specific role. Staff involved in the delivery of dermatology services, such as the screening and excision of moles and other lesions, confirmed they had not received any specialist training.

- There was no clear approach to staff appraisal. We reviewed staff files and were unable to find evidence of recent appraisal of any staff member. Our review of files included those of clinical staff working on a sessional basis. We found those staff had not been subject to a review of their performance within the service or auditing of their clinical decision making and patient treatment outcomes. Following our inspection, the provider sent us some brief notes of observations they had made of three staff members. For example, the registered manager had observed the removal of sutures for a patient by one staff member. The registered manager told us that clinical staff employed on a sessional basis conducted the registered manager's appraisal, but we were unable to see evidence of this.
- 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 no evidence of initial or ongoing monitoring of professional registration. There were no records held which confirmed doctors were registered with the General Medical Council (GMC) or 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 referred to and communicated effectively with some other services. For example, the service provided pre and post-operative consultations and care for surgical cosmetic treatments carried out at hospitals independent of the service. The service had appointed a surgical coordinator who liaised directly with the hospitals where surgery was carried out to ensure all necessary arrangements were in place. There was a flexible approach between the service and those other locations, in ensuring that patients received the support they required post-operatively.
- Before providing treatment, doctors who undertook cosmetic surgery consultations told us they ensured they had adequate knowledge of the patient's health and previous medical history. The service had developed links with a local psychotherapy service and referred patients directly where such support was required.
- Patients were asked for consent to share details of their consultation with their registered GP. However, patients' GP details were not always recorded and where a patient had declined to share their GP information, there was no documented evidence to state this. There was no evidence of an explanation to patients why sharing information with their GP was important, in line with General Medical Council guidance. 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. We found no records of occasions where this had happened.

Supporting patients to live healthier lives

- Patients were provided with some information about procedures, including the benefits and risks of treatments provided. The service provided responsive pre and post-operative 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 decline to treat the patient and would refer the patient back to their GP. In such an instance, the service relied upon the patient to contact their GP and did not share their concerns directly with the GP.
- Where lesions were removed or treated within the service, samples were not routinely sent for histology.

Consent to care and treatment

The service did not have adequate processes to ensure consent to care and treatment was obtained in line with legislation and guidance.

Inadequate

Are services effective?

- 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. Staff told us that all patients who attended the service for cosmetic surgery consultation were subject to a two-week cooling-off period before booking and consenting to surgery.
- However, 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 inadequate and did not clearly document the consent process and discussions between the practitioner and patient. There was no field for the clinician to sign and no date field on the form.
- The service had failed to adequately monitor the process for obtaining consent and had not undertaken auditing of the consent process, despite staff being aware of some problems associated with the storage of some documents within the clinical records system.

Requires Improvement

Are services caring?

Kindness, respect and compassion

Staff treated patients with kindness, respect and compassion.

- 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. We reviewed one recent example whereby the service had responded promptly and appropriately to negative feedback via direct contact with the patient and had identified learning as a result of the comments made. Feedback 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.
- Staff understood patients' personal, cultural, social and religious needs. They displayed an understanding and non-judgmental attitude to all patients.
- The service gave patients timely support and information in relation to their care and treatment.
- Prior to the inspection we reviewed publicly available information regarding patient experiences at the service. At the time of our review we saw there were 50 reviews on Google, which rated the service as 3.7 out of 5 stars. The positive comments included; kind and reassuring staff, tailored service, welcoming, polite staff. The negative comments related to unclear costs, treatment not meeting expectations, and disorganisation at the service.

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.

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. However, not all staff who provided chaperoning services had undergone required employment checks and received training to carry out the role.
- Information governance arrangements did not always ensure that confidential information was held securely. Staff had not received information governance training and we saw no evidence of an information governance policy to provide guidance to staff. Processes did not always ensure that all confidential electronic information was stored securely. For example, the security of access arrangements for online prescription ordering processes did not

Requires Improvement

Are services caring?

demonstrate that individual prescribers log-in details were kept safe. During our inspection we were informed of a technical error that resulted in some patient records being lost during electronic transfer. 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. However, at the time of our inspection we found some paper records were held insecurely within the reception area.

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 generally 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 an evening appointment to provide ease of access for a patient who was partially sighted.

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, a surgical coordinator liaised directly with the hospitals where cosmetic surgery procedures were carried out to ensure all necessary arrangements were in place for patients.

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. Staff treated patients who made complaints compassionately.
- The practice had recorded one complaint within the previous 12 months and was able to demonstrate how appropriate and timely actions were taken in response to a complaint.
- There were no arrangements in place to signpost patients who may not be satisfied with the response to a complaint. Staff were unclear as to what support was available to patients should their complaint remain unresolved. The practice's written complaints policy did not include up to date information to support patients should their complaint remain unresolved.
- There was no evidence that complaints had been discussed and the learning shared amongst the team. We were unable to see any documented evidence of staff meetings where complaints may have been discussed. Sessional staff we spoke with were unclear on the complaints policy or process.

Inadequate

Are services well-led?

Leadership capacity and capability:

Leaders had not demonstrated the capacity and skills to deliver high-quality, sustainable care.

- Leaders had not demonstrated the 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 had recently appointed a new manager within the service in order to further develop quality and governance processes.
- There were informal but 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 but there were no records of those meetings. Clinical staff employed on a sessional basis were subject to some informal observation by leaders but there were no documented arrangements for clinical supervision in place.

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.

Culture

There was a lack of systems and processes to support a culture of high-quality sustainable care.

- The service was focused upon the needs of patients but did not have the systems and processes in place to support a culture of high-quality sustainable care.
- We found no evidence that staff had received regular review of their performance or assessment of their training and professional development needs. There was a lack of performance review, monitoring and evaluation of the clinical decision making undertaken by clinical staff employed on a sessional basis. Staff had been provided with time to complete some required on-line training in the days preceding our site visit. There were no training records which reflected training completed prior to that time.
- Staff told us they could raise concerns and suggestions for improvement and were encouraged to do so. For example, one clinical staff member told us they had requested additional time between appointments to allow for cleaning of the treatment rooms. This had been responded to and implemented promptly by leaders.
- There were positive relationships between staff and regular informal communications within the team. Staff told us they felt respected, supported and valued.

Governance arrangements

There was a lack of clear responsibilities, roles and systems of accountability to support good governance and management.

Inadequate

Are services well-led?

- Structures, processes and systems to support good governance and management were not clearly set out, understood or established. The provider had been aware of some of the issues and priorities relating to the quality and governance of the service and highlighted those to us immediately prior to our inspection.
- Staff understood their individual roles and responsibilities. However, the provider had not identified individual members of staff to assume lead roles in key areas. For example, safeguarding and infection prevention and control and staff lacked training to assume those lead roles.
- The provider had not established appropriate policies, procedures and systems to ensure services were delivered safely. Prior to our inspection the provider sent us a range of key policies at our request. The policies were not dated and there was no date for review indicated. We found the 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. For example, there was no reference to local safeguarding arrangements or contact details of local safeguarding teams within the safeguarding policy or on display within the service. Some policies failed to provide essential information to staff and did not reflect current good practice guidance. For example, the policy for infection prevention and control had not taken into account relevant guidance such as the Health and Social Care Act 2008 Code of Practice on the prevention and control of infections and did not include specific guidance on handwashing, use of personal protective equipment, staff training or specimen handling.
- We found that patient safety and governance arrangements within the service did not always consider relevant guidance. In establishing processes for responding to medical emergencies, the provider had not taken into account relevant guidance such as the 'Resuscitation Council UK, Emergency treatment of anaphylaxis - Guidelines for healthcare providers.'
- The provider had not assured themselves that policies and procedures were operating as intended to ensure the safety of staff and patients. For example, the medicines management policy outlined the process to be followed should the temperature range of the medicines fridge fall outside of the recommended range. However, our review of records confirmed that in one 36-hour period the temperatures recorded exceeded the required range, but no action had been taken to ensure the safety of medicines stored within the fridge or to provide a reason for the high temperatures.
- There was a lack of defined and documented processes and systems for the management of some key areas. For example, there was no clear process for carrying out staff recruitment checks, DBS checks, monitoring staff immunisation status or monitoring of staff training. There were no documented policies which provided guidance on for example, the consent process, chaperoning or clinical governance processes.
- Staff told us they had regular one-to-one interaction with managers. Staff spoke of some team meetings they had attended but we saw no records of those meetings. We were unable to see any documented evidence of staff meetings where for example, updates, incidents and complaints may have been discussed and shared with staff.
- The registered manager told us that there were no clinical governance meetings held to discuss topics relating to clinical care, due to the sessional nature of clinical staff attendance within the service. Clinical discussions were held on a one to one basis with the registered manager. However, we were unable to see evidence of those discussions.
- 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 was a lack of clear and effective processes for managing risks, issues and performance.

- There was a lack of effective governance processes to ensure leaders were able to identify, understand, monitor and address current and future risks, including risks to patient safety.
- There was a lack of oversight and processes to ensure safety alerts were acted upon. Patient safety alerts had not previously been received or monitored by the service.

Inadequate

Are services well-led?

- We reviewed the provider's significant event policy and significant event log and 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. There was no evidence that incidents had been discussed and the learning shared amongst the team. We were unable to see any documented evidence of staff meetings where incidents may have been discussed.
- The service had a lack of effective processes to manage current and future performance. There were no clear processes for undertaking recruitment checks, or the ongoing monitoring of clinical staff employed on a sessional basis. There was a lack of performance review, clinical supervision and oversight of those clinical staff. There was no auditing of their clinical decision making, record keeping or prescribing practices or review of patient treatment outcomes. There was no peer review or evaluation of the clinical decision making of the registered manager who undertook a clinical role. There was no clear approach to staff appraisal. We reviewed staff files and were unable to find evidence of recent appraisal of any staff member.
- Clinical staff we spoke with who were employed by the service on a sessional basis, were unclear as to the terms of their agreement with the provider. They told us there was no formal contract or agreement in place which set out the terms of their provision of services to the provider. The expectations and requirements of both parties in the provision of services, had not been established or documented.
- There was no evidence of a quality improvement programme or continuous clinical and internal audit in place to monitor quality and to drive improvements. The service had carried out no audits of patient records to review compliance with the provider's expected standards of clinical record keeping. This was despite staff being aware of problems associated with the storage of some documents within the clinical records system.
- The provider did not have a clear business continuity plan in place. We reviewed the provider's business continuity policy which was a brief statement outlining arrangements in the event that the director was unable to continue in the role. The policy stated that key person's insurance was in the process of being obtained.

Appropriate and accurate information

There was a lack of appropriate and accurate information available.

- There was a lack of quality, governance and operational information to monitor performance and drive improvement.
- The provider had not established appropriate policies, procedures and systems to ensure appropriate guidance for staff and to ensure services were delivered safely.
- There was an inconsistent approach to clinical record keeping. Records we reviewed were incomplete and did not always contain sufficient or accurate information.
- Staff told us they had attended some staff meetings. However, we were unable to see any documented evidence of staff meetings, where for example, updates, incidents and complaints may have been discussed and outcomes and learning from the meetings cascaded to staff.
- Information governance arrangements did not always ensure that confidential information was held securely. The security of access arrangements for online prescription ordering processes did not demonstrate that individual prescribers log-in details were kept safe. During our inspection we were informed of a technical error that resulted in some patient records being lost during electronic transfer. We found some paper records were held insecurely within the reception area.
- The service had not submitted information and applications to CQC as required. Prior to our inspection 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. Immediately prior to our site visit, the provider submitted an application to provide Surgical procedures as a regulated activity.

Engagement with patients, the public, staff and external partners

Inadequate

Are services well-led?

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, changes to the layout of the premises had been made to enhance patient privacy.
- There was no other evidence of 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 18 HSCA (RA) Regulations 2014 Staffing The service provider had failed to ensure that persons employed in the provision of a regulated activity received such appropriate support, training, professional development, supervision and appraisal as was necessary to enable them to carry out the duties they were employed to perform. In particular: • There was a lack of monitoring of training undertaken by staff and those employed on a sessional basis. • There was a lack of training for staff in some key areas. • Staff undertaking chaperone duties had not received chaperone training. • Staff involved in the delivery of dermatology services had not received any specialist training. • There was a lack of policy in place which outlined the training requirements of staff. • There was a lack of performance review, clinical supervision and monitoring of clinical staff employed on a sessional basis. • Staff employed by the service had not recently undergone appraisal. This was in breach of regulation 18 (2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

This section is primarily information for the provider

Enforcement actions

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	S18 Notice of Decision to suspend registration of a regulated activity **Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Regulation 12(1) Safe care and treatment** Care and treatment was not always provided in a safe way to patients.

Regulated activity	Regulation
Diagnostic and screening procedures Treatment of disease, disorder or injury	S18 Notice of Decision to suspend registration of a regulated activity **Health and Social Care Act (Regulated Activities) Regulations 2014 Regulation 17(1) Good Governance** Systems and processes to ensure good governance in accordance with the fundamental standards of care were not always in place.