# My:Skyn Clinic Limited

## 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, individuals using the services, the public and other organisations.

## Ratings

| Overall rating for this location | Good |
|---|---|
| Are services safe? | Good |
| Are services effective? | Good |
| Are services caring? | Good |
| Are services responsive? | Good |
| Are services well-led? | Good |

# Overall summary

This service is rated as Good overall.

The ratings for individual key questions are:

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 of My:Skyn Clinic Limited on 4 March 2020 as part of our regulatory inspection programme.

My:Skyn Clinic Limited is an independent health service provider situated in Bell Dean Road, Allerton, Bradford, West Yorkshire, BD15 7WA. The service offers a range of therapist and clinician led services which include a range of non-surgical cosmetic interventions, for example facial fillers for skin rejuvenation, which are not within Care Quality Commission (CQC) scope of registration. Therefore, we did not inspect or report on these services. The lead doctor is the registered manager.

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

Our key findings were:

- The service provided care in a way that kept patients safe and protected them from avoidable harm.
- Procedures had been safely managed and there were effective levels of support and aftercare offered to individuals using the service.
- Clinical staff were able to demonstrate up to date safeguarding training in line with published guidance.
- Staff had the relevant skills, knowledge and experience to deliver the care and treatment offered by the service.
- The service encouraged and valued feedback from patients.
- Staff involved patients in decisions regarding their care and treatment.
- Staff treated people with kindness, compassion, dignity and respect.
- The provider was aware of the requirements of the Duty of Candour.
- Staff were aware of their own roles and responsibilities. They said they felt supported by leaders and managers who were accessible and visible. Communication between staff was effective.
- Treatment outcomes were evaluated using feedback from patients and reviews carried out by the provider which included a limited number of audits to support the services quality improvement processes.

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

- Develop detailed training records for all staff working within the service, ensuring staff complete all training relevant to their role.
- Gain assurance that staff immunity status has been assessed in line with national guidance.
- Develop documentation relating to fire evacuation drills and tests of the fire alarm.
- Maintain detailed records showing the frequency of cleaning undertaken within the service.
- Implement records relating to safety checks done by third parties.
- Develop systems and processes to record detailed pre-employment checks carried out for each staff member which are completed before staff commence employment.

## Our inspection team

Our inspection team was led by a CQC lead inspector. The team consisted of a GP specialist adviser, and a CQC inspector.

## Background to My:Skyn Clinic Limited

We carried out an announced comprehensive inspection at My:Skyn Clinic as part of our inspection programme. The inspection was carried out on 4 March 2020.

My:Skyn Clinic is an independent health services provider in Bell Dean Road, Allerton in Bradford, West Yorkshire, BD15 7WA, operated by My:Skyn Clinic Limited. The provider is registered as a limited company which offers a range of medical, cosmetic and aesthetic services to adults over the age of 18 years.

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. It was registered with the Care Quality Commission to deliver the following regulated activities:

- Diagnostic and screening procedures
- Treatment of disease, disorder or injury
- Surgical procedures

There are some exemptions from regulation by CQC which relate to particular types of regulated activities and services and these are set out in Schedule 1 and Schedule 2 of The Health and Social Care Act 2008, (Regulated Activities) Regulations 2014. My:Skyn Clinic offers a range of non-surgical cosmetic interventions, for example fillers for skin rejuvenation and non-surgical facials which are not within the CQC scope of registration. Therefore, we did not inspect or report on these services.

The service was delivered from modern facilities. Parking, including parking for those with mobility issues, was available on the site. The clinic is located on the ground floor of a building shared with other organisations, and so was accessible to individuals using the services with mobility issues.

My:Skyn Clinic offered a variety of non-surgical treatments. The services provided by My:Skyn which were in scope of CQC registration were:

1. Clinical consultations

2. Minor Surgery

The service was managed by two company officers who oversaw the daily running of the service. One of the officers of the company was the registered manager. A registered manager is a person who is registered with the Care Quality Commission to manage the service and carry out regulated activity. The other was the nominated individual. A nominated individual has responsibility for supervising the way that regulated activities are managed. 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.

During our inspection we:

- Looked at the systems in place relating to the safety and governance of the service.
- Reviewed a number of key policies and procedures.
- Explored clinical oversight and how decisions were made.
- Spoke with a range of staff.
- Reviewed CQC comment cards and other feedback received from individuals using the services where they shared their views and experiences.

To get to the heart of individuals using the services' 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 formed the framework for the areas we looked at during the inspection.

Good

# Are services safe?

**Safety systems and processes**

**The service had processes and systems to keep people safe and safeguarded from abuse, however these were limited in some areas.**

- A fire risk assessment for the premises had been undertaken by the building owners. Documentary evidence was sent to us after the inspection, which showed the assessment had been done and there were no actions to undertake.
- Fire training had been undertaken by all non-clinical staff. However, fire training had not been completed by clinical staff. At the time of the inspection, the provider did not keep documentary evidence of tests of the fire alarms undertaken by the landlord. This was subsequently sent to us and showed tests were being carried out on different parts of the building intermittently throughout the year.
- The service delivered care and treatment to adults, 18 years of age or over. Additional identity checks were in place for all individuals using the service under the age of 30 to ensure this was the case.
- Systems to manage infection prevention and control were in place. We saw that equipment and rooms were kept clean with cleaning occurring in-between use. At the time of our visit, the service had no readily available spillage kits present. Following the inspection, the provider took action to rectify this, and provided staff with appropriate training on how and when these should be used.
- The service had in place systems and processes for the safe handling and disposal of clinical specimens such as blood samples and associated apparatus.
- The service took appropriate steps to ensure that facilities and equipment were safe, and that equipment was maintained according to manufacturers' instructions. There were systems in place for safely managing healthcare waste.
- Staff received safety information from the service as part of their induction. Safeguarding policies were in place and accessible to staff. Additionally, staff received training to an appropriate level in child safeguarding and received regular safeguarding updates through newsletters and discussions in team meetings.
- Environmental risk assessments had been completed by other organisations located within the same premises. However, the provider did not have oversight of these assessments.
- The provider had not undertaken the necessary pre-employment checks for all persons working at the service. References and Disclosure and Barring Service (DBS) checks had not been completed 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. The provider had relied on checks carried out by other employing organisations where one of the clinicians were also employed but did not retain any evidence of these checks.

**Risks to individuals using the services**

**Systems to assess, monitor and manage safety were in place.**

- Staff were aware of their responsibilities to manage emergencies.
- There were arrangements for planning services which ensured there was capacity to meet service demand.
- At the time of the inspection the provider had not assessed the immunity status of all staff. Following our inspection the provider developed a policy and process to review the immunisation status of all staff members.
- Healthcare professionals were registered with their relevant professional bodies where required, this included the General Medical Council.
- There were appropriate staff indemnity arrangements in place.

**Information to deliver safe care and treatment**

**Staff had the information they needed to deliver safe care and treatment to individuals using the services.**

- Clinicians made appropriate and timely referrals in accordance to best practice and current guidance when this was required.
- The care records of individuals who used the service were written and managed in a way that kept them safe. The care records we saw showed that information needed to deliver safe care and treatment was available to relevant staff in an accessible way. There were secure systems for the safe storage of individual patient records.
- The service had systems and processes in place for sharing information with other agencies to enable the delivery of safe care and treatment.

Good

# Are services safe?

- The service ensured staff had the most current guidance and information, by facilitating attendance at local peer review meetings and national conferences. This also included providing teaching sessions for staff working at the service, delivered by experts in their relevant field.

**Safe and appropriate use of medicines**

**The service had systems for appropriate and safe handling of medicines, but improvements could be made.**

- The service had some medicines to deal with medical emergencies. We found that some were stored within the clinic and some shared with the GP practice, where the registered manager was a GP partner, which was located in the same building. We were informed by the service that these were available if required. Some emergency medicines which are recommended for healthcare providers to store were not present. A formal risk assessment which supported the decision not to keep those medicines had not been undertaken.
- Emergency equipment such as a defibrillator were also shared with a GP practice present in the same premises. We were informed by the service that these could be used when required.
- Processes to check medicines were within date, being stored appropriately and safe to use were infrequent, with some checks only undertaken every three months. The provider told us they had updated their processes to ensure these were carried out more frequently.
- The provider ensured that medicines were only prescribed and administered by suitably qualified and trained professionals. Those staff prescribed, administered or supplied medicines and gave advice on medicines in line with legal requirements and current national guidance.
- The service had appropriate systems to ensure safe prescribing was maintained. This included an audit of prescribing activity in which medical history was reviewed before and after treatments.
- The provider had appropriate protocols in place for verifying the identity of individuals using the service.
- In the event where medicines were prescribed for other reasons than their intended use, (unlicensed medication) there were systems in place to ensure risk was assessed and individuals using the services were given appropriate information to allow them to make an informed treatment choice. Where these were given, the service carried out patch testing on patients to ensure they would not have an adverse reaction to these medicines. There were also processes in place to review use and ensure usage of such medicines was for short term use only.

**Track record on safety and incidents**

**The service had a good safety record.**

- The service monitored and reviewed activity. This helped it to understand risks and gave a clear, accurate and current picture that led to safety improvements.
- There were some comprehensive risk assessments in relation to safety issues. These included specific welfare risk assessments for individual staff members identified as being at risk, for example when lone working

**Lessons learned and improvements made**

**The service learned and made improvements when things went wrong.**

- There was a system for recording and acting on significant events. Staff understood their duty to raise concerns and report incidents and near misses. Leaders and managers supported them when they did so.
- There were adequate systems for reviewing and investigating when things went wrong. The service learned and shared lessons identified and took action to improve safety in the service. For example, the service had identified an issue with its record keeping systems and processes. It had learned that all paperwork relating to individual patients needed more patient identifiable information present on each page rather than one and as a result all paperwork had been updated.
- 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.
- When there were unexpected or unintended safety incidents the provider told us that they would give affected people reasonable support, truthful information and a verbal and written apology.
- The service received and reviewed information from external safety events as well as individuals using the service and medicine safety alerts. However, on the day of the inspection there were no records or logs to

Good

# Are services safe?

demonstrate that appropriate action had been taken in relation to any alerts. The provider subsequently put arrangements in place to log all alerts and record whether it was necessary to take any further action.

Good

# Are services effective?

**Effective needs assessment, care and treatment**

**The provider had systems to keep clinicians up to date with current evidence based practice. We saw evidence that clinicians assessed needs and delivered care and treatment in line with current legislation, standards and guidance which were relevant to their service.**

- The provider assessed needs and delivered care in line with relevant and current evidence-based guidance and standards such as the National Institute for Health and Care Excellence best practice guidelines. Updates to guidelines were discussed at team meetings for which meeting records were kept and through conversations with peers.
- The immediate and ongoing needs of individuals using the service were fully assessed. Where appropriate, this included their clinical needs and their mental and physical wellbeing.
- Clinicians had enough information to make or confirm a diagnosis. This included gathering appropriate information prior to consultations to establish past medical history.
- We saw no evidence of discrimination when making care and treatment decisions.
- Arrangements were in place to deal with repeat individuals using the services.

**Monitoring care and treatment**

**The service was actively involved in quality improvement activity.**

- The service used information about care and treatment to make improvements. This included:
  - A review of prescribing using the World Health Organization recommendations in January 2020. As part of this work 42 care records were reviewed, and subsequently changes were made to the process of providing patient information and recording information from consultations. This included consent and cost information.
  - The service also made improvements through the use of completed audits. Clinical audit had a positive impact on quality of care and outcomes for individuals using the service. There was clear evidence of action to resolve concerns and improve quality. For example, in December 2019 the provider had carried out a records audit. As a result of this it had developed the forms it used and more specific information packs for individuals using the service. Due to the fact the service had only been established recently, this and other audits had only been undertaken over one-cycle. There were plans to repeat audits with follow up cycles to measure improvement.

**Effective staffing**

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

- All staff were appropriately qualified. The provider had an induction programme for all newly appointed staff. Clinical staff employed by the provider were experienced professionals who also worked for other nearby NHS or primary care providers. However, not all mandatory training had been completed by all staff.
- Relevant professionals were registered with the General Medical Council and were up to date with revalidation.
- The provider understood the learning needs of staff and provided protected time and training to meet them. Staff were encouraged and given opportunities to develop.

**Coordinating individuals using the service care and information sharing.**

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

- Individuals who used the service received coordinated and person-centred care. Staff referred to, and communicated effectively with, other services when appropriate.
- Before providing treatment, doctors at the service ensured they had adequate knowledge of the health and needs of individuals, any relevant test results and their medicines history.
- All individuals using the service were asked for consent to share details of their consultation and any medicines prescribed with their registered GP on each occasion they used the service.
- The provider had risk assessed the treatments they offered.
- We were informed vulnerable individuals had not used the service, but the provider was able to tell us how care and treatment for individuals using the service in vulnerable circumstances would be coordinated with other services if this was identified.

Good

# Are services effective?

- Information about individuals using the service was shared appropriately (this included when individuals using the service moved to other professional services), and the information needed to plan and deliver care and treatment was available to relevant staff in a timely and accessible way.

**Supporting individuals using the services to live healthier lives.**

**Staff were consistent and proactive in empowering individuals using the service, and supporting them to manage their own health and maximise their independence.**

- Where appropriate, staff gave people advice so they could self-care.
- Any risk factors which were identified were discussed with individuals using the service and where appropriate, with consent, highlighted to their normal care provider for additional support.
- Where patient needs could not be met by the service, staff redirected them to the appropriate service for their needs.

**Consent to care and treatment**

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

- Staff understood the requirements of legislation and guidance when considering consent and decision making.
- Staff supported individuals using the service to make decisions. Where appropriate, they assessed and recorded an individual's mental capacity to make a decision. We saw that staff had received training to support them better understand consent.
- The service monitored the process for seeking consent appropriately.

Good

# Are services caring?

**Kindness, respect and compassion**

**Staff treated individuals using the service with kindness, respect and compassion.**

- Feedback from patients about the service was positive.
- The service sought feedback on the quality of clinical care for patients and for their overall satisfaction with the service they had received. This included using online resources, social media and surveys. The service carried out a patient survey in January 2020, in which it had received 22 responses. All responses showed people had received a positive experience from the service.
- On the day of inspection we spoke with one service user and received ten completed CQC comment cards from patients. This feedback was universally positive.
- Staff displayed an understanding and non-judgmental attitude to all individuals using the service.
- The service gave individuals using the service timely support and information.

**Involvement in decisions about care and treatment**

**Staff helped individuals using the services to be involved in decisions about care and treatment.**

- Initial consultations and a number of other information resources were available for patients using the service to help them make an informed decision about their care.
- The service had not needed to access interpretation services, but this was available for people using the service who did not have English as a first language.
- People using the service told us through feedback left in comment cards, that they felt listened to and supported by staff and had sufficient time during consultations to make an informed decision about the choice of treatment available to them.
- The provider ensured information about cost and payment structures was clearly provided to individuals using the services.

**Privacy and Dignity**

**The service respected privacy and dignity of patients.**

- Staff recognised the importance of people's dignity and respect.
- Staff knew that if people using the service wanted to discuss sensitive issues or appeared distressed they could offer them a private room to discuss their needs.

Good

# Are services responsive to people's needs?

**Responding to and meeting people's needs**

**The service organised and delivered services to meet the needs of individuals. It took account of needs and preferences.**

- The service was offered on a private fee-paying basis. It was accessible to people who chose to use it and who were deemed suitable to receive procedures.
- The service offered people using the service a post-procedural support line whereby they could access medical support 24 hours a day following minor surgery.
- The provider understood the needs of people who used the service and improved services in response to those needs. For example, they offered flexible appointments at times to suit individual needs.
- The facilities and premises were appropriate for the services delivered.

**Timely access to the service**

**Individuals using the services were able to access care and treatment from the service within an appropriate timescale for their needs.**

- People who used services had timely access to initial assessment, test results, diagnosis and treatment.
- Waiting times, delays and cancellations were minimal and managed appropriately.
- Referrals and transfers to other services were undertaken in a timely way including those requiring further specialist advice.

**Listening and learning from concerns and complaints**

**The service took complaints and concerns seriously and had systems in place to respond to them appropriately to improve the quality of care.**

- Information about how to make a complaint or raise concerns was available for people using the service. Staff said they would treat patients who made complaints compassionately.
- The service informed patients of any further action that may be available to them should they not be satisfied with the response to their complaint.
- The service had complaint policy and procedures in place. They had also signed up to an independent adjudication service to help patients with any complaint and had an agreement in place to follow recommendations made by them. At the time of the inspection the service had not received any complaints. Compliments had been left by past patients.

Good

# Are services well-led?

**Leadership capacity and capability**

**Leaders had the capacity and skills to deliver high-quality, sustainable care.**

- Leaders were knowledgeable about issues and priorities relating to the quality and future of services. They understood the challenges and were addressing them. For example, the current system for records management needed to be updated and the provider was actively reviewing options.
- Leaders were visible and approachable. They worked closely with staff and others to make sure they prioritised compassionate and inclusive leadership.
- The provider had effective processes to develop leadership capacity and skills, including planning for the future leadership of the service.

**Vision and strategy**

**The service had a clear vision and credible strategy to deliver high quality care and promote good outcomes for individuals using the services.**

- There was a clear vision and set of values. The service had a realistic strategy and supporting business plans to achieve priorities. We were told by the senior team that they sought to develop a service which treated patients with utmost respect so that they felt their care was of the highest standard. The provider's vision was to develop a friendly, individualised service, which focused on quality and safety.
- The service monitored progress against delivery of the strategy.

**Culture**

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

- Staff felt respected, supported and valued. They were proud to work for the service.
- The service focused on the needs of individuals using the service.
- Leaders and managers knew how to act if behaviour and performance were inconsistent with the vision and values.
- Though the service had not had any complaints since they opened, the team showed an awareness of the need for openness, honesty and transparency when responding to incidents and complaints. The provider was aware of and had systems to ensure compliance with the requirements of the duty of candour.
- Staff told us they could raise concerns and were encouraged to do so. They had confidence that these would be addressed.
- There were processes for providing all staff with the development they needed. This included appraisal and career development conversations. All staff received regular annual appraisals. They were given protected time for professional development and evaluation of their clinical work.
- There was a strong emphasis on the safety and well-being of all staff with a number of employee focused initiatives available for staff.
- The service actively promoted equality and diversity. Staff had received equality and diversity training. Staff felt they were treated equally.
- There were positive relationships between staff and managers.

**Governance arrangements**

**Systems detailing clear responsibilities, roles and systems of accountability to support good governance and management were in place**

- The service had structures, processes and systems to support good governance and management. However, the governance and management of partnerships and joint working arrangements was not formally documented or monitored. The provider acted following the inspection to address this, with appropriate service level agreements and procedures developed to monitor these arrangements.
- Some medicines were stored within a GP practice located in the same building, where the registered manager was also a GP partner. Records which showed these medicines and the refrigerators where they were stored, were regularly checked were held by the GP practice and there were no documented assurance processes in place to monitor these.

**Managing risks, issues and performance**

**Processes for managing risks, issues and performance were in place.**

- There were processes to identify, understand, monitor and address current and future risks including risks to

safety of patients. However, at the time of the inspection monitoring and assurance arrangements for reviewing safety checks done by third parties required further development. For example, a legionella risk assessment had been undertaken by another organisation located within the same premises. The provider did not have oversight of this and was not aware whether any subsequent checks had been undertaken. Following the inspection, the provider took appropriate steps to address this and we were sent documentary evidence to show for instance that testing had been completed.

- A fire risk assessment had also been undertaken by another organisation. At the time of the inspection the service did not have this information nor were they aware of any actions taken to ensure that any issues identified as part of this assessment had been actioned. Following our inspection visit, the provider took appropriate steps to address this and we were sent documentary evidence they now had access to this information and that there were no concerns noted.
- Emergency equipment such as a defibrillator were shared with the GP practice, where the registered manager was a GP partner, which was located in the same building. Some emergency medicines which are recommended for healthcare providers to store were not present or were shared with a neighbouring provider. A formal risk assessment which supported the decision not to keep those medicines on site had not been undertaken for each of these

- The service had processes to manage current and future performance. Performance of clinical staff could be demonstrated through audit of their consultations and prescribing. Leaders had oversight of safety alerts, incidents, and complaints.
- Clinical audit had a positive impact on quality of care and outcomes for patients. There was clear evidence of action to change services to improve quality. It was planned to increase the scope and depth of clinical audit with the increase in patient numbers as the service became more established.
- The provider had plans in place and had trained staff for major incidents.

**Appropriate and accurate information**

**The service acted on appropriate and accurate information.**

- Quality and operational information was used to ensure and improve performance. Performance information was combined with the views of individuals using the service.
- Quality and sustainability were discussed in relevant meetings where all staff had sufficient access to information.
- The service used performance information which was reported and monitored, and management and staff were held to account
- The information used to monitor performance and the delivery of quality care was accurate and useful. There were plans to address any identified areas for improvement.
- The service was aware of the need to submit data or notifications to external organisations as required.

**Engagement with individuals using the services, the public, staff and external partners**

**The service involved individuals using the service, the public, staff and external partners to support high-quality sustainable services.**

- The service encouraged and heard views and concerns from the public, individuals using the service, staff and external partners. This had been done through open events where the service invited people to attend and experience the service first hand. It also utilised specialist expertise with education and in-house satisfaction/feedback surveys and sessions for staff from industry experts.
- There were systems in place both formal and informal for staff to give feedback and raise concerns.

**Continuous improvement and innovation**

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

- There was a focus on continuous learning and improvement.
- There were systems in place to support improvement and innovation work, this included service reviews and a limited programme of clinical audits.