St Michaels's Clinic

Inspection report

St. Michaels Street
Shrewsbury
Shrewsbury
SY1 2HE
Tel: 01743590010
www.stmichaelsclinic.co.uk

Date of inspection visit: 4 August 2022
Date of publication: 05/09/2022

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

Ratings

Overall rating for this location	Good
Are services safe?	Good
Are services effective?	Good
Are services caring?	Good
Are services responsive to people's needs?	Good
Are services well-led?	Good

Overall summary

We carried out an announced comprehensive inspection at St Michael's Clinic on 4 August 2022 following the change of ownership and registered provider.

This service is rated as Good overall.

The key questions are rated as:

Are services safe? – Good

Are services effective? – Good

Are services caring? – Good

Are services responsive? – Good

Are services well-led? – Good

The location was inspected under the previous registered provider on 16 December 2019 and rated good overall and across all five key questions.

St Michael's Skin Clinic is based in Shrewsbury, Shropshire and provides an outpatient dermatology service to private patients and NHS patients. The clinic specialises in skin treatments including medical, surgical and laser in addition to a range of non-surgical cosmetic interventions, for example botulinum toxin injections and dermal fillers which are not within CQC scope of registration. Therefore, we did not inspect or report on these services.

The service is registered with CQC under the Health and Social Care Act 2008 in respect of some, but not all, of the services it provides. There are some exemptions from regulation by CQC which relate to particular types of regulated activities and services and these are set out in Schedule 1 and Schedule 2 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Mr Paul Haycox 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.

CQC comment cards were not distributed to the provider prior to the inspection in order to minimise the risks associated with the COVID -19 pandemic. However, the clinic had systems in place to gain patient feedback.

Our key findings were:

- Patients were able to access care and treatment within an appropriate timescale for their needs. They received clear information about their proposed treatment which enabled them to make an informed decision.
- Patients received effective care and treatment that met their needs.
- There was a system in place to manage infection prevention and control (IPC). Audits were undertaken and action plans developed however, these did not include all identified actions for improvement.
- The service ensured that care and treatment was delivered according to evidence-based guidelines and current best practice.

Overall summary

- The service had systems in place to review the effectiveness and appropriateness of the care it provided.
- Systems, processes and records had been established to seek consent and to offer coordinated and person-centred care.
- Clinical staff were registered with the appropriate governing body and there was a system in place to ensure they were up to date with revalidation.
- Staff maintained the necessary skills and competence to support patients' needs, however a greater oversight of essential training staff had undertaken was required.
- People using the service were treated with compassion, kindness, dignity and respect.
- The provider and staff team demonstrated a positive culture and a commitment to the delivery of person-centred care and treatment and continuous learning and improvement.
- The provider was aware of, and complied with, the requirements of the duty of candour.

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

- Review recruitment processes to ensure all checks are carried out in line with policy and regulation.
- Review infection prevention and control audits and cleaning schedules to ensure they are effective.
- Maintain an accurate record of staff training and ensure all staff have completed essential training within the required timescales.
- Further develop quality improvement activity to include repeat clinical audits.
- Consider developing an information sharing agreement with local GP practices.
- Develop a documented business plan to achieve priorities.

Dr Sean O'Kelly BSc MB ChB MSc DCH FRCA

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

Our inspection team

Our inspection team was led by a CQC lead inspector**.** The team included a specialist advisor.

Background to St Michaels's Clinic

The provider, St Michael's Clinic Limited, is an independent Healthcare Company registered with the Care Quality Commission (CQC) to provide the regulated activities diagnostic and screening procedures, surgical procedures and treatment of disease, disorder, or injury from St Michaels Street, Shrewsbury SY1 2HE. The clinic provides a very limited service from their satellite premise in Much Wenlock, Shropshire and was not visited as part of this inspection and is managed by the same Registered Manager. The clinic also utilises rooms within a GP practice in Telford two days a week to support and sustain the Community Dermatology Service.

The clinic offers a private and NHS dermatology service to adults and children and is commissioned by Shropshire, Telford and Wrekin ICS, Powys Teaching Health Board and Betsi Cadwallader University Health Board. Currently 79% of treatment is NHS and the remainder private. The service was set up in 2003 and moved into its current premises in 2011 under the previous registered provider. Following the sale and transfer of ownership to The Dermatology Partnership (THP) the service was registered with CQC as St Michael's Clinic Limited on 6 January 2021. Dr Stephen Murdoch is the nominated individual and the clinical director.

The clinic is located on the outskirts of Shrewsbury. Clinical rooms, including one theatre, are located on the ground and first floors, with a main waiting area, reception and staff offices. There are accessible toilet facilities and free on-site parking.

The service employs four dermatology consultants, six speciality doctors, five GPs with a special interest, 16 nurses, four of whom are Clinical Nurse Specialists and five health care assistants. Four of the doctors work solely at the clinic and others work on a sessional basis. The clinical team are supported by a team of 22 administrative staff, a practice co-ordinator and a business manager. Some roles have been reorganised under the new provider.

The clinic is open between 9am and 8pm on a Monday to Wednesday and between 9am and 5pm Thursday and Friday and is closed weekends and bank holidays. A very limited service is offered from a satellite site in Much Wenlock, Shropshire on a Friday and an occasional Tuesday from 9am and 5pm. The provider also utilises rooms within a Telford GP practice on a Tuesday and Thursday to support and sustain the community dermatology service. More information about the services provided are available on the provider website: www.stmichaelsclinic.co.uk

How we inspected this service

We carried out this comprehensive 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 regulations associated with the Health and Social Care Act 2008 following the change of provider.

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

This included:

- Requesting a provider information return and additional evidence from the provider prior to and post our site visit.
- A presentation.
- Conducting staff interviews remotely using video conferencing.
- A site visit to undertake a tour of the premises, review clinical records, carry out observations and review key documents which support the governance and delivery of the 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.

Good

Are services safe?

We rated safe as Good because:

The service provided care in a way that kept patients safe and protected them from avoidable harm. However, some processes required greater overview.

Safety systems and processes

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

- The provider conducted safety risk assessments and had safety policies in place, which were regularly reviewed and communicated to staff. Staff received safety information from the service as part of their induction and refresher training. The provider had identified the need for staff to complete display screen equipment workstation assessments to protect staff health.
- The service had systems to safeguard children and vulnerable adults from abuse. Contact numbers for the local authority safeguarding team were accessible and staff had access to safeguarding policies. Staff spoken with knew how to identify and report concerns and had access to a designated safeguarding lead. Managers confirmed all but one staff member had completed safeguarding training appropriate to their role. A timescale had been set for the outstanding staff member to complete the required training. Managers shared an example of how they had escalated a safeguarding concern regarding a patient to external agencies in the best interest of the patient concerned.
- The provider employed an external cleaning company who visited daily, and cleaning schedules were in place. The cleaning company provided the cleaning products and the relevant safety data sheets. A book was maintained to aid communication regarding any identified cleaning issues.
- The provider ensured that facilities and equipment were safe at the main site and satellite site, and that equipment was maintained according to manufacturers' instructions. The service had risk assessments and procedures in place to monitor safety of both premises. These included environmental, fire and legionella risk assessments. Electrical equipment was checked to ensure that it was safe to use. Fire checks and drills were carried out at regular intervals and equipment serviced and tested at the recommended frequency. Electrical sockets were planned to be fitted in the theatre floor at the main site to avoid trip hazards in conjunction with the replacement of the floor covering.
- The clinic used software compatible with the NHS and had suitable data sharing protocols in place. This enabled the provider to check the identity and details of patients on the NHS electronic database.
- There were arrangements in place to verify the identity of the patient being treated.
- The provider had an employment policy in place. However, we found staff recruitment was not fully in line with policy. We reviewed four staff records and found most of all the required checks had been carried out at the time of recruitment. Although satisfactory evidence of conduct in previous employment had been obtained for three of the four staff prior to them commencing work, this had not been obtained for one staff member until a month post their start date. In addition, a Disclosure and Barring Service (DBS) check had been obtained post the start date for the same staff member and the level of check obtained was not appropriate to their role. Although we were advised the staff member was supernumerary, a risk assessment had not been completed in the interim. Checks had been undertaken for an overseas staff member where a DBS check could not be obtained. (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). DBS checks were repeated every three years and these checks were provided by the employee when requested. A full employment history or a written explanation for gaps in employment, had not been obtained for two staff and evidence of professional qualification and registration was not available on one clinician's record. Managers told us checks had been carried out at interview but had not been recorded, they confirmed this process would be amended with immediate effect.
- Information was displayed in waiting and reception areas advising patients that staff were available to act as chaperones. Designated staff who acted as chaperones were trained for the role and had received a DBS check.

Good

Are services safe?

- The provider held practice privileges agreements for doctors who performed treatment for private patients. (A practising privilege is the 'licence' agreed between individual medical professionals and a private healthcare provider).
- There was a system in place to manage infection prevention and control (IPC) and staff had access to an IPC policy and had received training. Additional policies and safety measures had been implemented during the Covid-19 pandemic to help safeguard patients and staff. We saw staff were appropriately dressed for theatre.
- The service had a designated infection prevention control lead who demonstrated an understanding of their role and responsibilities. Areas observed during our site visit were clean and hygienic and there were systems for safely managing healthcare waste. Infection prevention and control audits had been completed in January and April 2022. The pass mark for audits undertaken was 85%. The clinic achieved 87% compliance in January 2022 and 88% in April 2022. Action plans had been completed detailing the action required, person responsible and timescales. However, timescales were very generous for example a timescale of six months to remove dust in the waiting areas and clinic rooms. Action plans did not include all of the identified areas requiring improvement. For example, the need to replace the floor covering in the theatre and the replacement of staff fabric chairs. Risk assessments were in place to reduce the risk of waterborne infections, such as Legionella.

Risks to patients

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

- All appointments were booked in advance therefore there was a reduced risk of people requiring urgent medical attention when attending the clinic.
- Staff we spoke with understood their responsibilities to manage emergencies and knew where medicines and equipment were located in the event of a medical emergency.
- There were medicines and equipment appropriate to the procedures undertaken in the event of a medical emergency. These were stored appropriately and checked regularly. The clinic had developed a risk assessment for medicines not held and this was updated on the day of the inspection. A service level agreement was in place for rooms utilised in a Telford GP practice to support and sustain the Community Dermatology Service. This included equipment and supplies needed to facilitate the clinics, including access to equipment and medicine in the event of a medical emergency.
- When there were changes to services or staff the service assessed and monitored the impact on safety.
- There were arrangements for planning and monitoring the number and mix of staff needed. The clinic had its own bank staff should they require an additional member of staff. Arrangements were also in place to cover annual leave, sickness leave, training and for the recruitment to vacancies.
- There was a basic induction programme in place for staff. This included health and safety, welfare facilities and general safety rules.
- There was a fire risk assessment and fire policy and procedure in place. Staff completed online fire training. Fire alarms were tested each week and serviced with the recommended timescales. Staff had access to a designated fire warden.
- There were professional indemnity arrangements in place to cover potential liabilities and systems in place to ensure clinical staff were up to date with their professional registration and revalidation.
- The clinic had systems for sharing information with staff and other agencies to enable them to deliver safe care and treatment.

Information to deliver safe care and treatment

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

- Individual care records were written and managed in a way that kept patients safe. The care records we saw showed that information needed to deliver safe care and treatment was available to relevant staff in an accessible way.

Good

Are services safe?

- The clinic received referral forms for NHS patients and for some private patients from other healthcare professionals. The clinic sought consent from patients to contact their GP to share relevant information about their treatment where appropriate.
- The clinic had systems for sharing information with staff and other agencies to enable them to deliver safe care and treatment.
- Managers confirmed a system was in place to retain medical records in line with Department of Health and Social Care (DHSC) guidance in the event that they cease trading.
- Clinicians made appropriate and timely referrals in line with protocols and up to date evidence-based guidance.

Safe and appropriate use of medicines

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

- The systems and arrangements for managing medicines, emergency medicines and equipment minimised risks to patients. Any medicine administered was only done with an accompanying prescription by a doctor and in line with legal requirements and current national guidance.
- The clinic used local anaesthesia only. The clinic told us in the event of a medical emergency they would only offer immediate treatment as deemed necessary while awaiting the ambulance service.
- Patients prescribed medicines for acne were regularly reviewed. When psychological support was required for patients whose conditions had impacted adversely on their mental health; GPs were contacted and requested to make onward psychological referrals.
- The service kept prescription stationery securely and monitored its use.
- Sharps disposal was managed safely with an appropriate contract in place for their collection.

Track record on safety and incidents

The service had a good safety record.

- There were comprehensive risk assessments in relation to safety issues. These included environmental, fire, legionella and emergency medicines risk assessments.
- Skin multi-disciplinary team meetings (MDT) were held weekly with the hospital and handover arrangements were in place for patients with cancer diagnoses. Meetings were attended by a consultant and a specialist nurse.
- The service monitored and reviewed activity. This helped it to understand risks and gave a clear, accurate and current picture that led to safety improvements.
- There was a system in place managing safety alerts.

Lessons learned and improvements made

The service learned and made improvements when things went wrong.

- There were systems in place for reviewing and investigating when things went wrong. Staff had access to an incident reporting policy and incident reporting forms on the internal staff portal. The clinic had implemented an electronic incident reporting software system in December 2020 to report incidents, complaints and compliments and staff were provided with a presentation explaining the newly adopted system. Managers told us the system had enhanced the significant event analysis meetings held with the team, as they were able to utilise the electronic system to review the incidents, scrutinise the investigations and look at learning points more clearly. Where a Root Cause Analysis (RCA) was required this would be implemented as part of an investigation. Staff we spoke with understood their duty to raise concerns and report incidents and near misses and were able to share examples of incidents and the action taken to improve learning.

Good

Are services safe?

- Managers told us no significant events had been reported to commissioners in the previous 12 months, however they had investigated 21 minor incidents internally and amended processes accordingly. They advised of a needlestick injury and the action taken including liaising with the local occupational health department and securing an arrangement with them to manage any future needlestick events. Significant event analysis meetings were held, and actions taken were recorded. Significant events were also discussed in clinical governance meetings held.
- 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.
- The service acted on any relevant external patient and medicine safety alerts. The service had an effective system in place to disseminate alerts to all members of the team, including sessional staff. Safety alerts were discussed in clinical governance meetings held.

Good

Are services effective?

We rated effective as Good because:

Clinical staff were registered with the appropriate governing body and were up to date with revalidation. Records of skills, qualifications and training were maintained for most staff. Care and treatment was delivered in line with current legislation. Patients received coordinated and person-centred care.

Effective needs assessment, care and treatment

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

- 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 (NICE), British Association of Dermatologists (BAD) and the British Society for Paediatric Dermatology (BSPD). NICE guidance, BAD and BSPD standards were discussed at clinical governance meetings held to ensure clinicians were kept updated.
- Patients' immediate and ongoing needs 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.
- We saw no evidence of discrimination when making care and treatment decisions.

Monitoring care and treatment

The service was involved in quality improvement activity.

- The service used information about care and treatment to make improvements.
- The service made improvements through the use of audits. We reviewed three clinical audits that the clinic had carried out. There had been a repeat cycle audit of the patch testing service against national guidelines. This demonstrated change and improvement from the previous audit. There had been a repeat cycle audit of a medication prescribed for the treatment of acne against national guidelines. This demonstrated change and improvement from the previous audit and with no major contraventions. We found audits demonstrated identification of various domains of practice, benchmarking against national guidelines and a demonstration of continuous improvement against previous findings. However, these audits had not been carried out recently. A further audit we reviewed was a biologics audit undertaken in 2021 which was satisfactory with plans for reaudit. The clinic had also carried out an audit in June 2022 of three patients who had received Mohs surgery (a surgical technique used to treat skin cancer), a procedure recently provided by the clinic and achieved 100% compliance.
- The clinic had developed an audit schedule for 2022 as recommended at the previous inspection. The schedule included an audit of record management and care planning, safeguarding, infection, prevention and control, a medicine audit and a health and safety audit. Managers acknowledged the need to carry out further completed audits as part of their quality improvement activity to include a repeat Mohs audit at 12 months, using the NICE Mohs surgery guidelines to benchmark against.
- The clinic reported to its commissioners every quarter and included patient experience, waiting times, significant events, complaints, discharge letters the number of referrals and finance.

Effective staffing

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

Good

Are services effective?

- Staff were appropriately qualified. The provider had a basic induction programme for all newly appointed staff. New staff shadowed existing staff until they were competent and confident in their role.
- Relevant professionals (medical and nursing) were registered with the General Medical Council (GMC)/ Nursing and Midwifery Council and were up to date with revalidation.
- The provider understood the learning and development needs of staff and these were discussed as part of staff appraisal. Staff told us they were encouraged and given opportunities to develop and were provided with protected time for learning. Training, appraisal and revalidation was discussed in clinical governance meetings held, including current figures of staff compliance with essential training. Consultants were provided with 10 days study leave each year pro rota to fulfil their training. The clinic closed half a day a month for staff training and meetings.
- The clinic maintained an electronic log of essential training that staff had completed and when modules were next due. Essential training included safeguarding, health, safety and welfare, data security awareness, fire safety, moving and handling, resuscitation and equality, diversity and human rights. A review of this showed most staff were up to date with their essential training. Managers were aware of individuals who were not fully compliant and had taken action to address this, including setting timescales for the completion of outstanding modules. However, the clinic had not gained assurances that clinicians working at the clinic on a sessional basis had completed all essential training arranged through their main employer, for example GPs with a Special Interest.
- The clinic confirmed all consultants had a current responsible officer (RO) and had received an appraisal with their RO within the last 12 months. (All doctors working in the United Kingdom are required to have a responsible officer in place and required to follow a process of appraisal and revalidation to ensure their fitness to practice). The clinic was a designated body therefore had a responsibility to appoint a RO. The revalidation process included 360-degree feedback on performance.

Coordinating patient care and information sharing

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

- Patients received coordinated and person-centred care. Staff referred to, and communicated effectively with, other services when appropriate. This included local hospitals and GP practices. An information sharing agreement with local GP practices was not available. Skin cancer multi-disciplinary meetings were held weekly with the local hospital to discuss patients care and treatment.
- Before providing treatment, doctors at the service ensured they had adequate knowledge of the patient's health, any relevant test results and their medicines history. Patients were signposted to more suitable sources of treatment where this information was not available to ensure safe care and treatment.
- Patients were asked for consent to share details of their consultation and any medicines prescribed with their registered GP when they used the service.
- The provider had risk assessed the treatments they offered. Where patients agreed to share their information, letters were sent to their registered GP in line with GMC guidance.
- Patient information was shared appropriately, and the information needed to plan and deliver care and treatment was available to relevant staff in a timely and accessible way.
- Any treatment, including fees for private paying patients, was fully explained to the patient prior to the procedure to enable to make informed decisions about their care.
- The service monitored the process for seeking consent and this had been discussed in a recent significant event analysis meeting held with the action for managers to study consent guidance and assess how it fitted into the clinic's processes. During the inspection we saw a consent form was in place in advance of a patient receiving surgery.

Supporting patients to live healthier lives

Good

Are services effective?

Staff were consistent and proactive in empowering patients and supporting them to manage their own health and maximise their independence.

- Where appropriate, staff gave people advice so they could self-care.
- Risk factors were identified and highlighted to patients including factors such as smoking, and alcohol consumption and how these activities affected their skin.
- Where patients needs could not be met by the service, staff redirected them to the appropriate service for their needs.

Consent to care and treatment

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

- Staff spoken with understood the requirements of legislation and guidance when considering consent and decision making and were able to share examples of how and when consent was obtained.
- Clinicians essential training requirements included training in mental capacity and consent.
- Staff supported patients to make decisions. Where appropriate, they assessed and recorded a patient's mental capacity to make a decision. Notices were displayed in clinic rooms regarding capacity.

Good

Are services caring?

We rated caring as Good because:

Patients were treated with respect and staff were kind and caring and involved them in decisions about their care.

Kindness, respect and compassion

Staff treated patients with kindness, respect and compassion.

- The service sought feedback on the quality of clinical care patients received.
- 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.
- Staff had completed equality, diversity and human rights training.
- We observed staff were friendly, polite and courteous and supported patients with any queries when they telephoned or presented at the clinic.

Involvement in decisions about care and treatment

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

- Interpretation services were available for patients who did not have English as a first language. Double appointments were available if required.
- Before providing treatment, patients attended the clinic for a consultation. This ensured patients were advised of the risks and benefits of any treatment and provided with an opportunity to ask questions discuss outcomes and costs where applicable.
- A range of patient information was available on the clinic's website to help patients understand the service and range of treatments available.

Privacy and Dignity

The service respected patients' privacy and dignity.

- Staff recognised the importance of people's dignity and respect and shared examples of how they promoted this in their work.
- Staff told us if patients wanted to discuss sensitive issues or appeared distressed, they could offer them a private room to discuss their needs.
- Consultations were conducted behind closed doors away from waiting areas to ensure conversations could not be overheard.
- Staff we spoke with understood the importance of keeping information confidential, shared examples of how they maintained this in their work. Staff were required to complete training in data security awareness as part of their essential training.
- Patient records were stored securely.

Good

Are services responsive to people's needs?

We rated responsive as Good because:

Patients had timely access to initial assessment, test results, diagnosis and treatment. The service organised and delivered services to meet patients' needs within an appropriate setting. The clinic viewed complaints as an opportunity to improve the manner in which they provided care.

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.

- Patients' individual needs and preferences were central to the planning and delivery of tailored services. Appointment times had been extended to 20 minutes during the covid-19 lockdown.
- The provider understood the needs of their patients and improved services in response to those needs. They worked with local commissioners to understand the needs of the local population.
- The facilities and premises were appropriate for the services delivered and were accessible. A passenger lift was provided to aid patient access to the first floor at the main site and a ground floor room was available at the satellite site.
- The provider offered services for adults and children. The service ensured that all patients were seen face-to-face for their consultation.
- The service offered consultations to anyone who was referred by the NHS or paid the appropriate fee and did not discriminate against anyone.
- The service website was clear and simple to use. It included information regarding access to the service, treatments provided, fees where appropriate, information on clinicians, policies useful contacts and patient reviews.
- The clinic had recently offered Mohs surgery, a surgical technique used to treat skin cancer. This was currently only available to private patients.
- They provided services to patients with an ethos of providing individualised care and treatment, considering and respecting the wishes of its patients.
- During the height of the Covid-19 pandemic the clinic closed to patients for a short period. Telephone consultations replaced face-to-face appointments. The satellite site was set up as a cold site to ensure patients were able to access blood tests for monitoring.

Timely access to the service

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

- Patients had timely access to initial assessment, test results, diagnosis and treatment. Managers told us during 2021/22 the clinic had seen 22,859 NHS patients and 4,307 private patients and received an average of 464 NHS referrals per month. Many more appointments had been scheduled but cancelled and rearranged due to Covid-19. Urgent referrals were triaged, and patients seen within two weeks where appropriate.
- Waiting times, delays and cancellations were minimal and managed appropriately. Appointment and new patient waiting times were discussed in clinical governance meetings held. Managers told us the clinic was still catching up following the pandemic and had a back log of follow ups but were prioritising the most urgent patients. Waiting time was decreasing but there had been an increase in Covid-19 cases affecting appointments. The team were working hard to fill appointment slots, however there had been a high did not attend (DNA) rate at one clinic.
- All skin cancer patients referred through to the multi-disciplinary team were offered support and signposting from the specialist cancer nurse.

Good

Are services responsive to people's needs?

- We observed telephone calls were answered promptly. The telephone service had menu options for NHS enquiries, private enquiries and for people calling from other organisations so that calls could be directed appropriately.
- Patients with the most urgent needs had their care and treatment prioritised. Additional staff had been recruited in the last 12 months to increase capacity.
- Reasonable adjustments were in place so that wheelchair users, people with children and people with a disability could access and use services. The clinic had recently formed a link with a local charity supporting individuals who were deaf and had used their services to support a patient access treatment.
- The clinic was open between 9am and 8pm on a Monday to Wednesday and between 9am and 5pm Thursday and Friday and was closed weekends and bank holidays. There were plans to open on a Saturday from October 2022. The clinic also provided a limited service from their satellite site in Much Wenlock, Shropshire on a Friday and an occasional Tuesday from 9am and 5pm. The clinic utilised rooms within a Telford GP practice on a Tuesday and Thursday to support and sustain the community dermatology service.

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.

- The registered manager was the designated person for handling complaints. The clinic viewed complaints as an opportunity to improve the manner in which they provided care. Complaints received were discussed in clinical governance meetings held.
- Information about how to make a complaint or raise concerns was available. The service had a complaint policy and procedures in place which were detailed on their website and complaint leaflets were available within the clinic.
- Eight complaints had been recorded during the previous 12 months. We reviewed four complaints that related to the regulated activities provided. When a complaint was received by the clinic, it was acknowledged and the complainant was provided with a complaint leaflet that informed them of any further action that may be available to them should they not be satisfied with the response to their complaint. For example, the Parliamentary and Health Service Ombudsman (PHSO) for NHS patients and the Centre for Effective Dispute Resolution (CEDR) for private patients. We found complaints had been investigated and complainants informed of the outcome and the clinic had acted as a result to improve the quality of care. Managers acknowledged the need to amend their complaints response letter following the investigation to advise complainants of the escalation route. They confirmed they had not received any informal concerns.

Good

Are services well-led?

We rated well-led as Good because:

The clinic had a clear leadership and management structure in place and staff felt valued and supported in their work. The culture of the service and the way it was governed drove the delivery and improvement of good quality, person-centred care.

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. Areas identified included reducing patient wait times as a result of Covid-19, staff recruitment, replacing a key member of staff who was due to retire shortly, refurbishing clinical areas and equipment and recovering patient survey feedback.
- 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. They shared the plans they had in place for succession planning to reduce the impact on the team following the announcement of the retirement of a key member of the team.

Vision and strategy

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

- There had been a transfer of ownership in March 2020 when The Dermatology Partnership acquired the clinic and adopted their purpose, goal and vision.Staff were aware of and understood the vision, values and strategy and their role in achieving them.
- The clinic currently did not have a documented formal business plan in place to achieve priorities but told us they were working on developing one.
- The service monitored progress against delivery of the strategy.

Culture

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

- Staff we spoke with felt respected, supported and valued. They told us they were proud to work at the clinic.
- The service focused on the needs of patients.
- Leaders and managers acted on behaviour and performance inconsistent with the vision and values.
- Openness, honesty and transparency were demonstrated when responding to incidents and complaints. The provider wasaware 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 need. This included appraisal and career development conversations. Staff we spoke with confirmed they had received an annual appraisal in the last year. Staff were supported to meet the requirements of professional revalidation where necessary. Clinical staff, including nurses, were considered valued members of the team. They were given protected time for professional time for professional development and evaluation of their clinical work.

Good

Are services well-led?

- There was a strong emphasis on the safety and well-being of all staff. Leaders had supported staff through difficult circumstances including Covid-19, a change of ownership and both professional and personal challenges.
- The service actively promoted equality and diversity. Staff had received equality, diversity and human rights training.
- There were positive relationships between staff and teams. Staff we spoke with told us leaders were supportive, approachable and operated an open-door policy. They told us they enjoyed their work.

Governance arrangements

There were clear responsibilities, roles and systems of accountability to support good governance and management.

- The service was overseen by the Registered Manager on a day to day basis.
- Structures, processes and systems to support good governance and management were clearly set out, understood and effective. However, we found a greater oversight was required in relation to staff recruitment and infection, prevention and control.
- The governance and management of partnerships, joint working arrangements and shared services promoted interactive and co-ordinated person-centred care.
- Staff we spoke with demonstrated a clear understanding of their roles and accountabilities.
- Leaders had established policies, procedures and activities to ensure safety. However, we found they were not fully working in line with their employment policy. Policies were accessible to staff and a number of policies were available for patients to access on the provider website.
- Clinicians continued to work within NHS health care settings, as well as undertaking NHS and private work at the service. Four doctors worked solely at the clinic. All clinicians were subject to appraisals and revalidation procedures.
- A range of meetings were held to share information. These included clinical governance meetings, significant event analysis meetings, nurse meetings, reception/admin meetings and integrated governance committee meetings
- 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 weaknesses.
- The service submitted data or notifications to external organisations as required, for example commissioners.
- There were arrangements in line with data security standards for the availability, integrity and confidentiality of patient identifiable data, records and data management systems.

Managing risks, issues and performance

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

- There was an effective, process to identify, understand, monitor and address current and future risks including risks to patient safety.
- The service had processes to manage current and future performance. Leaders had oversight of safety alerts, incidents, and complaints and had acted when concerns had been raised regarding staff performance.
- Audits had a positive impact on quality of care and outcomes for patients. There was evidence of action to change services to improve quality.
- 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.

Good

Are services well-led?

- Quality and operational information was used to ensure and improve performance. Performance information was combined with the views of patients.
- Quality and sustainability were discussed in relevant meetings where all staff had sufficient access to information.

Engagement with patients, the public, staff and external partners

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

- The clinic encouraged and heard views and concerns from the public, patients, staff and external partners and acted on them to shape services and culture.
- Patients were able to leave a review about the care and treatment they received and rate the clinic to improve the service. Questions asked included their overall experience, friendliness of staff, wait time and cleanliness. Reviews were anonymous. Due to processing issues patient feedback had not been obtained since January 2022. The provider was working centrally to resolve these issues. Survey results between April 2021 and December 2021 were positive with 1,008 survey response received. Patients overall experience achieved a rating of 97%. The clinic had also done a 'you said we did' exercise.
- Patient experience was discussed in clinical governance meetings held. These included compliments, complaints and patient surveys.
- A staff survey had been undertaken in February 2022 and the results were positive.
- In preparation for the inspection the clinic had shared a link on their website for patients to share their feedback on care. However, we did not receive any feedback.
- There were systems to support improvement and innovation work.
- Managers advised 95% of clinics were supervised by a consultant who does not have their own list but supervised and supported the clinics being run to maximise the number of patients receiving consultant opinion.
- Staff we spoke with could describe the systems in place to give feedback, this included patient and staff surveys, compliments, complaints and feedback from commissioners. We saw evidence of feedback opportunities for staff and how the findings were fed back to staff. We also saw staff engagement in responding to these findings.
- The clinic was transparent, collaborative and open with stakeholders about performance and held meetings on a quarterly basis to share information regarding performance, including referral to treatment time.
- Managers told us they had provided an educational event for local GPs on contact dermatitis to raise their awareness.

Continuous improvement and innovation

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

- There was a focus on continuous learning and improvement. Staff told us they were encouraged and supported to develop their skills if they wished to.
- The service made use of internal and external reviews of incidents and complaints. Learning was shared and used to make improvements.
- Leaders and managers encouraged staff to take time out to review individual and team objectives, processes and performance.

The provider had introduced a rewards and recognition scheme for all employees employed across their sites. National awards were due to be held in October 2022. Local awards included an extra day leave for the member of staff awarded the most votes for 'going the extra mile'. Successful employees had to demonstrate they were following the values set by

Good

Are services well-led?

The Dermatology Partnership and were also presented with a certificate for their achievement. Outcome of awards which were given bi-monthly had been shared across the team in a recent meeting held. Staff were also provided with an extra day leave on their Birthday and now had access to a staff welfare programme to help with work life balance and improve health and wellbeing.