The Hogarth Health Club

Inspection report

1A Airedale Avenue
London
W4 2NW
Tel: 02087474746
www.drbela.clinic

Date of inspection visit: 09 November 2021
Date of publication: 29/11/2021

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?	Requires Improvement
Are services effective?	Good
Are services caring?	Good
Are services responsive to people's needs?	Good
Are services well-led?	Good

Overall summary

This service is rated as Good overall.

The key questions are rated as:

Are services safe? – Requires improvement

Are services effective? – Good

Are services caring? – Good

Are services responsive? – Good

Are services well-led? – Good

We carried out an announced comprehensive inspection at The Hogarth Health Club as part of our inspection programme of a new provider registration for the service. This was a first rated inspection for the service that was registered with the Care Quality Commission (CQC) in August 2017. During this inspection we inspected the safe, effective, caring responsive and well led key questions.

The Hogarth Health Club, also known as Dr Bela Clinic, is an independent dermatology clinic located in the London Borough of Hounslow. The provider 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.

This service is registered with CQC under the Health and Social Care Act 2008 in respect of some, but not all, of the services it provides. There are some exemptions from regulation by CQC which relate to particular types of regulated activities and services and these are set out in Schedule 1 and Schedule 2 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The Hogarth Health Club provides a range of non-surgical cosmetic interventions, for example dermal fillers, lip fillers and Botox injections which are not within the CQC scope of registration. Therefore, we did not inspect or report on these services.

Our key findings were:

- The service had a range of policies and procedures to govern activity.
- The provider organised and delivered services to meet patients' needs.
- Patients could access care and treatment from the service within an appropriate timescale for their needs.

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

- Ensure that care and treatment is provided in a safe way. (Please see the specific details on action required at the end of this report).

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

- Continue to monitor and review quality improvement for patients.

Overall summary

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 specialist advisor.

Background to The Hogarth Health Club

Dr Bela Clinic trading as Dermatic Limited at The Hogarth Health Club provides private dermatology, skin cancer screening and facial aesthetic services. It is located at 1A Airedale Avenue London W4 2NW. The clinic premises are not suitable for access by wheelchair users and some less able patients.

At the time of the inspection the provider did not offer a chaperone and patients were advised of this at registration. The service sees approximately 20 patients a week. The service is made up of one lead doctor who is registered with the General Medical Council GMC, the doctor is not on the GP register or the specialist register. The service is open Monday, Tuesday 9am-5pm, Wednesday, Thursday, Friday and Saturday 9am-1pm.

The service offers a range of non-surgical cosmetic interventions, for example dermal fillers and lip fillers, Botox injections which are not within CQC scope of registration.

Therefore, we did not inspect or report on these services.

Other services provided include private dermatology consultations by the lead doctor and total body screening for skin cancer, also prescribing of medicines and referrals to other healthcare specialists as required. They also provide minor surgical procedures using local anaesthetic for the removal of warts, moles, cysts, skin tags. Patients can register for either a general dermatological consultation and treatment, or melanoma and skin cancer screening or facial aesthetic treatments. The provider sees both children and adults.

The service website address is https://drbela.clinic. We visited The Hogarth Health Club on 09 November 2021. The team was led by a CQC inspector, accompanied by a GP specialist advisor. Before the inspection, we reviewed notifications received about the service, and a standard information questionnaire completed by the service. During the inspection, we interviewed staff, made observations and reviewed documents.

Requires Improvement

Are services safe?

We rated safe as Requires improvement because:

We identified safety concerns that were rectified soon after our inspection. The likelihood of this happening again in the future is low and therefore our concerns for patients using the service, in terms of the quality and safety of clinical care are minor. This included not having an effective chaperone system in place, not verifying patients identity, and not having specific medical equipment on the day of the inspection. All these issues were addressed after the inspection.

Safety systems and processes

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

- The provider conducted safety risk assessments. It had appropriate safety policies, which were regularly reviewed. They outlined clearly who to go to for further guidance. The service had systems to safeguard children and vulnerable adults from abuse.
- On the day of the inspection there were ineffective protocols for verifying the identity of patients including children, however the lead doctor explained that through conversation he would be able to identify if a child was attending with their parent or not. After the inspection the doctor informed us that he would now start to verify patients when they first visit and would make a record of this, we were also informed the service website questionnaire would be updated so patients would know they needed to bring identification.
- The service worked with other agencies to support patients and protect them from neglect and abuse. Staff took steps to protect patients from abuse, neglect, harassment, discrimination and breaches of their dignity and respect.
- There was only a lead doctor and we saw a Disclosure and Barring Service (DBS) check had been undertaken. (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 lead doctor received up-to-date safeguarding and safety training appropriate to their role. They knew how to identify and report concerns.
- We were told patients were asked prior to a visit if they required a chaperone, and patients tended not to request one. On the day of the inspection we identified there was no, chaperone process in place for sensitive examinations, no poster in the service, after the inspection the lead doctor, provided evidence of a reviewed chaperone system.
- The service had an adult and child safeguarding policy, with relevant contact details.
- There was an effective system to manage infection prevention and control.
- We saw the service undertook monthly infection control audits.
- A legionella risk assessment was completed October 2019 it had recommendations; we could not see that that the provider was assuring themselves with the building management that recommendations were being followed. After the inspection the provider informed us that a follow up assessment was now scheduled for November 2021.
- We saw a range of risk assessments to aid in patient safety, including hand washing, injury from failing, patient collapsing in the clinic, infection control, COVID, and medical emergency, such as anaphylactic shock.
- We saw an accident book that recorded the date, time, full description, what action was taken and the outcome.
- The provider ensured that facilities and equipment were safe, and that equipment was maintained according to manufacturers' instructions. There were systems for safely managing healthcare waste.
- The provider carried out appropriate environmental risk assessments, which took into account the profile of people using the service and those who may be accompanying them.

Risks to patients

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

Requires Improvement

Are services safe?

- There were arrangements for planning and monitoring the number and mix of staff needed.
- The lead doctor understood their responsibilities to manage emergencies and to recognise those in need of urgent medical attention. They knew how to identify and manage patients with severe infections, for example sepsis.
- When there were changes to services, the service assessed and monitored the impact on safety.
- There were appropriate indemnity arrangements in place.
- On the day of the inspection the provider did not have a thermometer, or pulse oximeter, however after the inspection the provider showed us proof that these pieces of equipment had been purchased.
- The service had undertaken a COVID risk assessment.
- We saw weekly fire alarm checks were undertaken and a fire policy.
- Fire safety signs/action notices were positioned around the service that explained what to do in the event of fire.
- There were suitable medicines and equipment to deal with medical emergencies which were stored appropriately and checked regularly.

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.
- The service had systems for sharing information with staff and other agencies to enable them to deliver safe care and treatment.
- The service had a system in place to retain medical records in line with Department of Health and Social Care (DHSC) guidance in the event that they cease trading.
- Clinicians made appropriate and timely referrals in line with protocols and up to date evidence-based guidance.
- The lead doctor did not always communicate with patients NHS GP, for example some patients he would send letters to the patients NHS GP if he had prescribed a certain medication, and sometimes he would not, however after the inspection, the lead doctor informed us of a changed process, that he would be following that enabled him to communicate with NHS GP.
- We saw there was a system in place to check staff immunisation status.

Safe and appropriate use of medicines

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

- The service only had one thermometer and was not keeping records of the fridge temperatures. Public Health England guidance recommends a second thermometer. After the inspection the provider showed us evidence that they had placed an order for a thermometer. They also showed us evidence of a daily record sheet.
- The systems and arrangements for managing medicines, including vaccines, emergency medicines and equipment minimised risks with the exception of recording fridge temperature, however this was resolved after the inspection. The service kept prescription stationery securely and monitored its use.
- The lead doctor prescribed, administered or supplied medicines to patients and gave advice on medicines in line with legal requirements and current national guidance. Processes were in place for checking medicines and staff kept accurate records of medicines. Where there was a different approach taken from national guidance there was a clear rationale for this that protected patient safety.

Track record on safety and incidents

The service had a good safety record.

Requires Improvement

Are services safe?

- There were comprehensive risk assessments in relation to safety issues.
- 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.

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. The lead doctor understood their duty to raise concerns and report incidents and near misses. There was a significant event policy and a reporting significant events reporting template, the service informed us there had not been any significant events in the last 12 months.
- There were adequate systems for reviewing and investigating when things went wrong. The service learned and identified themes and took action to improve safety in the service. For example, the lead doctor provided an example of a burn incident that occurred in 2018, that they had learned from.
- 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

Good

Are services effective?

We rated effective as Good because:

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) best practice guidelines, the provider told us they also used updates from the British College of Aesthetic Medicine (BCAM) to follow government guidelines and best practice.
- 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.
- Arrangements were in place to deal with repeat patients, for example if patients were receiving treatment for acne.
- Staff assessed and managed patients' pain where appropriate.

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 completed audits, for example we saw the provider had completed an audit for the treatment of acne, also a patient satisfaction survey was sent out after consultations. Clinical audit had a positive impact on quality of care and outcomes for patients. There was clear evidence of action to resolve concerns and improve quality. Although the provider had undertaken a range of audits, they were single cycle audits.

Effective staffing

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

- The lead GP was appropriately qualified.
- Relevant professionals were registered with the General Medical Council (GMC) and were up to date with revalidation.
- We saw a policy that explained relevant training for staff to complete, including basic life support, fire, equality and diversity, Infection Control, information governance, health & safety, whistle blowing.
- We saw a recruitment/staff induction and checklist policy.
- On the day of the inspection the lead doctor had not completed mental capacity act training or information governance, however shortly after the inspection, we saw the doctor had completed this training.

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. The lead GP was not always communicating with patients GPs. The lead doctor informed us they would send a letter to patient GP, if the patients agrees and consents, however he was not always doing this.

Good

Are services effective?

- 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. We saw examples of patients being signposted to more suitable sources of treatment where this information was not available to ensure safe care and treatment.
- All patients were asked for consent to share details of their consultation and any medicines prescribed with their registered GP on some occasions when they used the service.
- The provider had risk assessed the treatments they offered. They had identified medicines that were not suitable for prescribing if the patient did not give their consent to share information with their GP, or they were not registered with a GP. Where patients agreed to share their information, we saw evidence of letters sent to their registered GP in line with GMC guidance.
- Patient information was shared appropriately (this included when patients 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. There were clear and effective arrangements for following up on people who had been referred to other services.

Supporting patients to live healthier lives

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, highlighted to patients and where appropriate highlighted to their normal care provider for additional support.
- 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 understood the requirements of legislation and guidance when considering consent and decision making.
- Staff supported patients to make decisions.

Good

Are services caring?

We rated caring as Good because:

Kindness, respect and compassion

Staff treated patients with kindness, respect and compassion.

- The service sought feedback on the quality of clinical care patients received.
- Feedback from patients was positive about the way the lead doctor treated people
- The lead doctor 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.

Involvement in decisions about care and treatment

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

- Interpretation services were not available for patients who did not have English as a first language. The lead doctor informed us most of his patients were Hungarian which he spoke.
- We saw from the in-house patient survey that patients felt listened to and supported by the lead doctor.

Privacy and Dignity

The service respected/did not respect patients' privacy and dignity.

- Staff recognised the importance of people's dignity and respect.
- Consultations and treatments were undertaken in a private clinical room.

Good

Are services responsive to people's needs?

We rated responsive as Good because:

Responding to and meeting people's needs

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

- Appointments were 45 minutes now increased from 30 minutes an additional 15 minutes appointment time was added for cleaning and allowing air to circulate around the room.
- The provider understood the needs of their patients and improved services in response to those needs.
- The clinic premises were not suitable for access by wheelchair users and some less abled patients, however the provider told us they make reasonable and practical adjustments to provide a service to these patients to accommodate.
- The facilities and premises were appropriate for the services delivered.

Timely access to the service

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

- Patients had timely access to initial assessment, test results, diagnosis and treatment.
- Waiting times, delays and cancellations were minimal and managed appropriately.
- Patients reported that the appointment system was easy to use.
- Referrals and transfers to other services were undertaken in a timely way.

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.
- 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 a complaint policy and procedures in place.

Good

Are services well-led?

We rated well-led as Good because:

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.
- 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 clear vision and credible strategy to deliver high quality care and promote good outcomes for patients.

- There was a clear vision and set of values. The service had a realistic strategy and supporting business plans to achieve priorities.
- The service developed its vision, values and strategy jointly with staff and external partners
- The service monitored progress against delivery of the strategy.

Culture

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

- The service focused on the needs of patients.
- Openness, honesty and transparency were demonstrated 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.
- The service actively promoted equality and diversity. It identified and addressed the causes of any workforce inequality. The lead doctor had received equality and diversity training.
- The provider had his worked reviewed by his current appraiser.

Governance arrangements

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

- Structures, processes and systems to support good governance and management were clearly set out, understood and effective.
- Leaders had established proper policies, procedures and activities to ensure safety and assured themselves that they were operating as intended with the exception of the chaperone procedure, however this was resolved after the inspection.
- 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.

Good

Are services well-led?

- There were robust 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

After the inspection the provider ensured there were clear and effective processes for managing risks, issues and performance.

- On the day of the inspection we identified a few risks, however shortly after the inspection these risks had been resolved. For example, the service did not have a system in place to assure that an adult accompanying a child had parental authority.
- Patient identity was not verified on the initial visit to the clinic.
- The lead doctor did not always communicate with patients NHS GP effectively.
- The service only had one thermometer and was not keeping records of the fridge temperatures.
- A legionella risk assessment was completed October 2019 it had recommendations; we could not see that that the provider was assuring themselves with the building management that recommendations were being followed.
- After the inspection the provider updated their systems and process to address all of these concerns.
- The service had processes to manage current and future performance. Performance of clinical staff could be demonstrated through audit of their consultations, prescribing and referral decisions. Leaders had oversight of safety alerts, incidents, and complaints.
- Clinical audit had a positive impact on quality of care and outcomes for patients.
- The provider had plans in place and was aware of 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 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 service encouraged and heard views and concerns from the public, patients, and external partners and acted on them to shape services and culture.
- The lead doctor could describe to us the systems in place to give feedback
- For example, the lead doctor had undertaken a patient survey in October 2020, they also introduced an online patient satisfaction questionnaire tool, that was sent out to patients after their visit.

Continuous improvement and innovation

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

- The lead doctor was registered with the British College of Aesthetic Medicine (BCAM).

Good

Are services well-led?

- We saw that the lead doctor had written an article discussing the importance of putting patient safety first with cosmetic injectables.
- There was a focus on continuous learning and improvement.
- The service made use of internal and external reviews of incidents and complaints.

There were systems to support improvement and innovation work.

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 Surgical procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment The provider had failed to ensure that care and treatment is provided in a safe way to service users. In particular they had: • Ineffective chaperone procedure • Not always communicating with NHS GP • No system for checking patient identity • The was no system in place to assure that an adult accompanying a child had parental authority. • There was only one refrigerator thermometer and records of fridge temperatures were not being recorded. • There was incomplete equipment available (pulse oximeter, thermometer). This is in breach of regulation 12(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.