Sk:n Epsom

Inspection report

Epsom General Hospital
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Date of inspection visit: 27 April 2022
Date of publication: 08/06/2022

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

This service is rated as Good overall.

The key questions are rated as:

Are services safe? – Good

Are services effective? – Good

Are services caring? – Good

Are services responsive? – Good

Are services well-led? – Good

We carried out an announced comprehensive inspection of Sk:n Epsom on 27 April 2022 under Section 60 of the Health and Social Care Act 2008. This inspection was planned to check whether the service was meeting the legal requirements and regulations associated with the Health and Social Care Act 2008. This was the provider's first inspection of the service since it registered with the Care Quality Commission (CQC).

Throughout the COVID-19 pandemic the Care Quality Commission (CQC) has continued to regulate and respond to risk. However, taking into account the circumstances arising as a result of the pandemic, and in order to reduce risk, we have conducted our inspections differently.

This inspection was carried out in a way which enabled us to spend a minimum amount of time on site. This was with consent from the provider and in line with all data protection and information governance requirements.

This included:

- Speaking with staff in person, on the telephone and using video conferencing.
- Requesting documentary evidence from the provider.
- A site visit.

We carried out an announced site visit to the service on 27 April 2022. Prior to our visit we requested documentary evidence electronically from the provider. We spoke to staff on the telephone and using video conferencing prior to our site visit.

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

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

Overall summary

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

The clinic manager is the registered manager. A registered manager is a person who is registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

Our key findings were:

- Staff had received training in key areas. There was a clear plan of training for all staff employed by the service.
- Recruitment checks had been carried out in accordance with regulations, including for staff employed on a sessional basis.
- There were safeguarding systems and processes to keep people safe.
- Arrangements for chaperoning were effectively managed.
- There were appropriate arrangements to manage medical emergencies and suitable emergency medicines and equipment in place.
- There were effective systems and processes to assess the risk of, and prevent, detect and control the spread of infection.
- There were comprehensive health and safety risk assessments and processes in place.
- There was evidence of clinical audit and auditing of clinical record keeping processes.
- Clinical record keeping was clear, comprehensive and complete.
- Best practice guidance was not always followed in providing treatment to some patients prescribed medicines for the treatment of acne.
- There were clear and effective governance and monitoring processes to provide assurance to leaders that systems were operating as intended. Risks were promptly identified and responded to.

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

- Review processes for the monitoring of patients prescribed medicines for the treatment of acne, in order to promote consistency of approach in following current guidance.
- Continue to develop a revised approach to the monitoring of staff immunisations in line with current guidance.
- Review processes to ensure the attendance of a chaperone is recorded in clinical records.

Dr Rosie Benneyworth BM BS BMedSci MRCGP

Chief Inspector of Primary Medical Services and Integrated Care

Our inspection team

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

Background to Sk:n Epsom

Sk:n Epsom provides independent doctor-led dermatology services, offering skin treatments such as prescribing for acne and other skin conditions, and minor surgical procedures, including the excision of moles and other skin lesions. The service also provides non-regulated aesthetic treatments, for example, cosmetic Botox injections, dermal fillers and thread vein treatments, which are not within CQC scope of registration.

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

Sk:n Epsom is located at Epsom General Hospital, Langley Ward, Dorking Road, Epsom, Surrey, KT18 7EG.

The clinic opening times are:

Monday to Thursday: 10am to 8pm

Friday: 9am to 7pm

Saturday: 9am to 6pm

Sunday: 10am to 4pm

The staff team is comprised of a clinic manager and a nurse, supported by aesthetic practitioners who provide only non-regulated aesthetic treatments. Five doctors who specialise in dermatology, provide dermatology consultations and treatments on a sessional basis. One of the doctors is also employed as the medical director for the service. A consultant oral and maxillofacial surgeon provides consultations on a sessional basis. Staff are supported by the provider's regional and national management and governance teams.

The service is run from self-contained, ground floor premises which are leased by the provider and located within a general hospital setting. The premises include a suite of consultation and treatment rooms, a reception and waiting area. Access to the premises at street level, is available to patients with limited mobility. Toilet facilities are located on the ground floor.

How we inspected this service

To get to the heart of patients' experiences of care and treatment, we always ask the following five questions:

- Is it safe?
- Is it effective?
- Is it caring?
- Is it responsive to people's needs?
- Is it well-led?

These questions therefore formed the framework for the areas we looked at during the inspection.

Good

Are services safe?

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

- The service had systems and processes to safeguard children and vulnerable adults from abuse. The provider's safeguarding policies provided appropriate guidance for staff. Staff we spoke with had a clear understanding as to who was the safeguarding lead within the service and how to raise safeguarding concerns about a patient. Our review of training records confirmed that all staff had received training in safeguarding vulnerable adults and children at a level appropriate to their role.
- Treatment was offered to those aged over 18 years of age and to a small number of children aged eight years and above. The service asked patients to confirm they were aged 18 years or over in respect of certain treatments. They carried out identification checks if a patient appeared to be under the age of 25 years and recorded those checks within the clinical record. The service had systems in place to ensure that an adult accompanying a child had parental authority.
- The provider carried out all required staff checks at the time of recruitment and all required ongoing monitoring, such as professional registration status and medical indemnity confirmation. Disclosure and Barring Service (DBS) checks were undertaken for all staff. (DBS checks identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable).
- We saw there was signage on display within the service which invited patients to request a chaperone. All staff who acted as chaperones were trained for the role and had undergone a DBS check. However, staff told us that the presence of a chaperone in a consultation was not always recorded within a patient's clinical record.
- There were effective systems to manage infection prevention and control within the service. Cleaning and monitoring schedules were in place. The landlord of the premises provided cleaning services which were monitored by staff within the service. There were appropriate processes in place to minimise risks associated with COVID-19 transmission. The provider had undertaken an audit of their infection prevention and control processes and all resulting actions had been completed. Regular audits of hand hygiene processes were undertaken. All staff had received training in infection prevention and control.
- We reviewed processes for the monitoring of staff immunisations. We saw records which confirmed that the Hepatitis B status of relevant staff was monitored. At the time of our inspection, the provider did not hold other immunisation records, in line with current guidance, for all clinical staff employed within the service. Processes for the monitoring of staff immunisations had been recently reviewed and were subject to an ongoing change of approach which reflected current guidance.
- The service performed minor surgical procedures for which they used single-use, disposable items. There were sufficient stocks of personal protective equipment, including aprons and gloves, available to staff.
- There were systems for safely managing healthcare waste, including sharp items. We saw that clinical waste disposal was available in clinical rooms. Bins used to dispose of sharps items were signed, dated and not over-filled. There were suitable arrangements in place, managed by the landlord, for the collection of healthcare waste by a waste management company.
- The service had systems to manage health and safety risks within the premises, such as fire safety and legionella. Legionella risk assessments were carried out and resulting actions had been completed. (Legionella is a particular bacterium which can contaminate water systems in buildings). Testing of water samples was undertaken at suitable intervals. The provider had responded appropriately to low levels of bacteria identified periodically from some outlets within the premises since 2020. Staff had worked closely with the landlord to mitigate and continually monitor the associated risks. More frequent testing of samples had been undertaken where required. Staff undertook daily flushing of infrequently used outlets in order to reduce the risk of Legionella and other bacteria multiplying.
- There were documented risk assessments in place to manage risks associated with the premises and general environment. There was a documented fire evacuation plan and major incident plan in place. The provider had developed a comprehensive COVID 19 safety policy and associated local risk assessments. There was guidance and information, including risk assessments, available to staff to support the control of substances hazardous to health (COSHH).

Good

Are services safe?

- The provider had carried out regular fire safety risk assessments. A fire risk assessment had been undertaken by an external supplier in February 2022. Required remedial works, for example the servicing of a fire blanket, had been completed by the time of our inspection. There was appropriate fire-fighting equipment located within the premises which was regularly serviced and maintained. We noted that fire alarm testing was carried out weekly by the landlord. Fire extinguishers had been serviced in September 2021. The service had designated staff who were trained as fire marshals and staff had undertaken fire safety training. Staff had participated in regular rehearsal of fire evacuation procedures.
- The provider ensured that facilities and equipment were safe. Equipment was maintained according to manufacturers' instructions. We reviewed records to confirm that electrical equipment had undergone portable appliance testing.

Risks to patients

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

- There were arrangements for planning and monitoring the number and mix of staff required to meet patient needs. Clinical staff working on a sessional basis were scheduled according to patient demand.
- There were planned induction processes in place and a plan of required training for staff to complete as part of the induction process.
- The medical director for the service was available to offer advice and support to patients outside of opening hours. All patients undergoing minor surgical procedures were discharged with a direct telephone number for the medical director in case of complications.
- The provider's national contact centre implemented a triage system for patients which automatically recognised an existing patient's telephone number. Outside of opening hours this facility enabled the caller to access immediate medical advice from the service, triggering the provider's adverse reaction process. Callers were responded to by a manager or senior advisor who referred the call to a nurse for further medical advice where required.
- There were processes for sending samples for histology and receiving results for review. Samples were recorded in a histology log and a minor operations book, and all samples were tracked when dispatched. The medical director contacted patients if there was a cause for concern and made onward referrals as necessary. If there were no concerns, clinic staff phoned and sent patients copies of their results.
- The service implemented inclusive pricing which meant that patients who were required to attend for follow up appointments for example, for review of a wound or removal of sutures, were not charged for follow up appointments. This encouraged patients to attend for review and ensured effective wound care management following treatment.
- We reviewed arrangements within the service to respond to medical emergencies. We found there were appropriate supplies of emergency medicines available to staff in the event of a medical emergency, for example anaphylaxis. There was a comprehensive documented risk assessment in place to assess the level of risk to patients in the event of a medical emergency which included rationale for the emergency medicines held. There was oxygen available on the premises and a defibrillator in a closely located area of the hospital which were subject to regular checks.
- Staff understood their responsibilities to manage emergencies and to recognise those in need of urgent medical attention. Staff had received basic life support training which was annually updated. Staff had recently undergone one-to-one update training in the use of an autoinjector to treat anaphylaxis.
- The service had a first aid kit in place which was appropriately stocked, and its' contents were regularly checked.
- There were appropriate professional indemnity arrangements in place for clinical staff.
- The provider had in place public and employer's liability insurance policies.

Information to deliver safe care and treatment

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

Good

Are services safe?

- We reviewed clinical records relating to 16 patients who had received treatment within the service.
- Individual care records were written and managed in a way that kept patients safe. Clear, accurate and contemporaneous patient records were kept. Treatment planning and information were fully documented.
- 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 provider had developed a clinical notes booklet which provided a comprehensive template to ensure consistency of clinical record keeping.
- Photographs of lesions treated were routinely taken to enhance clinical record keeping and to promote comparisons before and after treatment.
- Clinical records were stored on a secure, password-protected, electronic system. Hand-written records were stored securely in locked cupboards within a locked room.
- Consent processes were comprehensive and consistently applied. There was a documented consent policy. We reviewed the comprehensive consent form templates developed by the provider for use with patients undergoing minor surgical procedures and prescription treatments for acne. Patient records clearly documented the consent process and discussions between the practitioner and patient.
- Patients attended the clinic for assessment and treatment of skin lesions such as moles, lipomas and cysts. Clinical staff providing dermatology services had received specialist dermatology training and followed best practice guidance, such as that provided by the British Association of Dermatologists (BAD). For example, screening of moles and other lesions included the use of a dermatoscope and removed lesions were routinely sent for histological examination. (A dermatoscope is a hand-held visual aid device used to examine and diagnose skin lesions and diseases).
- The service had systems for sharing information with staff and other agencies, for example, the patient's NHS GP, to enable them to deliver safe care and treatment.
- Clinicians made appropriate and timely referrals in line with protocols and up to date evidence-based guidance. For example, for patients requiring onward referral to secondary care services for skin cancer treatment. Staff told us if a lesion appeared suspicious, they would immediately refer the patient back to their registered GP or directly onto a secondary care pathway.
- 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.

Safe and appropriate use of medicines

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

- The service kept prescription stationery securely and monitored its use. There were systems and arrangements for managing the safe handling of medicines and prescribing practices in a way which minimised risks to patients. We noted that the provider had recently recorded an incident and issued an alert to local managers with regard to the incorrect printing of a batch of branded prescription pads. The provider had recalled the batch of prescriptions which did not include a prescription number and could therefore not be tracked and audited.
- Our review of clinical records confirmed that staff generally prescribed and administered medicines to patients, and gave advice on medicines, in line with legal requirements and current national guidance.
- However, we noted that in a small number of patients prescribed a particular medicine for the treatment of acne, best practice guidance was not always followed. The medicine, prescribed for the treatment of severe acne, can have serious side effects and must be prescribed and supervised by a specialist doctor. We found that patients were provided with clear and comprehensive information regarding the possible side effects associated with taking the medicine. Patients were required to consent to a pregnancy prevention plan prior to the issuing of each prescription, due to the significant risks associated with taking the medicine during pregnancy. However, we found that some blood testing to monitor the patient's liver function was not always carried out prior to a prescription of the medicine being

issued, in line with current guidance. Staff told us that blood testing was sometimes requested via the patient's GP at the time of issuing the first prescription. They told us that those results would be available at the next review appointment, eight to ten weeks later, prior to the issuing of a second prescription. We noted that clinicians promoted a low-dose regimen which mitigated the risks to patients to some extent.

- We reviewed the provider's documented patient pathway and pre-treatment checklist for the prescription of this particular medicine. We noted that both included the requirement for pre-treatment blood testing. However, the pre-treatment checklist stated that it was not intended to represent essential practice.
- Appropriate processes were in place for the ordering, receipt and monitoring of stock medicines held and staff kept accurate records of those medicines.
- Emergency medicines were readily available and in date and supplies were regularly checked. There were documented records of those checks.
- Medicines were stored securely in a locked cupboard in the consulting room. Medicines requiring refrigeration were stored in a refrigerator which was monitored to ensure it maintained the correct temperature range for safe storage. All temperatures recorded had been within the range for safe storage. We noted that the provider had recently issued a memorandum to local teams to remind them of fridge temperature monitoring and cold chain processes.

Track record on safety and incidents

- The provider had developed monitoring processes which provided a clear, accurate and current picture to local and national leaders which led to safety improvements. Central medical advisory and clinical governance committees ensured local and group oversight, and prompt intervention when required.
- There were monitoring and auditing processes in place to provide assurance to leaders that systems were operating as intended. Some of those processes were implemented by regional and national support roles who worked closely with local managers to identify risks and implement improvements. For example, regional audit staff worked with local managers to undertake six-monthly auditing of all aspects of service delivery.
- There were comprehensive risk assessments in relation to safety issues and to support the management of health and safety within the premises.

Lessons learned and improvements made

The service had systems to ensure they learned 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 and how to use the provider's electronic reporting system. There had been no serious incidents recorded within the past 12 months.
- There were appropriate systems for reviewing and investigating when things went wrong. The service learned, shared lessons across the group and took action to improve safety within the service.
- The provider was aware of and complied with the requirements of the Duty of Candour. The provider encouraged a culture of openness and honesty.
- The service had systems in place for knowing about notifiable safety incidents. The service acted on and learned from external safety events as well as patient and medicine safety alerts.
- Safety alert information and other organisational messaging, for example protocol changes, were cascaded effectively to staff within local services via update bulletins issued by central teams and reinforced by local managers.

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.

- Clinicians employed by the service had high levels of skills, knowledge and experience to deliver the care and treatment offered by the service.
- Clinicians kept up to date with current evidence-based practice. We found that clinicians generally assessed needs and delivered care and treatment in line with relevant current legislation, standards and guidance. These included the National Institute for Health and Care Excellence (NICE) and British Association of Dermatologists (BAD) best practice guidelines. However, we noted that in a small number of patients prescribed Isotretinoin for the treatment of acne, best practice guidance was not always followed. For example, we found that some blood testing to monitor the patient's liver function was not always carried out prior to a prescription for Isotretinoin being issued, in line with current guidance.
- We reviewed clinical records relating to 16 patients who had received treatment within the service. We found there was a consistent approach to clinical record keeping and risks to the patient were comprehensively assessed, discussed and documented. Clear, accurate and contemporaneous clinical records were kept. Treatment planning and information were fully documented.
- The service ensured they provided information to support patients' understanding of their treatment, including pre- and post-treatment advice and support. Staff within the service provide a telephone call prior to and following treatment. Patients were able to access post treatment support via follow up appointments and also on the telephone.
- Staff assessed and managed patients' pain where appropriate. Patients were prescribed local anaesthetic medicines prior to some procedures, where appropriate.
- We saw no evidence of discrimination when making care and treatment decisions.

Monitoring care and treatment

The service was able to demonstrate quality improvement activity.

- The service used information about care and treatment to assess the need to make improvements.
- Staff employed on a sessional basis were subject to review of their performance within the service and monitoring of their clinical decision making and patient treatment outcomes. Medical advisory and clinical governance committees provided a central structure under which patient treatment outcomes were monitored.
- The service carried out a regular series of audits of patient records to review compliance with the provider's expected standards of record keeping. For example, we saw records of clinical notes audits which had been undertaken every six months.
- Regional audit staff worked with local managers to undertake six-monthly auditing of all aspects of service delivery, including for example, premises safety, infection prevention and control, policy and procedural management and medicines management. Service locations received a score and rating which reflected the level of risk identified by the audit. Action points arising from the audits were identified and closely monitored until completion. We found that auditing of the service carried out in February 2022 had identified a small number of minor areas for improvement. A further audit undertaken in April 2022 confirmed that all required actions had been completed.

Effective staffing

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

- Staff had the appropriate skills and training to carry out their roles. There were planned induction processes in place. There was a plan of required training for staff to complete as part of the induction process.

Good

Are services effective?

- The provider understood the learning needs of staff and provided protected time and training to meet them. We found that up to date records of skills, qualifications and training were maintained.
- There was regular review of individual performance. Staff underwent monthly one-to-one review meetings with the service manager and annual appraisal. Clinical staff employed on a sessional basis provided evidence of their professional external appraisal summary to the provider and also participated in monthly one-to-one review meetings.
- The service held records which confirmed medical professionals were registered with the General Medical Council (GMC) and Nursing and Midwifery Council (NMC) and were up to date with revalidation.

Coordinating patient care and information sharing

- Patients who used the service received coordinated and person-centred care. Staff referred to, and communicated effectively with, other services where appropriate.
- Our review of care records confirmed that before providing treatment, doctors at the service ensured they had adequate knowledge of the patient's health, previous medical and medicines history.
- All patients were asked for consent to share details of their consultation and any medicines prescribed, with their registered GP, when they registered with the service.
- Patient information was shared appropriately, and the information needed to plan and deliver care and treatment was available to relevant staff in a timely and accessible way.
- There were effective arrangements for following up on patients where their care involved other services, for example there were processes for tracking histology results following lesion excision.

Supporting patients to live healthier lives

- Patients were provided with information about procedures, including the benefits and risks of treatments provided. The service provided pre- and post-treatment advice and support to patients, for example about wound care. Patients received a support telephone call in the days preceding their initial consultation and following their treatment.
- In the event that patients presented with concerns or complications post treatment, the service had access to advice and support from nurses from across the organisation, as well as a group medical standards team for advice, triage and support.
- Where patients' needs could not be met by the service, staff told us they redirected them to the most appropriate service for their needs. For example, staff told us that if they were concerned about a suspicious lesion, they would decline to treat the patient and would refer the patient back to their GP or directly onto a secondary care pathway.
- Where lesions were removed or treated within the service, samples were routinely sent for histology. Processes were in place to ensure the recording and tracking of samples sent for histological review. Staff told us that the treating clinician reviewed all results prior to patients being notified of the outcome.

Consent to care and treatment

The service had processes to ensure consent to care and treatment was obtained in line with legislation and guidance.

- Staff we spoke with understood the requirements of legislation and guidance when considering consent and decision making. Staff had completed training in the Mental Capacity Act 2005. Staff described processes for the assessment of patients' suitability for treatment which included their psychological well-being, mental capacity and vulnerability. Staff told us they would not agree to treat patients about whom they had any concerns.
- There was a documented consent policy. Consent processes were comprehensive and consistently applied. Patient records we reviewed clearly documented the consent process and discussions between the practitioner and patient.

Good

Are services caring?

Kindness, respect and compassion

Staff treated patients with kindness, respect and compassion.

- Staff understood patients' personal, cultural, social and religious needs. They displayed a welcoming, understanding and non-judgmental attitude to all patients.
- The service gave patients timely support and information in relation to their care and treatment.
- The service actively invited feedback on the quality of care patients received. The provider implemented an online service for all patients which enabled them to provide feedback after every appointment in the form of a score from one to ten. This feedback system also allowed patients to provide comments, whether positive or negative. Clinic managers responded to all comments and contacted patients who provided a score of seven or below to identify their concerns and explore how they felt improvements to the service could be made. Staff told us that in response to feedback, the service contacted patients prior to their appointment in order to make them aware of building works within the hospital grounds and associated restrictions to parking. The service tried to ensure it was flexible in its approach to patients arriving late for appointments for the same reason.
- Immediately prior to our inspection, the service had collected additional feedback from patients via the use of comment cards. Patients described staff as being kind and respectful whilst providing excellent advice and a professional service.

Involvement in decisions about care and treatment

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

- The service ensured that patients were provided with all the information they required to make decisions about their treatment prior to treatment commencing. During the first contact with a patient, the provider's national contact centre gathered information to ensure all the patients' needs could be met.
- Patients were contacted by staff within the service prior to their first appointment, in order to manage their expectations with regard to their consultation and future treatments.
- Staff told us they had responded directly to feedback regarding the ability to make direct contact with the service to amend appointments, for example, without having to go via the provider's central contact team. As a result, the service provided an email address to enable patients to contact them directly.
- Information about pricing was available to patients on the service's website and within the service. Patients were provided with individual quotations for their treatment following their first consultation.
- We saw that the service provided a patient information folder located within the reception and waiting area. This provided information which included the provider's statement of purpose, patient selection policy, governance structure, terms of business, complaints policy, data security information, General Medical Council guidance on cosmetic procedures and the service's COVID-19 risk assessment.
- Translation services were available for patients who did not have English as a first language. There was a hearing loop in place and reception staff could support patients in its use.

Privacy and Dignity

The service respected patients' privacy and dignity.

- Staff recognised the importance of people's dignity and respect. Patients were collected from the waiting area by the clinician and escorted into the consultation room.
- Consultations and treatments took place behind closed doors and conversations could not be overheard. Staff knocked and waited before entering a room, to maintain patients' privacy and dignity.

Good

Are services caring?

- Chaperones were available should a patient choose to have one. All staff who provided chaperoning services had undergone required employment checks and received training to carry out the role.
- Front of house staff were aware that if patients wanted to discuss sensitive issues or appeared distressed, they could offer them a private room to discuss their needs.
- Staff complied with the service's information governance arrangements. Processes ensured that all confidential electronic information was stored securely on computers. All patient records and information kept as hard copies was stored in locked cupboards within a locked room. Staff working in the reception area operated a clear desk policy and hard copy documents were promptly locked away.

Good

Are services responsive to people's needs?

Responding to and meeting people's needs

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

- The provider understood the needs of their patients and arranged services in response to those needs. Doctor-led dermatology services were provided according to patient need.
- The facilities and premises were well maintained and were appropriate for the services and treatments delivered.
- Reasonable adjustments had been made so that people in vulnerable circumstances could access and use services on an equal basis to others. For example, there was a hearing loop and translation support services were available.
- Prior to our inspection we reviewed publicly available information regarding patient experiences at the service. The service encouraged patients to use Trustpilot to review and rate their experience. The provider's website included a direct link to all Trustpilot reviews. At the time of our review we saw that Trustpilot showed the service was rated as 4.6 out of 5 stars. 32 reviews had been left within the 12 last months. Feedback from patients was generally very positive and indicated that patients found the service to be friendly helpful, efficient and person-centred, and that they would recommend the service to other people. All reviews had been responded to promptly by the provider.

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. Appointments could be booked in person or by telephone. Evening and weekend appointments were available.
- The provider operated a central contact centre which enabled patients to book appointments and make enquiries outside the service's normal opening times.
- Patients were able to register their interest in booking an appointment via the provider's website and this was followed up by the central contact centre.
- Waiting times, delays and cancellations were minimal and managed appropriately.
- Referrals to other services were undertaken in a timely way and were managed appropriately. For example, for patients requiring onward referral to secondary care services for skin cancer treatment.

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 service had a complaints policy in place and information about how to make a complaint or raise concerns was available for patients to read in the reception area and on the provider's website.
- The service had received six complaints within the previous 12 months, but these were received from patients who had undergone non-regulated aesthetic treatments and not services which fell within scope of CQC registration.
- There was evidence that complaints had been discussed and the learning shared across the organisation.
- The service clearly informed patients of further action that may be available to them should they not be satisfied with the response to their complaint. The service's written complaints policy included up to date information to support patients should their complaint remained unresolved. For example, there was reference within the policy to the Independent Sector Complaints Adjudication Service from whom additional advice and support may be sought.
- We noted that the provider had recently produced a short guide to improve the management of complaints which staff could use for additional guidance alongside the complaints policy.

Good

Are services well-led?

Leadership capacity and capability:

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

- Leaders at all levels within the service were visible and approachable. They worked closely with the small team of staff to make sure they prioritised compassionate and inclusive leadership.
- The service was part of a national organisation which implemented extensive governance and management systems. This provided a range of local and centralised reporting mechanisms and quality assurance monitoring processes to support the safe delivery of care.
- Leaders demonstrated the capacity to implement systems and processes to support the delivery of high-quality care. Leaders were knowledgeable about issues and priorities relating to the quality and future of services. They understood the challenges and had developed clinical strategies focused upon key areas including clinical governance, risk management, and the use of technology.
- There was a clear local, regional and national staffing structure in place across the organisation and staff were aware of their individual roles and responsibilities. The provider had identified individual members of staff to assume lead roles in key areas. For example, safeguarding and infection prevention and control.
- There were open lines of communication between staff based within the service and those working at a regional and national level and also those employed by the service on a sessional basis. Staff we spoke with felt well supported and described leaders within the service as approachable. Staff told us they had regular formal and informal one-to-one interaction with managers. Staff spoke of regular team meetings they had attended, and we saw records of those meetings.

Vision and strategy

- There was a clear vision and set of values. The provider had set out clear brand values which were to be accessible, approachable, expert and responsible. The company values focused upon brand reputation, customer experience and customer loyalty.
- The service had a realistic strategy and supporting business plans to achieve their priorities.
- Staff were aware of and understood the vision, values and strategy and their role in achieving them. We saw that all staff were fully engaged in ensuring the promotion of optimum outcomes for patients.
- The service monitored progress against delivery of the strategy. It carried out comprehensive audits to assess the quality of care provided.

Culture

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

- Leaders and managers encouraged behaviour and performance consistent with the vision and values.
- Staff felt respected, supported and valued. The service focused on the needs of patients.
- Staff told us they could raise concerns and were encouraged to do so. They had confidence that these would be addressed.
- There had been no serious incidents in the past 12 months relating to the regulated activities carried out by the service. 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, and these were embedded in corporate policies.
- There were processes for providing all staff with the development they needed. Staff had received regular review of their performance in the form of regular one-to-one review and annual appraisal. Staff were supported to meet the requirements of professional revalidation where necessary.

Good

Are services well-led?

- There was a strong emphasis on the safety and well-being of all staff. We saw records which confirmed all staff had participated in monthly one-to-one review meetings with their line manager.
- The service actively promoted equality and diversity. Staff had received equality and diversity training. Staff felt they were treated equally.
- There was a culture of promoting positive relationships and prompt and effective communications between staff. Staff meetings were held regularly. Organisational communications were shared effectively across the group, for example, in the form of regular bulletins which staff within local services were required to sign to confirm their receipt and understanding. For example, we noted that a recent bulletin had informed staff of a newly appointed freedom to speak up guardian.

Governance arrangements

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

- Structures, processes and systems to support good governance and management were clearly set out and understood.
- Regional and national structures and processes implemented by the provider, for example, central medical advisory and clinical governance committees, ensured appropriate levels of support to local teams, to ensure consistent and effective governance arrangements.
- Staff clearly understood their individual roles and responsibilities and were well supported by the service manager in fulfilling those roles.
- Leaders had established appropriate policies, procedures and activities to ensure safety, and assure themselves they were operating as intended.
- The provider demonstrated a focus on ongoing review and continuous improvement. For example, they had recently reviewed their approach to the monitoring of staff immunisations in line with current guidance.
- The service manager had regular update meetings with the medical director, to highlight any changes and to discuss patients' specific needs.
- There was an effective staff meeting structure and systems for cascading information within the organisation.
- The service used performance information, which was reported and monitored, and management and staff were held to account.
- The service submitted data or notifications to external organisations as required.
- There were arrangements in line with data security standards for the availability, integrity and confidentiality of patient identifiable data, records and data management systems. All patients were allocated a unique identifier code. Correspondence sent from the service was emailed though an encryption service to ensure confidentiality.

Managing risks, issues and performance

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

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

Good

Are services well-led?

- Auditing of patient records was undertaken to review compliance with the provider's expected standards of clinical record keeping.
- The provider had plans in place and had trained staff to respond to major incidents. The service held an emergency 'grab' box, which contained a range of items which might be needed in an emergency situation. For example, items such as blankets, a torch, bottled water and hazard tape were included.

Appropriate and accurate information

The service acted upon appropriate and accurate information.

- Quality and operational information was used to monitor performance and drive improvement.
- The service used feedback from patients combined with performance information, to drive improvement.
- The provider carried out all required staff checks at the time of recruitment and all required ongoing monitoring, such as professional registration status and medical indemnity confirmation.
- Individual care records were 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. Clear, accurate and contemporaneous patient records were kept. Treatment planning and treatment records were fully documented.
- Staff told us they had attended regular staff meetings. We saw documented evidence of staff meetings, where for example, updates, patient feedback and complaints had been discussed and outcomes and learning from the meetings cascaded to staff.
- There were arrangements in line with data security standards for the availability, integrity and confidentiality of patient identifiable data, records and data management systems. Processes ensured that all confidential electronic information was stored securely on computers. All patient information kept as hard copies was stored in locked cupboards within a locked room. Staff demonstrated a good understanding of information governance processes.
- The provider ensured document management protocols were followed, which included version control, author and review dates.

Engagement with patients, the public, staff and external partners

The service involved patients, staff and external partners to support sustainable services.

- The service encouraged and heard views and concerns from the public, patients, staff and external partners and acted on them to shape services and organisational culture.
- The service was transparent, collaborative and open with stakeholders about performance.
- All patients were asked to provide feedback following their treatment at the service. Concerns raised were acknowledged and responded to promptly. Where necessary a further follow up telephone call or appointment took place in order to resolve concerns.
- The service reported upon 'You said, we did' actions. For example, some patients had commented on experiencing difficulty in parking on site due to building works being undertaken within the hospital grounds. As a result, the service contacted patients prior to their appointment in order to make them aware of the building works.
- Staff could describe to us the systems in place for them to give feedback. Staff felt confident in providing feedback to managers. The staff team worked closely together and had both formal and informal opportunities to provide feedback through staff meetings, appraisals and discussion. The provider had identified a freedom to speak up guardian to provide additional support to staff.
- The provider offered staff the use of an online well-being and rewards platform.

Continuous improvement and innovation

Good

Are services well-led?

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

- There was a focus on continuous learning and improvement.
- 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 review individual and team objectives, processes and performance.
- There were systems to support improvement and innovation, including a focus on the use of digital technology to drive improvement.
- The provider told us they were working in partnership with the Joint Council for Cosmetic Practitioners in raising standards relating to patient safety, disseminating best practice and identifying emerging trends and themes across the sector.