Diamond Skin Care

Inspection report

25-27
Dr Torrens Way, New Costessey
Norwich
NR5 0GB
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www.diamondskincare.co.uk

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

Ratings

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

Overall summary

This service is rated as Inadequate overall.

The key questions are rated as:

Are services safe? – Inadequate

Are services effective? – Requires improvement

Are services caring? – Good

Are services responsive? – Good

Are services well-led? – Inadequate

We carried out an announced comprehensive inspection of Diamond Skin Care on 8 November 2021, as part of our inspection programme. Diamond Skin Care Limited is registered under the Health and Social Care Act 2008 to provide the following regulated activities:

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

This service provides a full range of independent dermatology services, offering a mix of regulated skin treatments as well as other non-regulated aesthetic treatments. 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. We only inspected and reported on the services which are within the scope of registration with the CQC.

The Director of Diamond Skin Care 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.

Due to the current pandemic we were unable to obtain comments from patients via our normal process of asking the provider to place comment cards within the service location. We saw from reviews on the service website and on Google, that patients were consistently positive about the service, describing staff as professional, helpful and caring. We did not speak with patients as the service did not have patients booked to be seen on the day of the inspection.

Our key findings were:

- The service did not have adequate safety systems and processes in place, or oversight of these, to keep people safe.
- The provider had systems to keep clinicians up to date with current evidence-based guidance. We saw some evidence that clinicians assessed patients' needs and delivered care and treatment in line with current legislation, standards and guidance. Not all staff had completed training relevant to their role.
- Staff treated patients with compassion, respect and kindness and involved them in decisions about their care.
- The service encouraged and valued feedback from patients. Feedback was positive which included timely access to the service.

Overall summary

- The leadership and governance arrangements at the service were not effective. There was little understanding of the management of risks, a lack of assurance and significant failures in the systems and processes to ensure safe, effective and well led services.

The areas where the provider **must** make improvements as they are in breach of regulations are:

- Care and treatment must be provided in a safe way for service users.
- Establish effective systems and processes to ensure good governance in accordance with the fundamental standards of care.

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

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

- Improve the arrangements in place for the follow up of referral requests made to GPs, for referral on when a skin cancer diagnosis had been made.
- Improve the system to review policies and procedures and document the review dates. This is so there is a clear audit trail of when documents have been reviewed and amendments made, and so policies and procedures are clear, current and reflect the services provided.
- Improve the arrangements for informing patients about the complaints process.

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

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

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

Dr Rosie Benneyworth BM BS BMedSci MRCGP
Chief Inspector of Primary Medical Services and Integrated Care

Our inspection team

Our inspection team was led by a CQC lead inspector. The team included a GP specialist adviser and a second CQC inspector.

Background to Diamond Skin Care

- The name of the registered provider is Diamond Skin Care Limited. The registered address of the provider is 129 School Lane, Little Melton, Norwich, Norfolk, NR9 3LB.
- The provider has two registered locations. One is based in Colchester at Abbey Field Medical Centre, Ypres Road, Colchester, CO2 7UW. This location was not included in this inspection. The other location is based in Norwich at 25-27 Dr Torren's Way, Norwich, Costessey, NR5 0GB, with a branch site at Eastpoint Consulting Rooms, Lowestoft Rd, Gorleston-on-Sea, NR31 6LA. We visited this location as part of the inspection but did not visit the branch site.
- The provider first registered with CQC in 2013 and is registered to provide services to the whole population. The service is available to both children and adults. However, surgical treatments were available to children over the age of 12 and adults only. The services offered include those that fall under registration, such as mole and cyst removal, medical acne treatment and Botox injections for the treatment of excessive sweating. Other procedures, that do not fall under the scope of registration include for example, non-surgical wart and verruca removal.
- There were approximately 150 patients who were currently undergoing treatment with the service.
- The clinic is located at 25-27 Dr Torrens Way, a purpose-built GP practice on the outskirts of Norwich. Diamond Skin Care used two rooms within the premises. There is free parking at this clinic.
- The service was open Monday to Friday from 9am to 5pm. The service is accessed through booking a free advice call or appointment online on the service website. Patients could also book an appointment by telephone, could complete an online request for a call back within 24 hours (Monday to Friday) and there was a live chat on their website.
- The providers website is www.diamondskincare.co.uk

How we inspected this service

Before the inspection, we asked the provider to send us some information, which was reviewed prior to the inspection day. We requested information from Healthwatch Norfolk. We also reviewed information held by CQC on our internal systems.

During the inspection we spoke with the staff present including the Registered Manager, non-clinical and clinical staff. We made observations of the facilities and service provision and reviewed documents, records and information held by 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.

Inadequate

Are services safe?

We rated safe as Inadequate because:

- The service could not evidence safety risks were assessed and managed appropriately, for example fire safety and infection prevention and control. Risk assessments had not been completed, for example where clinical staff were working and the service had not yet received a Disclosure and Barring Service check.
- The service was not able to evidence staff immunisation checks were complete and up to date.
- The service was not able to evidence that all staff received up-to-date training appropriate to their role. This included safeguarding children and safeguarding adults, basic life support, infection prevention and control and fire safety training.
- The service could not evidence appropriate arrangements were in place for the management and oversight of infection prevention and control and management of clinical waste.
- Arrangements for the management of medical emergencies were not clear and staff had not all been trained to respond to medical emergencies.
- The service did not have a process to ensure medicines and medical equipment were in date. We reviewed a sample of medicines and equipment and found some which were out of date.
- The service could not provide evidence or assurance that refrigerator temperature checks were completed and that refrigerated medicines were fit for use.
- The service did not have a system to check that an adult accompanying a child had parental responsibility and they did not check the identity of patients before offering treatment.
- The Registered Manager had taken steps to update their indemnity arrangements. However, at the time of the inspection, they were not able to provide evidence that appropriate and current indemnity was in place.
- The service should improve the arrangements in place for the follow up of referral requests made to GPs, for further referral when a skin cancer diagnosis had been made.

Safety systems and processes

The service did not have clear systems to keep people safe and safeguarded from abuse.

- The provider did not evidence they conducted safety risk assessments, for example health and safety checks. They could not evidence they had assurance that safety risks were assessed and managed appropriately, for example fire safety and infection prevention and control. They had some appropriate safety policies, however we found these did not always contain up to date information. For example, the provider advised the service was available for patients aged 12 and over. However, their Safeguarding People policy detailed they would see patients aged 0 to 12 years. Staff received some safety information from the service as part of their induction.
- The service had some systems to safeguard children and vulnerable adults from abuse. The Registered Manager advised they would not see a patient under the age of 18 without a parent/guardian being present. However, they did not have systems in place to check that an adult accompanying a child had parental responsibility. The service did not check the identify of patients before offering treatment.
- 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.
- The provider carried out staff checks at the time of recruitment. The provider's policy stated all staff will have an enhanced Disclosure and Barring Service (DBS) check. (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). These were undertaken for all staff, however, we identified three clinical staff who had commenced work before all recruitment checks had been received, including DBS checks and two references. The

Inadequate

Are services safe?

Registered Manager advised these staff did not work alone and always had another clinician who worked with them when they were working with patients. There was no risk assessment in place to identify and mitigate any associated risks, in line with the providers own policy. Following the inspection, the provider submitted the DBS certificate for one of these clinicians.

- The service was not able to evidence staff immunisation checks were complete and up to date. We reviewed three staff files. Two did not contain any staff immunisation information. One contained evidence of immunisation status, with a note to follow up Hepatitis B immunisation, but this had not been actioned.
- The service was not able to evidence that all staff received up-to-date safeguarding and safety training appropriate to their role, for example fire safety, infection prevention and control, safeguarding children and safeguarding adults training. Staff knew how to identify, and report concerns, and referral information was available in the clinical room. Clinical staff, which included nurses and health care assistants, acted as chaperones and although they had not received formal training for the role, this role was learnt through shadowing other staff. The Registered Manager told us they were aware of the need to ensure staff training had been completed and to ensure there was oversight of the completion of this. An external company had been sourced to provide training deemed mandatory by the Registered Manager and it was planned that staff would begin completion of this online mandatory training imminently.
- There was not an effective system to manage infection prevention and control. The Registered Manager was the infection control lead. The service was not able to evidence staff had all completed infection control training, appropriate to their role. They were not able to evidence an infection control audit had been undertaken and room cleaning completed by staff was not documented. They did not have any assurance that appropriate arrangements were in place for the oversight of infection and prevention control undertaken at the premises. The service was not able to provide evidence that there were suitable arrangements for the management of Legionella risk associated with hot and cold-water systems (Legionella is a specific bacterium found in water supplies, which if undetected can cause ill health or death). We noted the disposable curtains in the clinic room used by Diamond Skin Care were last changed in 16 August 2018.
- The service advised that staff at the premises disposed of their healthcare waste. The service's policy detailed that clinical waste would be identified and labelled with Diamond Skin Care clinic details for traceability. However, the service was not able to provide any assurance this was undertaken.
- The service performed minor surgical procedures and used single use, disposable medical equipment. They did not have a process to ensure medical equipment was in date and we found a box of nine disposable scalpels which had an expiry date of June 2021. There were sufficient stocks of personal protective equipment, including aprons and gloves.
- The service completed portable appliance testing of their equipment at the administration site at School Lane. They did not have oversight of the portable appliance testing at the premises. Equipment was maintained according to manufacturers' instructions.
- The service was not able to evidence that environmental risk assessments were completed, which took into account the profile of people using the service and those who may be accompanying them.

Risks to patients

There were not systems to assess, monitor and manage risks to patient safety.

- There were arrangements for planning and monitoring the number and mix of staff needed.
- The service had an induction process for new staff. We reviewed three staff files. One contained a completed induction, the other two did not contain a completed induction. The provider advised one of these was with the member of staff who was at another site. The other completed induction was submitted following the inspection.
- Arrangements for the management of medical emergencies, which included the medicines and equipment which would need to be used, were not clear. There was no risk assessment in place to inform the decision around what

emergency medicines were kept by the service, and no oversight of what emergency medicines and equipment were kept at the premises. The service was not able to evidence what checks were undertaken at the premises to ensure these emergency medicines and equipment were in date and fit for purpose and how these could be accessed by staff. There was no process for checking the expiry dates of emergency medicines kept by Diamond Skin Care.

- Staff had not all been trained to respond to medical emergencies. We reviewed three staff files and there was no evidence these staff had completed training on basic life support. The service was not able to evidence that any staff had completed basic life support training. Following the inspection, on 15 November 2021 and 17 November 2021 the provider submitted basic life support training certificates for eight members of staff. There was one staff member who did not have evidence of this training.
- There was an established process for sending samples for histology (analysis) and receiving results for review. Results were accessed via the services' computer system and reviewed by a clinician. Patients were contacted if skin cancer had been confirmed and a referral was made to the patient's GP to request a referral to the multidisciplinary team. Patients were advised to follow this up with their GP to check the referral had been made. The service did not have arrangements in place to check that their request for a referral had been actioned by the GP practice.
- The service gave patients information and guidance documents relating to their treatment and after-care. They included advice on possible side effects and what to do.
- The Registered Manager had taken steps to update their indemnity arrangements. However, at the time of the inspection, they were not able to provide evidence that appropriate and up to date indemnity was in place.

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 ceased 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 some systems for appropriate and safe handling of medicines.

- The service had processes in place for checking stock levels of medicines, including emergency medicines they provided. However, they did not have a process to ensure medicines and medical equipment were in date. We reviewed a sample of medicines and equipment and found some which were out of date. For example, we found a box of nine disposable scalpels which had an expiry date of June 2021, patch test units which had an expiry date of August 2021 and four biopsy punches which had an expiry date of November 2019.
- Medicines that required refrigeration were locked in a separate box and stored in a shared refrigerator. The service could not provide evidence or assurance that refrigerator temperature checks were completed and that refrigerated medicines were fit for use.
- Staff 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 maintaining accurate records.
- There was a safe system for managing prescriptions. The service issued private prescriptions which were stamped with the service's information and included the appropriate details on the prescription.

Inadequate

Are services safe?

- The service does not prescribe Schedule 2 and 3 controlled drugs (medicines that have the highest level of control due to their risk of misuse and dependence). Neither did they prescribe schedule 4 or 5 controlled drugs.

Track record on safety and incidents

The service could not evidence a good safety record.

- They were not able to evidence risk assessments had been completed in relation to safety issues.
- The service did not have effective arrangements to monitor and review activity. There was limited measurement and monitoring of safety performance.

Lessons learned and improvements made

The service learned and made improvements when things went wrong.

- There was a system for recording and acting on significant events. Staff understood their duty to raise concerns and report incidents and near misses. Leaders and managers supported them when they did so.
- There were systems for reviewing and investigating when things went wrong. The service had not had any significant events in the past year.
- 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. The service had an effective mechanism in place to disseminate alerts to all members of the team.

Requires Improvement

Are services effective?

We rated effective as Requires improvement because:

- Arrangements were in place to discuss and document risks from specific treatments, however, we identified one patient who had been commenced on a medicine which can have a serious side effect, and lead to changes in mood and behaviour, although rare. There was a lack of detail in the patient's notes that low mood, suicidal ideas or any other mental health problems had been specifically discussed with them.
- Checks of registration with General Medical Council and Nursing and Midwifery Council were completed at recruitment, however there was no process to check this on an ongoing basis.
- Non-clinical audits were completed for recording keeping, for example, to check that follow up appointment reminders had been recorded appropriately. However, these had not been documented.
- The service did not have up to date records of the completion of staff training.
- We found some records lacked detail in relation to prescriptions. There were arrangements in place which had identified this issue and it had been acted upon.

Effective needs assessment, care and treatment

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

- 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.
- During the inspection we reviewed patients' records. Patients' immediate and ongoing needs were assessed, as well as their expectations of treatment carried out. This included their clinical needs and where appropriate this usually included their mental and physical wellbeing.
- Arrangements were in place to discuss and document risks from specific treatments, however, we found one patient who had been prescribed a medicine which can have a serious side effect, and lead to changes in mood and behaviour, although rare. There was no documentation in the patient's notes that low mood, suicidal ideas or any other mental health problems had been specifically discussed with them.
- During our review of patient records, we found some records lacked detail in relation to prescriptions. There were arrangements in place which had identified this issue and it had been acted upon.
- Clinicians had enough information to make or confirm a diagnosis.
- We saw no evidence of discrimination when making care and treatment decisions.
- Staff advised patients of any side effects and risks, including pain, and understood how to assess patients' pain where appropriate.

Monitoring care and treatment

The service was actively involved in quality improvement activity.

- The service used information about care and treatment to make improvements. Clinical audits had a positive impact on quality of care and outcomes for patients. For example, clinical audits were undertaken to review minor operations and skin treatments. The service audited post-surgical complications between 1 January 2021 and 30 September 2021. 290 skin lesions had been removed. 12 post-surgical infections were reported, which were distributed evenly amongst practitioners. There were ten cases of wound dehiscence (wound opening) and appropriate action was taken following the audit to further reduce post-surgical infections.
- Non-clinical audits were also completed for recording keeping, for example, to check that follow up appointment reminders had been recorded appropriately. However, these had not been documented.

Requires Improvement

Are services effective?

Effective staffing

The service could not evidence that all staff had the skills, knowledge and experience to carry out their roles.

- All staff were appropriately qualified. Up to date records of qualifications were maintained.
- Relevant professionals (medical and nursing) were registered with the General Medical Council (GMC)/ Nursing and Midwifery Council. Checks of registration were completed at recruitment, however there was no process to check this on an ongoing basis, as appropriate. The Registered Manager advised they planned to develop this area and have increased involvement with nurse revalidation.
- The provider had an induction programme for all newly appointed staff. The service had completed staff competency documents for a range of different clinical procedures.
- Staff were encouraged and given opportunities to develop. For example, a health care assistant had been supported to successfully complete a phlebotomy course and a nurse was being supported to complete a nurse prescribing course. However, there was not an up to date record or oversight of the completion of staff training deemed mandatory, for example, safeguarding children and adults, infection prevention and control and basic life support.

Coordinating patient care and information sharing

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

- Whilst the opportunity for working with other services was limited, the service did so when this was necessary and appropriate. Staff referred to and communicated effectively with the patient's own GP, as appropriate.
- Before providing treatment, clinicians at the service ensured they had adequate knowledge of the patient's health, any relevant test results and their medicines history.
- All patients were asked for consent to share details of their consultation and any medicines prescribed with their registered GP on each occasion they used the service.
- The provider had risk assessed the treatments they offered. 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. For example, medicines liable to abuse or misuse.
- The service monitored the process for seeking consent appropriately.

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 written and verbal advice to help with their post treatment recovery, for example, wound care.
- Risk factors were identified, highlighted to patients before undergoing treatment.
- Where patients' needs could not be met by the service, staff redirected them to their GP.

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. Information leaflets were provided to patients and explanations of the risks and benefits of treatments discussed during consultations.

Good

Are services caring?

We rated caring as Good because:

Staff treated patients with kindness and compassion and involved them in decisions about their care. Staff protected patients' privacy and dignity.

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 available on the Diamond Skin Care website and on Google reviews. The service had a 4.9 out of 5 score from 53 reviews received.
- Feedback from patients was positive about the way staff treated people. Patients reported staff were kind, friendly and professional and ensured patients were comfortable.
- Staff understood patients' personal, cultural, and social 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 helped patients to be involved in decisions about care and treatment.

- The provider advised that translation services would be made available if this was identified as a need. They advised patients would usually bring someone with them who could help with communication needs, if necessary. They gave an example where this was facilitated for a patient who was deaf.
- Patients reported from reviews on the service website and from Google, that they felt listened to and supported by staff and had sufficient time during consultations to make an informed decision about the choice of treatment available to them. They also reported that procedures were explained fully to them, which included any risks.

Privacy and Dignity

The service respected patients' privacy and dignity.

- Staff recognised the importance of people's dignity and respect.
- Clinic doors were locked from the inside when staff were with patients. Other staff knocked on the door and waited before entering, to maintain patients' privacy and dignity.

Good

Are services responsive to people's needs?

We rated responsive as Good because:

The service organised and delivered services to meet patients' needs. There were short waiting times for dermatology and minor surgery appointments and patients were advised of treatment prices in advance. The service should improve the arrangements for informing patients about the complaints process.

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 improved services in response to those needs so patients could access services on days and times that were convenient to them.
- The facilities and premises were appropriate for the services delivered. Access to the premises and treatment room was suitable for patients with restricted mobility.
- Patients were supported to have another adult present, if this was their preference, for example to support with any anxiety.
- Prices for different treatments were displayed on the service's website. They were discussed in advance of any treatment programme.

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 with the most urgent needs had their care and treatment prioritised.
- The service was open Monday to Friday from 9am to 5pm. The service is accessed through booking a free advice call or appointment online on the service website. Patients could contact Diamond Skin Care by telephone, could request a call back within 24 hours (Monday to Friday) and there was a live chat on their website.
- Patients reported from reviews on the service website and from Google, that the appointment system was easy to use, and positive comments were received in relation to the organisation of the service provided.
- Feedback from patients from January to July 2020 showed 100% of patients found the appointment times were flexible, 97% of patients said they would recommend Diamond Skin Care to others and 99% of patients found the clinicians and staff to be polite and empathic.
- Referrals to other services were undertaken in a timely way. For example, when test results indicated cancerous tissue, the patient was immediately referred to their GP for 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 and procedure in place. However, information about how to make a complaint or raise concerns was not available in the clinic. On the service's website, patients were directed to contact the service by email if there was anything they wanted to discuss, that they did not want to leave in a review.

Good

Are services responsive to people's needs?

- 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 Registered Manager was the complaints lead. The service had received one complaint in the previous 12 months. We reviewed this complaint and found it had been dealt with appropriately. The service learned lessons from individual concerns and complaints. It acted as a result to improve the quality of care.

Inadequate

Are services well-led?

We rated well-led as Inadequate because:

- Leaders were not always aware of the risks and issues relating to the quality of services and were not always clear about their roles and accountability.
- The service did not have oversight of the completion of mandatory training and staff had not all received training relevant to their role.
- The service could not evidence they had systems and processes in place to assess, monitor and mitigate the risks relating to the health, safety and welfare of patients and others who may be at risk. This included for example, health and safety, infection prevention and control, and fire risks.
- Structures, processes and systems to support good governance and management were not always clear, understood and effective.
- The service should improve the system to review policies and procedures and document the review dates. This is so there is a clear audit trail of when documents have been reviewed and amendments made, and so policies and procedures are clear, current and reflect the services provided.

Leadership capacity and capability

Leaders did not have the knowledge and skills to lead effectively.

- Leaders we spoke with did not demonstrate they were fully aware of the risks and issues relating to the safety of patients and staff. They had identified some issues, although steps to address them had not been fully implemented. For example, the completion and oversight of appropriate training to keep patients and staff safe from harm.
- Leaders were visible and approachable and worked closely with staff.
- Staff had a range of communication systems available. These supported for example, the smooth running of clinics, the sharing of general information about the service and reminders about tasks which need to be completed.

Vision and strategy

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

- There was a clear mission statement to deliver innovative dermatology services and promote good outcomes for patients.
- The service had a realistic strategy to achieve priorities.
- Staff were aware of and understood the mission statement and values promoted by the service.
- The service monitored progress against delivery of the strategy.

Culture

The service did not always promote a culture of high-quality sustainable care.

- Staff felt respected, supported and valued. They were proud to work for the service.
- The service focused on the needs of patients and supported them with their expectations and preferences for treatment. However, they did not always have safe systems and processes in place.
- Leaders and managers acted on behaviour and performance inconsistent with the vision and values.
- Openness, honesty and transparency were demonstrated when responding to complaints. The service had not had any incidents reported. The provider was aware of and had systems in place to ensure compliance with the requirements of the duty of candour.

Inadequate

Are services well-led?

- Staff told us they could raise concerns and were encouraged to do so. They had confidence that these would be addressed.
- Staff were not provided with all the training and development they needed to provide a safe service. The service did not have oversight of the completion of mandatory training and were not able to evidence that staff had safeguarding children and adults training, infection prevention and control training, basic life support and fire safety training. The service had registered as a responsible body and could undertake appraisals for their own doctors. Meetings were held to review staff work and these were documented. Clinical staff, including nurses, were considered valued members of the team. The service had identified the need to improve support to nurses to meet the requirements of professional revalidation.
- Staff had not received equality and diversity training. Staff felt they were well treated and they themselves treated all patients equally and with kindness.
- There was a culture of promoting positive relationships between staff.

Governance arrangements

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

- Structures, processes and systems to support good governance and management were not always clear, understood and effective. The governance and management of joint working arrangements and shared services was not effective. This included arrangements for the management of medical emergencies, infection prevention and control, medicines storage and safety, and fire safety. We identified staff who had not had a completed Disclosure and Barring Service check before commencing work and no risk assessment had been completed. This did not follow the service's 'Safeguarding people who use services from abuse' policy.
- Leaders we spoke with did not demonstrate they were fully aware of the risks and issues relating to the safety of patients and staff.
- Policies and procedures were available, and the service confirmed these were regularly reviewed, although the system to record this was not clear. Some of the policies we reviewed did not contain current and up to date information. For example, the safeguarding people who use services from abuse policy advised safeguarding training would be provided as necessary, proportionate to the nature of the patient care service being provided, and did not reference current statutory training levels for adult safeguarding and safeguarding children.
- They did have some systems for the assurance of clinical work which included completion of post-surgical audits and competency assessments for staff, to assure themselves that they were operating as intended.

Managing risks, issues and performance

There were not clear and effective processes for managing risks, although there were some processes for managing issues and performance.

- The service could not evidence they had systems and processes in place to assess, monitor and mitigate the risks relating to the health, safety and welfare of patients and others who may be at risk. For example, health and safety risk assessments and checks were not undertaken. There was no oversight that fire risk assessments had been undertaken and managed appropriately in the buildings where staff worked.
- There was not an effective process to identify, understand, monitor and address current and future risks including risks to patient safety.
- The service ensured there was co-ordinated person-centred care and that consent was obtained to both treatment and to providing treatment details to patients' GPs.

Inadequate

Are services well-led?

- The service had some processes to manage staff 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. There was some evidence of action to change services to improve quality.
- The provider had arrangements in place for disruptions to the service, with patients being offered to be seen at another registered location.

Appropriate and accurate information

The service did not always have appropriate and accurate information to monitor performance and deliver high quality care.

- The service had some quality and operational information which was used to ensure and improve performance. Performance information was combined with the views of patients. This was mainly in relation to the caring and responsiveness of the service. However, they did not always have appropriate information available to monitor the safety of the service provided.
- The service used clinical and 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 robust arrangements in line with data security standards for the availability, integrity and confidentiality of patient identifiable data, records and data management systems.

Engagement with patients, the public, staff and external partners

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

- The service encouraged and heard views and concerns from patients, the public and staff. Patient feedback was closely monitored and acted upon to shape services. Patient feedback forms were available. Patients were encouraged to leave reviews and feedback on the Diamond Skin Care website and were also encouraged to leave reviews on Google. Patients were also encouraged to contact the service by phone or email to discuss anything they did not want to leave in a review.
- Staff could describe to us the systems in place to give feedback.
- The service was transparent and open with stakeholders about the feedback received. Feedback was available to be viewed on the service's website and a link was given to see feedback left via a Google review.

Continuous improvement and innovation

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

- Staff were supported to attend conferences for their own professional development.
- The service had reviewed the one complaint they had received in the previous 12 months. They had a system to learn from incidents, however they had not had any incidents reported. Learning was shared and used to make improvements.
- Diamond Skin Care had created and provided a Dermoscopy mentoring course for GPs, practice nurses, dermatology nurses, dermatologists and plastic surgeons. This was a newly developed course.

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 17 HSCA (RA) Regulations 2014 Good governance Systems or processes must be established and operated effectively to ensure compliance with the requirements of the fundamental standards as set out in the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. How the regulation was not being met. • The registered person had systems or processes in place that operated ineffectively in that they failed to enable the registered person to assess, monitor and mitigate the risks relating to the health, safety and welfare of service users and others who may be at risk. • Some of the policies we reviewed did not contain clear, current and up to date information. For example, in relation to managing medical emergencies and safeguarding people. • We identified three clinical staff who had commenced work before all recruitment checks had been received, including DBS checks and two references. The Registered Manager advised these staff did not work alone and always had another clinician who worked with them when they were working with patients. However, there was no risk assessment in place to identify and mitigate any associated risks, in line with the service's own policy. • The service did not have a system to check that an adult accompanying a child had parental responsibility and they did not check the identity of patients before offering treatment. • Checks of registration with General Medical Council and Nursing and Midwifery Council were completed at recruitment, however there was no process to check this on an ongoing basis.

This section is primarily information for the provider

Requirement notices

- Non-clinical audits were completed for recording keeping, for example, to check that follow up appointment reminders had been recorded appropriately. However, these had not been documented.
- The Registered Manager had taken steps to update their indemnity arrangements. However, at the time of the inspection, they were not able to provide evidence that appropriate and up to date indemnity was in place.

This section is primarily information for the provider

Enforcement actions

Action we have told the provider to take

The table below shows the legal requirements that were not being met. The provider must send CQC a report that says what action they are going to take to meet these requirements.

Regulated activity	Regulation
Diagnostic and screening procedures Treatment of disease, disorder or injury Surgical procedures	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment We served a Section 29 Warning Notice to the provider for Regulation 12, Safe Care and Treatment on 18 November 2021. The provider was given 8 weeks to comply with the Warning Notice. • Arrangements were not in place to take appropriate action if there was a clinical or medical emergency and the risks had not been assessed. • There was no oversight that emergency medicines were in date and emergency medicines checked regularly to ensure they were fit for purpose. • There was not a system to ensure the proper and safe management of medicines. This included the safe management of refrigerated medicines and medicines and equipment stocked by the service. • Infection prevention and control risks were not assessed. This included the completion of infection prevention and control audits, documentation of cleaning undertaken by the service and the appropriate management of clinical waste. • The service was not able to evidence the completion and oversight of staff training, including safeguarding adults and children, infection prevention and control, basic life support and fire safety. • Staff immunisation records were not available or up to date and no risk assessment had been completed for their roles. • We identified one patient who had been prescribed isotretinoin. This medicine can have a serious side effect, and lead to changes in mood and behaviour, although rare. There was no documentation in the patient's notes that low mood, suicidal ideas or any other mental health problems had been specifically discussed with them.