Discover Laser Ltd

Discover Laser

Inspection report

Crow Wood Leisure
Royle Lane
Burnley
BB12 0RT
Tel: 01282420886
www.discoverlaser.co.uk

Date of inspection visit: 10 August 2022
Date of publication: 19/10/2022

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?	Requires Improvement

Summary of findings

Overall summary

Our rating of this location improved. We rated it as good because:

- The service provided mandatory training in key skills to all staff and made sure everyone completed it. Managers could demonstrate that all staff had up to date training on how to recognise and report abuse. The service had identified systems in place to monitor infection prevention and control measures. Staff completed and updated risk assessments for each patient and took action to remove or minimise risks. Staff had the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment. The service had systems and processes in place to safely prescribe, administer, record and store medicines. Staff recognised and reported incidents and the service managed patient safety incidents.
- Managers had introduced systems for monitoring the effectiveness of the service. Staff provided good care and treatment, gave patients enough to eat and drink, and gave them pain relief when they needed it. Staff worked well together for the benefit of patients and supported them to make decisions about their care. Key services were available six days a week.
- Staff treated patients with compassion and kindness, respected their privacy and dignity, and helped them understand their conditions. They provided emotional support to patients, families and carers.
- The service planned care to meet the needs of local people and made it easy for people to give feedback. People could mostly access the service when they needed it.
- Leaders supported staff to develop their skills. Staff understood the service's vision and values, and how to apply them in their work. Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. Staff were clear about their roles and accountabilities. Staff were committed to improving services continually.

However:

- The service did not have an effective system to ensure Mohs Micrographic Surgery (MMS) equipment was kept secure and systems for Mohs Micrographic Surgery (MMS) laboratory equipment maintenance were not always clearly implemented. Environmental risk assessments for the Mohs Micrographic Surgery (MMS) laboratory were inconsistent and actions to mitigate risks were not fully identified.
- Staff mostly kept detailed records of patients' care and treatment, but records of multidisciplinary review were not always included in patient notes.
- Managers did not always ensure all staff were up to date with appraisals.
- The service mostly took account of patients' individual needs but did not have robust systems for identifying and meeting the needs of patients with disabilities, including sensory loss.
- Although leaders understood the priorities and issues the service faced, their overall ability to manage these was limited by the extent of the daily clinical demands. Relevant risks were not always identified, and actions taken to reduce their impact. Governance systems and processes had been strengthened but were not fully embedded.

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Surgery	Good 	We rated it as good. See summary above for details.

Summary of findings

Contents

Summary of this inspection

Background to Discover Laser

Discover Laser is a registered location of Discover Laser Ltd, an independent health clinic providing a range of services to fee paying members of the public. The service is registered for the regulated activities diagnostic and screening services, surgery, and treatment of disease, disorder or injury. The registered manager who is also the lead consultant for the service, has been in place since 2011.

We last inspected the service in January 2022 and rated it as Inadequate overall. At the last inspection we found the service breached regulations of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 for:

- Regulation 5 HSCA (RA) Regulations 2014 Fit and proper persons: directors
- Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment
- Regulation 16 HSCA (RA) Regulations 2014 Receiving and acting on complaints

Following the last inspection in January 2022 we also issued two section 29 Warning Notices and the service was required to make significant improvements for failing to comply with the requirements of the Health and Social Care Act 2008 Regulation 12 Safe care and treatment, and Regulation 17, Good governance.

We found the service had taken action to improve in response to areas of concern identified at the last inspection.

How we carried out this inspection

We carried put a comprehensive inspection to assess the actions taken by the provider and to review progress made since the last inspection. We looked at key questions of the safe, effective, caring, responsive and well-led domains. We reviewed specific documentation, interviewed key members of staff including the registered manager; consultants working in the service; nursing, healthcare and administrative staff, and the senior management team who were responsible for leadership and oversight of the service. We also spoke with three patients about their experience of treatment and care as a service user.

You can find information about how we carry out our inspections on our website: https://www.cqc.org.uk/what-we-do/how-we-do-our-job/what-we-do-inspection.

Areas for improvement

Action the service MUST take is necessary to comply with its legal obligations. Action a service SHOULD take is because it was not doing something required by a regulation but it would be disproportionate to find a breach of the regulation overall, to prevent it failing to comply with legal requirements in future, or to improve services.

Action the service MUST take to improve:

- The service must ensure that it reviews and updates risk assessments for the Mohs Micrographic Surgery (MMS) laboratory area. Regulation 17(1)(2)(a)(b)
- The service must ensure there are effective systems for cleaning and equipment checking regimes are updated and clearly documented for the Mohs Micrographic Surgery (MMS) laboratory area. Regulation 17(1)(2)(a)(b)

Summary of this inspection

- The service must ensure there are effective systems for pathological specimens are retained and stored in accordance with relevant guidance and standards. Regulation 17(1)(2)(a)(b)

Action the service SHOULD take to improve:

- The service should ensure there is appropriate signage and security for the Mohs Micrographic Surgery (MMS) laboratory area.
- The service should ensure there is clear oversight and documentation of multidisciplinary team (MDT) review for patients in the Mohs service.
- The service should ensure systems are in place for appraisal review for all staff.
- The service should review and take action to improve systems for identifying and meeting the needs of patients with disabilities including sensory loss.
- The service should continue to develop and embed progress in their vision and strategy.

Our findings

Overview of ratings

Our ratings for this location are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Surgery	Good	Good	Good	Good	Requires Improvement	Good
Overall	Good	Good	Good	Good	Requires Improvement	Good

Good

Surgery

Safe	Good
Effective	Good
Caring	Good
Responsive	Good
Well-led	Requires Improvement

Are Surgery safe?

Good

Our rating of safe improved. We rated it as good.

Mandatory training

The service provided mandatory training in key skills to all staff and made sure everyone completed it.

Staff received and kept up to date with their mandatory training. Since the last inspection, the service had identified and updated their training matrix, which included learning in key subject areas for staff relevant to their area of activity. Core mandatory training subjects included Health and Safety, Infection Prevention and control, Basic Life Support, Fire Safety, Information Governance, Moving and Handling, Equality and Diversity, and Safeguarding. We reviewed the service's staff records which showed staff had completed their mandatory training as required by the service. In addition, further mandatory training subjects were being introduced for staff to complete between June and December 2022. These included records management, complaints and customer care.

Two consultants and another member of staff who worked flexibly in the service completed their mandatory training as part of their primary roles in the NHS. The service held appropriate records to demonstrate that these staff had completed relevant mandatory training for the service.

The mandatory training was comprehensive and met the needs of patients and staff.

Staff had completed Mental Capacity Act training and had an awareness of the needs of patients with mental health conditions. Medical staff had completed psycho dermatology training to identify any patients who may have concerns relating to their mental health

Managers monitored mandatory training and alerted staff when they needed to update their training.

Safeguarding

Staff understood how to protect patients from abuse. Staff had training on how to recognise and report abuse and they knew how to apply it.

Good

Surgery

Staff received training specific for their role on how to recognise and report abuse. Since the last inspection, staff in the service had completed updated safeguarding training relevant to their role. All staff in the service had completed safeguarding level two adults and children; clinical staff had completed safeguarding children and adults' level three. The registered manager was the designated safeguarding lead in the service and the service had updated their safeguarding policy and process since the last inspection. Staff we spoke with could describe the kinds of issues they would consider as a safeguarding concern in the service and were confident of processes they needed to follow.

Staff knew how to make a safeguarding referral and who to inform if they had concerns. The service had established a governance meeting for oversight and review of any incidents or safeguarding concerns that had been identified and to share any learning from these. There had not been any safeguarding concerns raised in the last six months.

During the inspection we reviewed five staff files. We saw that each contained photo ID, job description, written references and current full records of ongoing Disclosure and Barring Service (DBS) checks. We noted that one staff contract had not been signed by the employee, although other records were complete. The service had up to date records for staff who were required to have professional registration for their work. Details of the arrangements for practising privileges for the two consultants who were working in the service were also included in their staff files.

Cleanliness, infection control and hygiene

The service-controlled infection risk. The service used systems to identify and prevent surgical site infections. Staff used equipment and control measures to protect patients, themselves and others from infection. They kept equipment and the premises visibly clean.

The clinic and reception areas were visibly clean and had suitable furnishings which were clean and well-maintained. Daily cleaning was completed by a private company and the service had implemented a weekly cleaning schedule, which was maintained by staff in the service and results monitored through a routine monthly audit. Legionella testing was completed weekly and the service had a current legionella safety certificate.

Staff used records to identify how well the service prevented infections. The service reviewed any incidences of surgical site infections or when patients had needed to be prescribed antibiotics. This had occurred for only two patients since the last inspection.

Staff followed infection control principles including the use of Personal Protective Equipment (PPE). We observed staff following an Aseptic Non-Touch Technique (ANTT) when providing clinical treatments for patients.

Staff cleaned equipment and instruments used after each patient contact and recorded these.

Environment and equipment

The design, maintenance and use of facilities, premises and equipment mostly kept people safe although systems for laboratory equipment maintenance were not always clearly implemented. Staff were trained to use equipment. Staff managed clinical waste.

The service had secure entrances at front and rear of the premises, with access to reception by remote control. A separate door provided one-way access to the adjacent leisure centre. We saw during inspection how staff provided directions or accompanied service users on their entry to the clinic and reception area. Six clinical rooms, four procedure rooms and two consulting rooms were available, with various equipment kept in each room, used for specific procedures. In addition, there were two waiting areas, a histology laboratory, medicines and equipment storage area, kitchen,

Good

Surgery

Staff completed routine safety checks on emergency equipment, with monthly checklists accurately maintained for the emergency resuscitation equipment and emergency grab bag. The service also had access to a defibrillator, which was available in the adjacent leisure centre.

The design of the environment was not always in line with national guidance for specialist areas of provision in the service. Specifically, this was regarding the Mohs Micrographic Surgery laboratory area, which was in a narrow-partitioned room adjacent to the kitchen; the room partition was not full height and there was a shared air space between the lab and the kitchen. Within the laboratory area was a cryostat machine used for preparing slides of tissue samples, and a high energy particulate air (HEPA) filter positioned on top of a control of substances hazardous to health (COSHH) cupboard. We saw 'post it' notes on top of the cryostat machine which appeared to reference three patients and their procedures. A paper notice titled 'Mohs Embedding technique' was sellotaped to the wall above an area of laboratory equipment for preparation of tissue samples. Adjacent to these was a tray containing tissue slides for 16 patients. We saw a bottle of Pertex solution in this area, a substance classified under Control of Substances Hazardous to Health (COSHH) requirements, which was not locked away. The Mohs Laboratory area was not a locked area and the environment for storage did not meet Guidance from The Royal College of Pathologists and the Institute of Biomedical Science for the retention and storage of pathological specimens. This guidance states 'In the case of specimens and preparations, the pathologist has a duty to ensure that they are kept not only confidentially, but also safely and securely, so as to guard against accidental or non-accidental mishap. Some specimens and derived materials may need to be stored in locked containers and in secure laboratory premises with restricted and controlled access.'

Staff did not always carry out daily safety checks of specialist equipment. The service had a cryostat machine for use when taking tissue samples during Mohs micrographic surgery procedures. Following the inspection, the service provided evidence of current servicing and maintenance for this specialist equipment, which included details of a new condenser motor being fitted. However, systems for ongoing daily and weekly checks of this equipment were less clear. During the inspection, we reviewed a 2022 Cryostat maintenance log kept in a folder in the Mohs laboratory area. This was a tick list, signed as completed for Mohs clinics on dates in 2022 in January (four), February (three), March (eight), and April (two). There was no record of checks for any of the clinics held in May, June and July 2022.

Following inspection, the service provided further information regarding the laboratory maintenance, including a 'routine lab maintenance' document dated January 2022 which identified specific tasks for completion. These included: checking and recording cryostat temperatures were at required settings (-20: -24 to -28 degrees centigrade), documenting that daily maintenance had been completed and the microscope has been cleaned by initialling the Mohs Lab Daily checklist; and that The Cryostat needed to be allowed to run at higher temperatures and reduced 24 hours prior to Mohs surgery (-20 & -24.).

This document identified that temperatures needed to be checked Mondays (Mohs days only), Wednesdays & Fridays and recorded on the Mohs Lab Daily checklist. The service provided one page of their Mohs Lab daily checklists, which was a tick list, completed for two dates in August 2022; this was a different form from the Cryostats daily log form we had seen during inspection. Staff we spoke with during inspection provided varying responses as to who was responsible for completing the daily lab checks for the Mohs clinic days and this was not clearly identified in the various related documents we reviewed.

The service provided details of local risk assessments for the Mohs Laboratory area in two separate risk assessment documents. These identified certain risks, such as risk of injury from sharp instruments, or risk of frostbite from the cryostat machine. However, the risk assessments did not include all potentially relevant risks or any actions to mitigate

these. For instance, there was no reference to risks of the use of solvents in the area, or how unrestricted access was being managed. During staff interviews we were told there was a chemical spill kit available in the lab area, however we did not observe this on the day of inspection. There was no signage to indicate the designated Mohs laboratory area or the potential hazards of the environment.

The service overall however had suitable facilities to meet the needs of patients and their families.

The service had enough suitable equipment to help them to safely care for patients. Records confirmed portable appliance testing (PAT) and arrangements for routine equipment maintenance were in place.

Arrangements were in place for disposal of clinical waste.

Assessing and responding to patient risk

Staff completed and updated risk assessments for each patient and removed or minimised risks. Staff identified and quickly acted upon patients at risk of deterioration. The service made sure patients knew who to contact to discuss complications or concerns.

Staff completed risk assessments for each patient on initial appointment and reviewed this regularly. All patients completed a health assessment form prior to an individual consultation appointment. Staff recorded any relevant risk factors in the care plan document for patients, identified and documented these. The service had an exclusion criterion which confirmed they did not see patients who had a cancer diagnosis, including melanoma.

Since the last inspection, the service had developed and implemented a local surgical safety checklist (LocSSIP) for all surgical procedures carried out, to ensure compliance with the World Health Organisation (WHO) surgical checklist five steps to safe surgery. Patient records we reviewed during the inspection showed LocSSIPs were completed and documented in the electronic patient record system. The surgical safety checklist identified monitoring procedures and observations of vital signs (pulse, blood pressure, oxygen saturations) for patients having treatment. Clinical staff noted any relevant underlying health conditions patients may have and patient records we reviewed confirmed these, and any actions taken.

Patients having Mohs surgery were referred principally by the two consultants working in the service. Patients would be seen initially for biopsy and investigation at other local independent and NHS healthcare settings. After a confirmed diagnostic biopsy in this setting, consultants would discuss treatment options with the patient. Discussions also included a multidisciplinary team (MDT) case review by relevant clinicians at the referring sites. Consultants referred and accepted patients for Mohs surgery at Discover Laser who were clinically assessed as needing superficial surgery only. Patients would be referred after a biopsy conducted at another healthcare setting had confirmed their diagnosis. On occasions where biopsy had not previously confirmed diagnosis, tissue samples would be sent for histological tests by an external provider.

During the inspection we spoke with medical staff who confirmed that they did not refer any patients for Mohs surgery who required complex surgical procedures. All the records we reviewed for patients undergoing Mohs treatment confirmed this. On the day of Mohs surgery after patients were discharged, consultants contacted patients by phone the same day to monitor their condition and provide further advice as needed. Mohs patients would then be followed up in clinics at other local independent and NHS clinics.

Staff had completed updated training in how to manage patients who were unwell and were aware of how to respond to any specific risk issues patients may have. All staff had completed basic life support training and there were clear

procedures for responding to patient emergencies, with emergency resuscitation equipment being accessible. Staff reported there had been no incidents of deteriorating patients in the clinic. There had been one patient who experienced bleeding post-surgery at home; medical staff were available to respond immediately and visit the patient to provide appropriate treatment and care. Patients were given clear advice and instructions following any treatment and there were systems in place for staff to respond to any emergencies or concerns.

The service had identified an Isotretionoin protocol. Isotretionoin is a medicine used for treatment in cases of severe acne, which has known potential patient risks. Prior to commencing this treatment, the service carried out prior baseline blood tests to establish this was clinically appropriate for the patient. Patients continued with regular reviews whilst continuing this medication, according to clinical and manufacturers guidance. Additional risk factors for any female patients at risk of pregnancy would be discussed with patients; the service would also carry out a pregnancy test prior to commencing this treatment where this applied for female patients.

Staff shared key information to keep patients safe when handing over their care to others. Medical staff documented treatment and discharge summaries for patients in the Mohs services, when being transferred to other locations for review.

Staffing

The service did have enough medical and support staff with the right qualifications, skills, training and experience and to provide the right care and treatment to meet demand in the service. Managers reviewed staffing levels and skill mix.

The service did have enough medical staff to provide the right care and treatment and to keep up with demand in specialist parts of the service. There were two consultants working under practising privileges in the service, in addition to the registered manager who was a permanent member of medical staff. There was a continuing demand for patients who required Mohs surgery. The service had capacity to cover Mohs surgery three days a week, however the average was one day per week which meant there was sufficient cover.

Managers regularly reviewed any staff shortages and discussed service needs in staff meetings. At the time of inspection, there was a view the service needed to continue to expand, but there were no immediate plans for recruitment.

The service did not use any bank or agency staff.

Records

Staff kept detailed records of patients' care and treatment. Records were mostly clear, up-to-date, stored securely and easily available to all staff providing care.

Patient notes were stored in an electronic patient record, accessible to all staff in the service, including the doctors who were working under practising privileges. Patient notes were mostly clear and well documented. Staff recorded any medicines administered or prescribed in patient records. Care plan and consent documents were stored together as part of the overall patient record. Staff followed systems in line with general data protection regulations (GDPR) to protect patient's confidential information.

Following inspection, the service shared details of the multidisciplinary team meeting notes for patients who had been referred and seen in the service for Mohs surgery. However, at the time of inspection we did not see the MDT notes included in any patient records for any related patients seen in the service for this procedure.

Good

Surgery

After patients had completed their treatment, the service sent discharge letters to the patient's GP, with details and photographs of the treatment provided.

Medicines

The service used systems and processes to safely prescribe, administer, record and store medicines.

Staff followed systems and processes to prescribe and administer medicines safely. Since the last inspection the service had reviewed and updated their medicines management policy, including updated Standard Operating Procedures (SOP) for prescription and administration of medicines. This included a separate SOP for use of Controlled Drugs (CDs). The only CD used in the service was diazepam, classified as a schedule four medication, and subject to minimal controls. However, the service had included this as a CD and identified the SOP to align with other medicines management policies.

Staff reviewed each patient's medicines regularly and provided advice to patients and carers about their medicines. The service did not routinely prescribe medicines for patients; however, we saw two patient records which showed antibiotics had been appropriately prescribed post-surgery.

Staff completed medicines records accurately and kept them up to date. The service identified a formulary of medicines which were kept as stock items. During the inspection we reviewed medicines records and stored medicines, which were up to date and correct. All the medicines we checked, including oxygen and drugs for emergency resuscitation, were within manufacturers expiry dates.

Staff stored and managed all medicines and prescribing documents safely. Medicines which required storage in medicines fridges were kept at the correct temperatures. The service had systems for checking fridge temperatures were in range, we saw that action had been followed up on one occasion where the fridge temperature was noted as out of range.

Staff learned from safety alerts and incidents to improve practice.

Incidents

The service managed patient safety incidents. Staff recognised and reported incidents and near misses. Managers investigated incidents and shared lessons learned with the whole team and the wider service. Managers ensured that actions from patient safety alerts were implemented and monitored.

Staff knew what incidents to report and how to report them. Since the last inspection, the service had updated systems and processes for reporting incidents in the service. Staff raised concerns and reported incidents and near misses in line with the service's updated incidents reporting policy. We saw an incident report was raised when the fridge temperature was recorded as out of range. The provider took appropriate action in following up and investigating this incident, sharing details with all staff from this.

Staff understood the duty of candour. They were open and transparent and gave patients and families a full explanation if and when things went wrong. Since the last inspection, there had been no occasions where the duty of candour had needed to be followed

Staff received feedback from investigation of incidents. Managers discussed any findings and improvements following incident investigations, sharing these in discussion during staff meetings.

Good

Surgery

There was evidence that staff had an improved awareness of the types of incident which could occur in the service, as a result of the updated systems and processes for incident reporting and management, as compared to the last inspection.

Are Surgery effective?

Good

Our rating of effective improved. We rated it as good.

Evidence-based care and treatment

The service provided care and treatment based on national guidance and evidence-based practice. Managers checked to make sure staff followed guidance.

Staff followed up-to-date policies to plan and deliver high quality care according to best practice and national guidance. Since the last inspection, the service had identified, reviewed and updated an extensive range of policies across the service, including for quality assurance, and standard operating procedures for minor surgery.

The service followed a range of national and international guidelines relating to the clinical procedures and treatments offered. These guidelines included National Institute of Health and Care Excellence (NICE) guidance for acne vulgaris management, and other condition specific guidance and standards.

The service managed care in accordance to the NICE guidance [NG125] for surgical site infections. The service use recommended skin preparation for patients and staff, and the service provided wound care information to patients after their procedures.

The service had updated their policy for equal opportunities and diversity. Staff recognised the individual needs of patients who had a protected characteristic under the Equality Act 2010, identifying any arrangements that needed to be in place to support patients making care and treatment decisions.

At service meetings, staff considered the psychological and emotional needs of patients, their relatives and carers. They identified any patients who may require further support.

Nutrition and hydration

Staff ensured that patients were not without food or drinks for long periods

The service provided hot and cold drinks for patients and checked regularly with patients if they needed anything to eat or drink.

The adjacent leisure centre provided a wide range of hot and cold food, which could be ordered and delivered to patients attending the service.

Pain relief

Staff assessed and monitored patients regularly to see if they were in pain and gave pain relief in a timely way.

Patients received pain relief soon after requesting it.

Good

Surgery

Staff prescribed, administered and recorded pain relief accurately. Patient records confirmed that any medicines administered to patients were correctly documented.

Patient outcomes

The service had improved their systems and processes to monitor the effectiveness of care and treatment. They used the findings to make improvements.

Since the last inspection, the service had identified and implemented a range of audits, based on updated and additional policies. Included among these were routine monthly audits for IPC, records audits and medicines audits. Managers and staff carried out a comprehensive programme of repeated audits to check improvement over time. We reviewed documentation and monthly audit results for infection prevention and control. We saw these were comprehensive for infection prevention and control management of the environment, and for clinical practice and completed accurately. Audit outcomes were reviewed in management meetings.

Specific audits for clinical practice had also been revised, including for different procedures and elements of the Mohs surgery provision. An audit showed 100% of patients had completed a serum lipid check before and during Isotretinoin treatment. Serum lipid checks are required for identifying any risk factors prior to patients receiving this medicine.

The audit of minor surgery activity 2021 to 2022 identified 100% of patients had recorded excision documented in patient notes; 100% of patients had excised tissue sent for histology analysis, 100% of patients had histology reports filed in notes. Learning outcomes from the audit were identified, which concluded that no treatment had been carried out for diagnostic uncertainty.

The two consultants working in the Mohs service were registered with the British Society of Dermatological Surgeons to participate in the external quality assurance scheme for compliance with the Mohs Standards 2020 document. Managers held quarterly meetings to review outcomes of the Mohs service. The service provided details of service review April to June 2022 which identified there was 100% concordance with histology, no complications, flap or graft failures, or infections.

Managers shared and made sure staff understood information from the audits and had plans for checking and monitoring ongoing improvements.

Competent staff

The service made sure staff were competent for their roles. Managers appraised staff's work performance and held supervision meetings with most staff to provide support and development.

Staff were experienced, qualified and had the right skills and knowledge to meet the needs of patients.

Managers gave all new staff a full induction tailored to their role before they started work. The service had an induction policy with checklist, identifying relevant training and induction sessions completed. Staff files confirmed staff had completed inductions.

Managers supported staff to develop through regular, constructive appraisals of their work. Since the last inspection staff had completed updates of appraisals and there was evidence of continued support for individual staff development.

Good

Surgery

Aesthetic therapist staff working in the service had completed healthcare assistant care certificates. One member of staff was completing training for an accredited qualification as a laboratory technician. In addition to this, there had also been a programme of informal in-house learning during May 2022, including observed practice for staff, provided by an international clinical expert in Mohs surgery.

The service kept records of appraisals for medical staff with practising privileges in their staff files. These had been completed in their main job roles outside of the service and we did not see direct evidence of individual regular, constructive clinical supervision meetings held in the service for some staff. We were told of regular informal meetings and discussions between medical staff in the service, however these were mainly relating to service issues and not regarding areas for individual staff development. A biomedical scientist also regularly worked in the service one day a week, outside of their main employment in the NHS. The service kept records of their original qualifications and appraisal documents, however, again did not have any arrangements for individual supervision in the service.

After the inspection the registered manager told us they were the responsible officer for the clinic and supported the external responsible officer and the appraiser to the two consultants providing evidence of their practice at the clinic.

Managers made sure staff attended team meetings or had access to full notes when they could not attend.

Staff had the opportunity to discuss training needs with their line manager and were supported to develop their skills and knowledge.

Multidisciplinary working

Doctors, nurses and other healthcare professionals worked together as a team to benefit patients. They supported each other to provide good care.

Staff held regular meetings to discuss patients and improve their care.

The pathway for patients having Mohs surgery was principally led by the two consultants working in the service. There was a process through which Mohs patients had multidisciplinary team (MDT) review, however, this would take place in settings external to the service.

The service informed us that prior to Mohs surgery, diagnostic biopsies would be undertaken in another independent hospital setting and findings discussed there in the Cellular Pathology Services multidisciplinary team. The two doctors working under practising privileges in the service both attended this meeting and referred patients who were appropriate for Mohs surgery to Discover Laser. Following MDT discussion, a report would be issued for each patient discussed and a skin cancer MDT referral and discussion form completed. The Skin cancer MDT referral and discussion form contained details of the patient demographics, clinical details and anatomical site, biopsy details and outcome; and recommended treatment. Once patients had completed their Mohs surgery, they would be referred back to the original clinic MDT setting for any ongoing monitoring or further treatment needed.

Staff worked across health care disciplines and with other agencies when required to care for patients. The two consultants involved in the Mohs surgery worked closely with other healthcare settings to manage ongoing patient care needs.

Seven-day services

Patients could contact the service seven days a week for advice and support after their surgery.

Good

Surgery

The service was available six days in the week, having variable opening hours on different days.

Patients had access to advice available at any time (24-hour / seven days a week) following discharge, in case of any queries or concerns. During working hours, if any clinical issues were raised, these would be referred to and discussed with medical staff by other members of staff as needed. The registered manager or consultant for the day of surgery would be on call. Outside working hours, medical staff provided cover for any emergency contacts made by patients.

Health promotion

Staff supported patients and helped them to make informed decisions about their treatment and care.

The service had relevant information about treatments available to improve their health and took time to explain the different options available.

Consent

Staff supported patients to make informed decisions about their care and treatment. They followed national guidance and ensured that patients gave consent in a two-stage process with a cooling off period of at least 14 days between stages for surgery. They understood how to support patients.

Staff in the service took time to explain treatments fully to patients prior to patients giving consent.

Staff gained consent from patients for their care and treatment in line with legislation and guidance and made sure patients consented to treatment based on all the information available.

Staff clearly recorded consent in the patient's records. Written consent was obtained for every treatment during individual consultations with a doctor. The service would send an electronic copy of the consent form to the patient to allow prior reading and understanding of the consent to their surgery or treatment. The service followed a process which allowed patients a 'cooling off' period of 14 days before they returned for their actual appointment. At this treatment appointment, the patient would be asked again to give their consent to treatment as part of the two-stage process for consent, this would also be documented in their records.

Staff understood the relevant consent and decision-making requirements of legislation and guidance and had completed training in the Mental Capacity Act 2005 regarding this.

Are Surgery caring?

Good

Our rating of caring stayed the same. We rated it as good.

Compassionate care

Staff treated patients with compassion and kindness, respected their privacy and dignity, and took account of their individual needs.

Good

Surgery

Staff were discreet and responsive when caring for patients. Staff took time to interact with patients and those close to them in a respectful and considerate way. During the inspection we observed many different patient interactions and noted that staff were courteous, professional and helpful towards patients during these.

Patients said staff treated them well and with kindness. We spoke with several patients during the inspection who were appreciative and who praised staff for their care and attention to individual needs.

Staff followed policy to keep patient care and treatment confidential. Staff were sensitive to the types of treatments requested by patients and were consistent in ensuring privacy and patient confidentiality was maintained throughout the service.

Staff understood and respected the individual needs of each patient and showed understanding and a non-judgmental attitude when caring for or discussing patients.

Staff understood and respected the personal, cultural, social and religious needs of patients and how they may relate to care needs. Staff were able to describe how they ensured a personalised and patient centred approach when providing care for patients. This was particularly when considering response for patients who had any sensitive personal needs, or who had particular needs in relation to their cultural background.

Emotional support

Staff provided emotional support to patients, families and carers to minimise their distress. They understood patients' personal, cultural and religious needs.

Staff gave patients and those close to them help, emotional support and advice when they needed it. Staff took time to understand patients' individual situations and were thorough when providing information for patients. Staff were experienced and knowledgeable in their discussions with patients and provided encouragement where they could.

Staff were aware of the possibility of treatment outcomes not being in line with patients' expectations. Although there had not been any recent situation where this had arisen, staff were confident when describing their approach if this should arise or when having difficult conversations.

Staff understood the emotional and social impact that a person's care, treatment or condition had on their wellbeing and on those close to them.

Understanding and involvement of patients and those close to them

Staff supported patients, families and carers to understand their condition and make decisions about their care and treatment.

Staff made sure patients and those close to them understood their care and treatment. Staff talked with patients, families and carers in a way they could understand. During the inspection we saw staff providing different treatments for patients, during which staff explained what would be happening as part of the procedure. If patients needed any individual support such as a translation service, this could be arranged.

Patients and their families could give feedback on the service and their treatment and staff supported them to do this. The service provided feedback forms for patients to complete following their treatment. Patients could also give feedback on the services website; staff explained to patients where to find this.

Good

Surgery

Patients gave positive feedback about the service. We reviewed patient satisfaction survey reports for April to June 2022. All patients provided positive feedback. During April 2022, in a sample of 25 patient feedback forms, 20 patients described the service as 'excellent' and five described their experience as 'very good'.

Are Surgery responsive?

Good

Our rating of responsive improved. We rated it as good.

Service delivery to meet the needs of local people.

The service planned and provided care in a way that met the needs of local people and the communities served.

Managers planned and identified service arrangements that were appropriate for the needs of people. The service ensured patients had flexibility and choice regarding their treatment and care. Services continued to be in high demand, particularly for specialist treatments including Mohs micrographic surgery.

Facilities and premises were appropriate for the services being provided.

Meeting people's individual needs

The service took account of patients' individual needs and preferences. The service could not always demonstrate that reasonable adjustments were made to help patients access services.

Since the last inspection the service had updated their policy for equal opportunities and diversity. Staff we spoke with had a general understanding of the individual needs of patients, however staff gave limited examples of how this applied to the service in practice. The service provided information leaflets and website information in English, but this was not routinely available in other languages spoken by the local community, or for patients who had a sensory loss. Managers stated that leaflets in other languages could be available for patients who requested this.

Managers informed us that patients, loved ones and carers could get help from interpreters or signers if this was needed. The premises were fully accessible for disabled patients.

Patients were given a choice of food and drink to meet their needs, with a choice of sandwiches available from the adjacent leisure centre restaurant. The service noted if patients had any dietary requirements prior to attending the appointment.

Access and flow

People could access the service when they needed it and received the right care.

Managers monitored waiting times and made sure patients could access services when needed and received treatment within agreed timeframes and national targets. Maximum waiting time for Mohs surgery was 4 weeks Jan -Mar 2022. There had been 71 patients seen for Mohs surgery in the service during 2021, and 76 patients seen during 2022 to date. Average waiting times for minor surgical procedures were around four weeks. Patients could access appointment treatment times at a time to suit them.

Good

Surgery

Managers worked to keep the number of cancelled appointments to a minimum. The service explained any delays or waiting times to patients at the time of their consultation appointment.

The service offered clinic appointments only with no inpatient facilities. Treatments were offered on a same day basis. Arrangements were in place for medical staff to follow up patients who may need this after having specific procedures. Consultants contacted patients at home by phone on the day of their procedure, to monitor their condition and provide advice for any concerns.

Learning from complaints and concerns

The service treated concerns and complaints seriously. There were processes to investigate complaints and share lessons learned with all staff.

Since the last inspection the service had updated their complaints policy and provided further information to staff about complaints handling. The service offered a variety of methods through which patients could raise a complaint. This would include in person at the clinic, via post, phone or text message to the service. The service also provided information via its website and social media platforms about how to raise a complaint.

Information was also available for patients about how to raise a complaint in the services terms and conditions document, provided prior to patients first appointment.

The service displayed information about how to raise a concern in patient areas. Patients we spoke with during the inspection knew how to complain or raise concerns.

Managers would review complaints at monthly meetings and share any feedback with staff. There had not been any complaints raised to the service since the last inspection.

Are Surgery well-led?

Requires Improvement

Our rating of well-led improved. We rated it as requires improvement.

Leadership

Leaders mostly had the skills and abilities to run the service. Although leaders understood the priorities and issues the service faced, their overall ability to manage these was limited by the extent of the daily clinical demands. They were visible and approachable in the service for patients and staff. They supported staff to develop their skills.

The senior leaders in the service were the registered manager who was also the medical director for the service, and the managing director. The registered manager had a primary qualification as a general practitioner, with postgraduate qualifications in the field of cosmetic surgery, dermatology, and nonsurgical facial aesthetics. The registered manager's main focus was in providing the aesthetic treatments in the service. They also had responsibility for the overall clinical decision making in the service and were the responsible officer for medicines management. In addition, the registered manager continued to run a full daily clinic list.

Good

Surgery

We saw how the registered manager's ongoing clinical responsibilities impacted on their overall capacity for a sustained focus on clinical oversight across the service. Whilst the registered manager had the skills, knowledge and integrity to lead the service, the practical day-to-day demands of their clinical role were a limitation to their full effectiveness in leading the service. The service's business plan identified capacity issues and proposed actions, but these were not yet significantly progressed. The registered manager reported after the inspection they had weekly and monthly protected time for clinical and business review.

The managing director had a long and established working relationship with the registered manager. The managing director also held a wide range of responsibilities in day-to-day operational management in the service. These responsibilities included contract negotiation and management, regulatory compliance, stakeholder engagement and relationship management, financial management, business planning and service development, as well as direct line management of staff in the service. The managing director's ongoing operational responsibilities also impacted on their capacity for a sustained focus on full oversight across a very busy service. There was an over reliance on a limited number of medical staff in the service, with only a general aim which identified the need to engage additional staff.

Following the last inspection, the service had completed a review of staff records to meet the requirements of the Fit and Proper Persons Requirement (FPPR) (Regulation 5 of the Health and Social Care Act (Regulated Activities) Regulations 2014). We saw that directors and staff files had been standardised, containing details of DBS checks, evidence of photographic ID checks, and completed references.

Vision and Strategy

The service had a vision and a business plan for what it wanted to achieve. The business plan identified aspirations for service development in key areas but progress was not yet fully embedded.

The Discover Laser Limited Business Plan 2022 set out the service's vision of 'promoting skin health and general well-being, using evidence-based medicine, highly skilled staff, the newest best protocols and technologies in a warm, safe and welcoming environment.' Staff were committed to the service ethos and values of a 'patient before profit' model. We observed staff having a patient centred focus and demonstrating the service ethos in different ways during the inspection.

The business plan recognised the increasing demand for dermatology services and set out the broad aims to extend staffing capacity to support growth in the service. At the time of inspection, the actions were continuing but were not yet significantly progressed.

Culture

Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. The service provided opportunities for career development. The service had an open culture where patients, their families and staff could raise concerns without fear.

Staff we spoke with during inspection told us they felt supported, valued and respected. The culture in the service appeared positive, with open, and friendly communications being shared in a professional manner between staff and patients. Staff described having a sense of being part of a family as employees in the service.

There was a sense of optimism in the service, with a continuing focus on the needs of patients receiving care and treatment. Staff were realistic and spoke openly about the challenges following the last inspection and were focused on where they could continue to make improvements in different areas of their work.

Good

Surgery

Managers supported staff to develop and provided opportunities for career development. Staff were enthusiastic about the possibility of gaining new skills in different areas and were able to raise these in discussion with managers.

Since the last inspection the service had identified a whistleblowing policy, which staff were aware of. We did not hear staff raise any concerns or negative issues about the service during the inspection.

Governance

Leaders had identified governance processes, throughout the service which had been strengthened but were not yet fully embedded. Staff at all levels were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service.

Since the last inspection the service had completed extensive work to identify and update key organisational policies. Core service policies, including incident and complaints management, quality assurance, information governance, staff performance and appraisal, and staff recruitment, had all been reviewed or were now in place. Staff were aware of new policy content and were involved in discussions about these or any latest service changes during regular weekly staff meetings. Policies identified clear roles and responsibilities as well as dates for policy review. Leaders had identified relevant audits and timescales to ensure there was effective monitoring of service policies. However, we saw during inspection there was a lack of identification and full implementation of some policies. In particular, the service did not demonstrate how it ensured pathological specimens were retained and stored in accordance with relevant guidance and standards.

Staff were clear about their roles and responsibilities. They knew where to access service information and policy guidance in documents and on the service intranet. Staff met in weekly team meetings to review service activity and share key learning.

Systems and processes had been introduced to support the delivery of quality improvements and to promote good outcomes for patients. Following the last inspection, the service had held regular monthly clinical governance meetings. In these meetings key agenda items included review of incidents, any safeguarding or complaints; discussion about service activity and any key staffing issues; and review of any changes in clinical protocols. Any applications from doctors working under practising privileges would also be reviewed and approved during these meetings. Further audits were being planned from which outcomes could be used for monitoring quality and sustainability of the services provided.

The service meetings now included discussion on quality and patient outcomes. Patient feedback was positive and was considered in discussions about improving the care and treatment provided.

The service had service level agreements with local services. The service had service level agreements with two local laboratories for their histology testing, which included transport of histology samples. There were arrangements in place for removal of clinical waste with external contractors under a service level agreement.

Management of risk, issues and performance

Leaders and teams mostly used systems to manage performance effectively. They identified and escalated most relevant risks and issues and identified actions to reduce their impact, although key risks were not always identified, and actions taken to reduce their impact. They had plans to cope with unexpected events.

Since the last inspection the service had introduced revised processes for managing performance effectively. Based on the improvements made to service policies, audit systems, and the plans for ongoing monitoring and review of safety and quality, there was an overall improvement in the level and quality of assurance across the service.

Good

Surgery

However, a number of risks we assessed during the inspection relating to the environment of the Mohs Micrographic Surgery (MMS) laboratory area were not included in the risk register, or actions identified to reduce their impact The service did not ensure there were robust systems for cleaning and equipment checking in the Mohs Micrographic Surgery (MMS) laboratory area and that these were clearly documented. There were unclear systems for ensuring pathological specimens were retained and stored in accordance with relevant guidance and standards.

The current risk register identified ten risks which were described in categories related to environmental, treatment and business areas of the service. Amongst the potential risks identified were staffing risks, personal injury and damage to health, and reputational damage. All mitigating actions were stated as in place; although the mechanism for adding new risks or removing closed risks was not clearly set out.

The service had plans to cope with unexpected events. An agreement was in place with a local GP practice for use of a clinical treatment room in the event of clinic facilities being unavailable for any reason. Communications, IT and patient management systems could be accessed remotely in a secure manner, in the event of system failure.

Information Management

The service collected some available data and analysed it. Staff could find the data they needed, to understand performance, make decisions and improvements.

Information Technology systems were secure and accessible for staff to use. The service followed processes to ensure compliance with general date protection regulation (GDPR).The service was beginning to identify data and outcomes from audits to analyse performance in some areas. However, we saw this was not yet fully established across the whole service.

Engagement

Leaders openly engaged with staff to plan and manage services.

Regular staff meetings were held where staff could participate and contribute their views about the service and any improvements to make. We saw that staff meetings were now formally documented with standing agenda items for discussion. Leaders encouraged staff to actively make suggestions on all aspects of the service.

Learning, continuous improvement and innovation

All staff were committed to continually learning and improving services. However, leaders were unable to demonstrate how they were improving outcomes for the service.

Leaders and staff were focused on making improvements where they could. However, the service did not have a standardised approach, or use recognised tools and methods for quality improvement. There was a lack of evidence of a collective focus for innovation work, such as achieving recognised accreditation, or the use of systems and processes for evaluating results of improvement.

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
Surgical procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance The service did not always ensure there were effective systems and processes for assessing, monitoring, and reviewing the quality and safety of services for the Mohs Micrographic Surgery (MMS) laboratory area. This was regarding cleaning, documentation, and equipment checking regimes, also the retention and storage of pathological specimens to meet relevant guidance and standards.