Stratum Clinics Limited

Inspection report

1 Lambton Road
London
SW20 0LW
Tel:

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

Overall summary

This service is rated as Requires improvement overall.

The key questions are rated as:

Are services safe? – Good

Are services effective? – Requires improvement

Are services caring? – Good

Are services responsive? – Good

Are services well-led? – Requires improvement

We carried out an announced comprehensive inspection of Stratum Clinic on 13 February 2023. This was the first CQC inspection of this location under the current CQC inspection methodology.

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

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

Our key findings were:

- Not all staff had completed training required for their role.
- Not all documents had been reviewed or retained for staff recruitment.
- Some audits had no conclusions or outcomes recorded to demonstrate improvements.
- There was no formal mechanism for shared clinical learning as there were no clinical meetings.
- The service provided care in a way that kept patients safe and protected them from avoidable harm.
- Patients received effective care and treatment that met their needs.
- Staff dealt with patients with kindness and respect and involved them in decisions about their care.
- The service organised and delivered services to meet patients' needs. Patients could access care and treatment in a timely way.
- The way the service was led and managed promoted the delivery of high-quality, person-centre care.

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

- Review safeguarding systems, processes and record keeping.

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

Overall summary

- Ensure care and treatment is provided in a safe way to patients
- Establish effective systems and processes to ensure good governance in accordance with the fundamental standards of care .

Dr Sean O’Kelly BSc MB ChB MSc DCH FRCA

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

Our inspection team

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

Background to Stratum Clinics Limited

Stratum Clinics is an independent provider of medical services. The service provides a broad range of minor surgery and aesthetic services. Some of these are not regulated by the Care Quality Commission (CQC), but some services are, including skin tag and wart removal, mole surgery, minor surgery and removal of skin abnormalities. This report references only those services that are regulated by CQC.

Stratum Clinics is based at Raynes Park Health Centre, 1 Lambton Rd, London SW20 0LW. The service is for private fee-paying patients only, the service does not see NHS patients. The provider is registered with the CQC to deliver the regulated activity of surgical procedures, diagnostic and screening procedures and treatment of disease, disorder or injury. The provider primarily provides services to patients throughout London.

The clinic has two consultation rooms and three treatment/procedure rooms that can also be used to perform minor surgery. There are eight doctors, two nurses, one beauty therapists, a manager and two administrators.

The service operates on Monday to Friday:

Monday: 8.30am-5pm

Tuesday: 8.30am-5pm

Wednesday: 8.30am-6pm

Thursday: 8.30am-5pm

Friday: 8.30am-5pm

The service does not formally provide a service outside of these hours. The service employs administrators who oversees appointments and administration for all patients.

How we inspected this service

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

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

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

Good

Are services safe?

We rated safe as Good because:

Safety systems and processes

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

- Some staff had not completed safeguarding training or records had not been retained to ensure that staff had all completed safeguarding training. Immediately following the inspection the provider ensured that all staff had completed training.
- The service had systems to safeguard children and vulnerable adults from abuse. However, one clinician that we spoke to was not aware of who was the safeguarding lead.
- The provider did not always carry out staff checks at the time of recruitment and on an ongoing basis where appropriate. We found that some staff were missing recruitment documents such as employment history, references or Disclosure and Barring Service checks (DBS) (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). Immediately following the inspection the provider obtained all of the recruitment documents that were missing.
- Staff who acted as chaperones were trained for the role and had received a DBS check.
- There was an effective system to manage infection prevention and control.
- The provider carried out appropriate environmental risk assessments, which took into account the profile of people using the service and those who may be accompanying them.
- The provider ensured that equipment was safe and maintained according to manufacturers' instructions. We saw calibration and safety testing had been completed in 2022. There were systems for safely managing healthcare waste.

Risks to patients

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

- Staff understood their responsibilities to manage emergencies and to recognise those in need of urgent medical attention. They knew how to identify and manage patients with severe infections, for example sepsis.
- There were appropriate indemnity arrangements in place for clinicians.
- There were suitable medicines and equipment to deal with medical emergencies which were stored appropriately and checked regularly. If items recommended in national guidance were not kept, there was an appropriate risk assessment to inform this decision.

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 a system in place to retain medical records in line with Department of Health and Social Care (DHSC) guidance in the event that they cease trading.

Safe and appropriate use of medicines

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

Good

Are services safe?

- The systems and arrangements for managing medicines, including vaccines, controlled drugs, emergency medicines and equipment minimised risks. The service kept prescription stationery securely and monitored its use.
- 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).
- 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 staff kept accurate records of medicines. Where there was a different approach taken from national guidance there was a clear rationale for this that protected patient safety.

Track record on safety and incidents

The service had a good safety record.

- There were comprehensive risk assessments in relation to safety issues.
- The service monitored and reviewed activity. This helped it to understand risks and gave a clear, accurate and current picture that led to safety improvements.

Lessons learned and improvements made

The service learned and made improvements when things went wrong.

- There was a system for recording and acting on significant events. Staff understood their duty to raise concerns and report incidents and near misses. Leaders and managers supported them when they did so.
- There were adequate systems for reviewing and investigating when things went wrong.

Requires Improvement

Are services effective?

We rated effective as Requires improvement because:

- The service was not able to show how care was effectively monitored and improvements made.
- Staff training was not monitored and reviewed.

Monitoring care and treatment

The service was not actively involved in quality improvement activity.

- Although the provider had multiple audit cycles in place to review quality and implement improvements, these audits were largely ineffective. For example, one audit had reviewed all clinicians' consultation notes and had concluded that some areas of suboptimal record keeping had been found. Out of the eight clinicians reviewed, six were recorded in the audit as having failed to review medical history, allergies, whether a chaperone was requested or family history. However, this audit was found to have been incorrectly completed by a member of staff who was not a clinician. Another audit had been completed to review safeguarding measures over the past year. This audit had incorrectly concluded that all staff were trained to the correct levels, knew who the safeguarding leads were and that all recruitment files were in order. We found these conclusions to be incorrect.
- All of the audits that had been completed lacked clear conclusions which then resulted in action or improvements which had been recorded or found as evident.
- Although patient feedback had been obtained and measured, there had been no outcome or changes made in result of the feedback.
- There was no audit or quality assessment of the outcomes of care given to review treatments and clinical work.

Effective needs assessment, care and treatment

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

- We saw no evidence of discrimination when making care and treatment decisions.
- Patients' immediate and ongoing needs were fully assessed. Where appropriate this included their clinical needs and their mental and physical wellbeing.
- Patients had an initial consultation where detailed information was recorded and considered before any treatment was advised.

Effective staffing

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

- The provider did not hold evidence of the training records for several staff. The records of staff training were not well organised or logged. This meant that the provider could not easily demonstrate staff training had been completed or that it was being monitored.
- Immediately following the inspection the provider was able to show evidence that most staff were appropriately trained.
- Relevant professionals were registered with the General Medical Council and Nursing Midwifery Council and were up to date with revalidation.

Requires Improvement

Are services effective?

Coordinating patient care and information sharing

There was insufficient evidence of internal clinical collaboration and patient co-ordination with other services, to deliver effective care and treatment.

- Although patients received coordinated and person-centred care, there was no protocol or clear policy for when patients should be referred back to their GP. We did see evidence that staff referred to, and communicated effectively with, other services when appropriate. Test results were routinely sent off to test for histology and there was a log to audit this process to ensure consistency and follow up.
- 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.
- 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 advice so they could self-care.
- Risk factors were identified, highlighted to patients and where appropriate highlighted to their normal care provider for additional support.

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.

Good

Are services caring?

We rated caring as Good because:

Kindness, respect and compassion

Staff treated patients with kindness, respect and compassion.

- The service sought feedback on the quality of clinical care patients received
- Feedback from patients was positive about the way staff treat people
- Staff understood patients' personal, cultural, social and religious needs. They displayed an understanding and non-judgmental attitude to all patients.
- The service gave patients timely support and information.

Involvement in decisions about care and treatment

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

- Staff communicated with people in a way that they could understand, for example, communication aids and easy read materials were available.

Privacy and Dignity

The service respected patients' privacy and dignity.

- Staff recognised the importance of people's dignity and respect.
- Staff knew that if patients wanted to discuss sensitive issues or appeared distressed they could offer them a private room to discuss their needs.
- Patients medical records were securely stored electronically.

Good

Are services responsive to people's needs?

We rated responsive as Good because:

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 waiting area was large enough to accommodate patients attending the service.
- The website for the service was very clear and easy to understand. In addition, it contained clear information about the procedures offered.
- The facilities and premises were appropriate for the services delivered.

Timely access to the service

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

- Patients had timely access to initial assessment and treatment.
- Waiting times, delays and cancellations were minimal and managed appropriately.
- Patients reported that the appointment system was easy to use.

Listening and learning from concerns and complaints

The service took complaints and concerns seriously and responded to them appropriately to improve the quality of care.

- Information about how to make a complaint or raise concerns was available. Staff treated patients who made complaints compassionately.
- The service had complaint policy and procedures in place. There had been two complaints in the last year. Both of these had been responded to appropriately.

Requires Improvement

Are services well-led?

We rated well-led as Requires improvement because:

- The provider did not have adequate oversight of staff training and recruitment.
- The service did not have effective processes in place for monitoring quality improvement.
- There was no formal mechanism for shared clinical learning.

Leadership capacity and capability:

Leaders did not always have the capacity and skills to deliver high-quality, sustainable care.

- There was ineffective leadership at the service. This was evidenced by the lack of organisation of staff training, recruitment and quality assessment
- Leaders at all levels were visible and approachable. They worked closely with staff and others to make sure they prioritised compassionate and inclusive leadership.

Governance arrangements

There weren't always 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 clearly set out, understood or effective.
- Leaders had not always established proper policies, procedures and activities to ensure safety and assured themselves that they were operating as intended. For example, there was no protocol or clear policy for when patients should be referred back to their GP. We did not find any clinical audit which could demonstrate that there were effective quality assessment systems in place.
- There were no clinical meetings between consultants, therapists or the nurses to create cohesion, review or improvements.

Vision and strategy

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

- There was a clear vision and set of values. The service had a realistic strategy and supporting business plans to achieve priorities.
- Staff were aware of and understood the vision, values and strategy and their role in achieving them.

Culture

The service had a good culture but there was insufficient evidence of quality assessment.

- Staff felt respected, supported and valued. They were proud to work for the service. Although a staff survey had been completed, no changes or improvements had been made and it had not been discussed in any staff meetings. No staff raised any concerns or issues with us during the inspection.
- The service focused on the needs of patients.

Requires Improvement

Are services well-led?

- There were processes for providing all staff with the development they need. This included appraisal and career development conversations. Staff were supported to meet the requirements of professional revalidation where necessary.
- Not all staff had received equality and diversity training. Staff felt they were treated equally.
- There were positive relationships between staff and teams.
- There were robust arrangements in line with data security standards for the availability, integrity and confidentiality of patient identifiable data, records and data management systems.

Managing risks, issues and performance

The processes for managing risks, issues and performance were ineffective.

- The service did not have processes to manage current and future performance.
- Leaders had oversight of safety alerts, incidents, and complaints.
- The provider had plans in place and had trained staff for major incidents.

Appropriate and accurate information

The service acted on appropriate and accurate information.

- Although patient feedback had been obtained consistently, it had not been used to drive improvements or implement changes. The feedback was mostly positive but there was room for review and analysis which could in turn drive improvements at the service.

Engagement with patients, the public, staff and external partners

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

- The service encouraged and heard views and concerns from the patients.

Continuous improvement and innovation

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

- One project the service had promoted was an outreach project with local GP services where a consultant gives a presentation on a topic that GPs have requested. This is also an opportunity for GPs to ask questions about some dermatology cases in their practice.
- The service made use of internal and external reviews of incidents and complaints.

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 Diagnostic and screening procedures	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment The provider had not ensured that care and treatment is provided in a safe way. In particular; • Some of the staff had not completed expected training, including fire safety, infection control and safeguarding training appropriate to their role. • Some recruitment checks had not been completed.

Regulated activity	Regulation
Treatment of disease, disorder or injury Surgical procedures Diagnostic and screening procedures	Regulation 17 HSCA (RA) Regulations 2014 Good governance The provider did not ensure there were effective arrangements in place for identifying, managing and mitigating risks. In particular, • Ensuring staff are up to date with training. • Some audits had no conclusions or outcomes recorded to demonstrate improvements. • There was no formal mechanism for shared clinical learning as there were no clinical meetings.