Stratum Clinic

Inspection report

38 Park End Street
Oxford
OX1 1JD
Tel: 01865320790

Date of inspection visit: 14 September 2023
Date of publication: 01/11/2023

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?	Requires Improvement
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 Requires improvement overall.

The key questions are rated as:

Are services safe? – Requires improvement

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 at Stratum Clinic to follow up on concerns and breaches of regulation following our previous inspection in March 2023. The previous inspection led to a rating of requires improvement. At this inspection we identified some improvements had been made but there was a continued breach of regulation and governance processes were not sufficient, posing a risk to the health and welfare of patients. We will add full information about our regulatory response to the concerns we have described to a final version of this report, which we will publish in due course.

Stratum Clinic provides consultations and dermatological treatments for a variety of conditions including surgery for the treatment of skin cancers. They provide diagnostic tests and provide information and choices about potential treatments. Some medicines are prescribed by the service, where appropriate, which include treatment for acne. Some of the services are not regulated by the Care Quality Commission (CQC), such as cosmetic therapies. This report references only those services that are regulated by CQC.

There was no CQC registered manager in post but an application to add a new registered manager had been made. A registered manager is a person who is registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

Our key findings were:

- The service did not always operate effective processes to ensure it provided safe care.
- Care was not monitored via appropriate systems of clinical audit.
- Clinicians were qualified and experienced in the areas of care they provided.
- There was insufficient monitoring of doctors' training, background checks such as immunisations and their individual work.
- Record keeping for patient notes was not consistent with recording systems and policies. A new clinical record system had been introduced but was not being utilised as intended by doctors.
- There were arrangements to ensure consent was sought and that patients were fully informed about their care options.
- Reasonable adjustments were made to protect people's privacy, dignity and enable access to the service where they had specific requirements.
- There were insufficient governance arrangements and lead roles were not defined properly. For example, the safeguarding and clinical governance lead was unsure of their responsibilities.

Overall summary

- There had been improvements to the monitoring and oversight non-clinical elements of the service. However, some processes were still not fully implemented or in line with national guidance.

The provider **must**:

- Operate systems and processes to ensure services are monitored, safe and effective as part of a system of good governance.

Dr Sean O'Kelly BSc MB ChB MSc DCH FRCA

Chief Inspector of Healthcare

Our inspection team

Our inspection team was led by a CQC lead inspector and supported by a clinical adviser.

Background to Stratum Clinic

Stratum Clinic Ltd

Cantay House

Park End Street

Oxford

OX1 1JD

- Stratum Clinic provides consultations and dermatological treatments for a variety of conditions including surgery for the treatment of skin cancers.
- They provide diagnostic tests and provide information and choices about potential treatments. Some medicines are prescribed by the service, where appropriate, which include treatment for acne.
- Cancer treatments include Mohs surgery (the removal and real time analysis of layers of skin).
- The service cares for approximately 5,000 patients a year.
- There are designated consultation and treatment rooms available.

Some of the services are not regulated by the Care Quality Commission (CQC), such as cosmetic therapies. This report references only those services that are regulated by CQC.

Opening hours

- Monday: 08:00 to 18:00
- Tuesday: 08:00 to 18:00
- Wednesday: 08:00 to 18:00
- Thursday: CLOSED
- Friday: 08:00 to 18:00
- Saturday: (09:00 to 14:00 Alternate Saturdays)
- Sunday: CLOSED

How we inspected this service

We requested information in advance of the inspection from the provider and undertook a site visit on 14 September 2023. We reviewed 10 care records, documents related to the management of the service, patient feedback and observed the premises. We spoke with 2 clinical members of staff.

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.

Requires Improvement

Are services safe?

At our previous inspection we rated the service as requires improvement for the provision of safe services because: We identified concerns regarding medicines management, patient record keeping, the monitoring of clinical equipment, significant event/incident reporting, staff not receiving safety training and non-completion of actions following risk assessments.

At this inspection we found some improvements but there remained concerns regarding safety processes. This included poor recording of patient care and treatments.

We rated Safe as Requires improvement because:

We found there were not always appropriate systems to protect patients from the risk of harm. Patient records were not consistent and posed a risk to patients' wellbeing. Safeguarding processes were not embedded, policies were incomplete and the safeguarding lead was not aware of their role. The safeguarding (and other) training for doctors was not fully monitored. Medicines were not stored in line with national guidance.

Safety systems and processes

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

- The provider conducted safety risk assessments. It had policies, such as safeguarding vulnerable adults, fire safety and infection control. Permanent staff received an induction. However, doctors and consultants working at the service did not have their adherence to some areas of training checked. For example, training on infection control.
- The clinical lead was the designated safeguarding lead. However, they informed us they were not aware of who the safeguarding lead was. There was a laminate sheet in the nurses' station that stated the clinical lead was the safeguarding lead. Nursing staff were aware of how to identify abuse and their responsibilities in reporting suspected abuse. However, the safeguarding policies for children and adults did not list a lead for the location or local referral information. This posed a risk that clinicians may not have information they require when referring to the policy. Doctors were not trained to safeguarding adults or children level 3 and the provider had not assured themselves which staff required this level of training in safeguarding children. This posed a risk that processes designed to protect people from harm or abuse may not be operated effectively or consistently. There was a lack of oversight and assurance that safeguarding processes would be followed.
- The provider demonstrated staff checks were completed for nurses and non-clinical staff working at the service. Disclosure and Barring Service (DBS) checks were undertaken for all staff working with patients. (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). However, some doctors did not have full vaccination records and no health check disclosures or questionnaires to declare any health related issues which may impact on their ability to provide care safely.
- The provider ensured facilities and equipment were safe to use. The provider had calibrated their clinical equipment in September 2023.
- A fire risk assessment had been undertaken. We found actions from this assessment had been completed by the time of the inspection.

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. Staff had undertaken basic life support training.

Requires Improvement

Are services safe?

- Medicines and equipment to deal with most medical emergencies were stored appropriately and checked regularly.
- The provider ensured staff had medical indemnity cover (a form of insurance to protect patients and clinicians against potential medical negligence).
- Infection control processes were in place, including an audit tool. Actions required from the audit were undertaken. We observed the premises were clean and well maintained in order to minimise the risk of healthcare associated infection. There were systems for safely managing healthcare waste.
- There was an appropriate mix of staff and skill sets amongst the team of clinicians. Nursing staff reported being able to access support and advice when needed.

Information to deliver safe care and treatment.

Staff did not always have the information they needed to deliver safe care and treatment to patients.

- The clinical system was not being used appropriately by consultants when assessing, planning and delivering patient care. We reviewed 10 clinical records and found 5 did not contain assessments and treatment plans and did not always contain medical histories, allergies, and other pertinent information.
- The service manager advised that the clinical records system was new (this was also a finding from the inspection in March 2023). They explained that it was still under implementation, therefore clinicians were still learning how to use the new system.
- The risk associated with poor monitoring of patient records was exacerbated by a lack of appropriate clinical record audits.
- The service had a system to retain medical records in line with Department of Health and Social Care (DHSC) guidance in the event they ceased trading.
- Clinicians made appropriate and timely referrals in line with protocols and up to date evidence-based guidance.
- Where patients may have an urgent clinical need, such as a suspected cancer, the service could fast-track them into an appointment for urgent clinical review.

Safe and appropriate use of medicines

The service did not always have systems for appropriate and safe handling of medicines.

- Emergency medicines were monitored frequently and an appropriate stock of medicines were onsite, which may be required in the event of a medical emergency. .
- Staff monitored fridge temperatures to ensure medicines were stored at the correct temperature. However, we found fridge temperature records continued to be incorrectly recorded and therefore this monitoring was not appropriate (this was a finding at the March 2023 inspection). The nurses who explained the recording of fridge temperatures stated they only recorded the high and low temperatures that the fridge was set to alarm at, not the thermometers recording of high and low temperatures since the previous recording. The fridge temperature records were consistently being recorded above the maximum temperature required for cold chain of 8 degrees Celsius. We asked to see the cold chain policy or standard operating procedure in relation to the storage of refrigerated medicines but staff were unable to locate one.
- Staff had processes to follow to ensure they stocked, prescribed, administered or supplied medicines to patients and gave advice on medicines in line with legal requirements and current national guidance. However, there was minimal prescribing audit to ensure medicines were provided to patients safely and in line with guidance.

Lessons learned and improvements made

The service learned and made when things went wrong.

Requires Improvement

Are services safe?

- There was a system for recording and acting on significant events. We saw a log was kept and incidents were discussed with non-clinical, management and nursing staff. The incidents were discussed at provider governance level at clinical board meetings.
- The provider was aware of and complied with the requirements of the Duty of Candour. The provider encouraged a culture of openness and honesty. We found that, where necessary, complaints contained an apology and accountability where mistakes had been made.
- The service acted on and learned from external information such as changes in guidance as well as medicine safety alerts. The service had an effective mechanism to disseminate alerts to clinicians.

Requires Improvement

Are services effective?

At our previous inspection we rated the service as requires improvement for the provision of effective services because: There was no monitoring or adequate audit of patient care. Training was not appropriately monitored for non-permanent staff who provided treatments. Patients were provided with information on their lifestyle to enable them to make informed decisions about their care.

At this inspection we found some concerns identified at the previous inspection had not been addressed.

We rated effective as Requires improvement because:

There were insufficient systems for monitoring patient care, training was not always monitored appropriately and care records were not effectively recorded.

Effective needs assessment, care and treatment

The provider had systems to keep clinicians up to date with current evidence based practice.

- The clinical lead explained that patients were assessed and their care was delivered in line with relevant and current evidence based guidance. We saw that clinical care records were designed to gather pre-treatment assessment, medical histories and treatment plans. This included the National Institute for Health and Care Excellence (NICE) best practice guidelines. However, we found clinicians were not consistently using the record templates as intended. There were missing medical histories, allergies and other information missing which posed a risk to the effective and safe provision of care.
- Once patients attended an initial consultation, diagnostic tests were undertaken as required and a full medical history was ascertained. A treatment plan letter was provided to patients and shared with their GPs with the patient's consent.
- We saw no evidence of discrimination when making care and treatment decisions.

Monitoring care and treatment

The service was not actively involved in quality improvement activity.

- There were insufficient systems for the monitoring of the quality of care and patient outcomes. Clinical audit was not embedded and there was no clear system of clinical governance. For example, we looked at a consultation record audit which was used to review a small number of patients' records in August 2023. This identified areas where doctors needed to make improvements to their clinical recording. The service manager had undertaken the audit and was responsible for communicating these findings with the doctors individually. However, this was not part of a system of clinical governance or service wide quality improvement. The audits did not identify the systematic failures in the recording of patient consultations and treatment plans. There was no oversight of this audit as part of a system of clinical governance.
- There were limited audits to systems to assess improvements as part of a system of clinical governance. We looked at a Mohs (a surgery for the treatment skin cancer) audit and this did not include all the parameters as set out in British Association of Dermatologists (BAD) guidance. It was not undertaken by a clinician familiar with Mohs surgery and there were no service wide learning outcomes to identify improvements and measure them over time. The audit therefore did not ensure that this treatment was being conducted effectively and safely. The provider was not assessing and monitoring the quality and safety of the services provided in the carrying out of regulated activities in order to make improvements where required.
- Patient feedback was used to identify potential improvements.

Requires Improvement

Are services effective?

Effective staffing

The provider did not always ensure all staff had the skills, knowledge and experience to carry out their roles.

- All staff were appropriately qualified and experienced in their field of care.
- The clinicians were registered with the General Medical Council (GMC) or Nursing and Midwifery Council (NMC).
- The provider identified the learning needs of nursing and non-clinical staff and ensured training was maintained periodically as required. However, there were limited records related to the monitoring of training for doctors and consultants working at the service. For example, there was no monitoring of infection control and Mental Capacity Act (2005) training. Doctors were not trained to safeguarding adults or children level 3 and the provider had not assured themselves which staff required this level of training in safeguarding children.
- The provider had an induction programme for permanent staff.

Coordinating patient care and information sharing

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

- Staff referred to, and communicated effectively with, other services when appropriate.
- Before providing treatment, doctors at the service ensured they had adequate knowledge of the patient's health, any relevant test results and their medicines history.
- All patients were asked for consent to share details of their consultation and any medicines prescribed with their registered GP.
- The provider had risk assessed the treatments they offered. They had identified medicines that should not be prescribed if a patient was not suitable to receive them.

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. For example, patients were provided with information on how to manage their skincare needs. Patients were given treatment letters to share with their GPs.
- If follow up support or advice was needed, the provider was contactable by phone 8am to 8pm Monday to Friday and 9am to 3pm on Saturdays. If necessary, there were nurses available during these hours to provide clinical advice.
- Where patient's needs could not be met by the service, staff redirected them to the appropriate service for their needs.

Consent to care and treatment

The service had systems to obtain 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.
- Staff had training in the Mental Capacity Act (2005), although this was undertaken by consultants in their NHS roles, adherence to training was not monitored by the provider.

Good

Are services caring?

We rated caring as Good because:

Patients reported a caring service and there were arrangements to protect patients' dignity and privacy.

Kindness, respect and compassion

Staff treated patients with kindness, respect and compassion.

- The service sought feedback on the quality of clinical care patients received.
- Patient feedback was sought and patients reported a positive experience overall. Where comments indicated improvements could be made to the service, these were acted on. For example, post treatment advice and care pathways were improved following complaints received.
- The service shared a summary of 125 patients' feedback from summer 2023. 112 patients felt staff were professional and caring. 113 patients felt the surroundings were welcoming and comfortable.
- The service gave patients timely support and information prior and after their treatments.
- A chaperone policy was in place. Patients could request a chaperone and information about chaperoning was available at reception.

Involvement in decisions about care and treatment

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

- Interpretation services were available for patients who did not have English as a first language.
- Patient feedback identified that staff explained patients' conditions and symptoms to them and their care and treatment options clearly.

Privacy and Dignity

The service respected patients' privacy and dignity.

- Staff recognised the importance of respecting people's dignity and privacy.
- Treatment rooms had lockable doors and a coding system in corridors which indicated when rooms were in use.
- Patient records were stored securely.

Good

Are services responsive to people's needs?

We rated responsive as Good because:

Patients' individual needs were considered in the delivery of the service.

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. For example, there were private post-treatment recovery booths for patients to utilise.
- The facilities and premises were appropriate for the services delivered.
- Reasonable adjustments had been made so people in vulnerable circumstances could access and use services on an equal basis to others. For example, there was a lift for patients with limited mobility.
- Translation services were available.

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 depended on the urgency of need and there were systems to manage waits appropriately.
- Patients with the most urgent needs had their care and treatment prioritised and where necessary, this was shared with their GP.
- Referrals and transfers to other services were undertaken in a timely way.

Listening and learning from concerns and complaints

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

- Information about how to make a complaint or raise concerns was available. Staff treated patients who made complaints compassionately.
- The service informed patients of any further action that may be available to them should they not be satisfied with the response to their complaint.
- The service had a complaint policy.
- The provider reviewed complaints every month. Themes were analysed to identify areas where improvements may be required to the service.
- Where improvements were required as a result of complaints, actions were identified. For example, the service manager informed us there was a trend of patients reporting poor post-treatment clinical advice. The system for accessing this was reviewed and the system was changed to nurse call backs.

Inadequate

Are services well-led?

At our previous inspection we rated the service as requires improvement for the provision of well led services because: The provider did not have adequate governance and quality assurance processes. Risks to patients were not always assessed and mitigated.

At this inspection we found continued breaches of regulation and concerns regarding governance.

We rated well-led as Inadequate because:

There was a lack of clinical leadership and oversight. Governance processes were not developed or effective. Feedback from CQC had not been acted on sufficiently in relation to where there were risks to patients.

Leadership capacity and capability.

There was not sufficient leadership capacity to ensure high-quality, sustainable care.

- Leaders were knowledgeable about their field of care and the services they provided. However, there was a lack of clinical leadership and oversight. For example, the clinical lead was not aware of the small number of audits which were being undertaken by the service manager. They were also not aware of their own defined accountabilities such as safeguarding lead.
- The clinical lead did not attend staff meetings to ensure appropriate communication and clinical governance.
- The provider did not ensure there were appropriate leaders across all aspects of the service. For example, there was no clear monitoring of the consultant doctors who worked on a sessional basis at the service.
- A non-clinical service manager was in post and had made some improvements to the non-clinical aspects of the service such as oversight of clinical equipment maintenance.

Vision and strategy

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

- There was a clear vision and set of values. However, the provider did not have a strategy which connected with any governance processes. For example, there was no quality assurance programme and insufficient monitoring of clinical services.
- The risks and gaps in governance identified by CQC in March 2023 had not been fully assessed and appropriate action had not always been taken to mitigate the risks and ensure improvements to the quality of services were made.

Culture

The service's culture was not always consistent with the requirements of delivering high-quality sustainable care.

- Nursing and support staff felt supported and valued by the service's leadership team. Nurses told us they could access support from senior clinicians.
- The provider was aware of and had systems to ensure compliance with the requirements of the duty of candour.

Inadequate

Are services well-led?

- There were processes for providing all staff with professional development. This included appraisal in line with the registration requirements of the clinicians. However, training was not always monitored to ensure adherence to the provider's list of mandatory training. The provider did not assure themselves that doctors were trained to the appropriate levels of safeguarding adults or children, in line with national guidance.
- The service actively promoted equality and diversity. Nursing and support staff had received equality and diversity training.

Governance arrangements

There were no clear responsibilities, roles and systems of accountability to support good governance and management.

- There was a lack of clearly defined structures, processes and systems to support good governance. Accountabilities with regards to effective governance arrangements were not clearly defined for the leadership team.
- There was limited oversight of the performance of individual clinicians' patient care.
- Staff were not always clear on their roles and accountabilities.
- Leaders had not established proper policies, procedures to cover all aspects of the service and there was not an effective system to provide assurance they were providing a safe service which was operating as intended. For example, the medicine fridge was not being monitored in line with national guidance. The safeguarding policy did not provide locally pertinent information for staff working in the location.
- Significant event and incident logs had been implemented since the last inspection and these had been used to record and monitor incidents. However, the log contained no clinical incidents or learning events since the last inspection.

Managing risks, issues and performance

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

- There was no effective identification, assessment and mitigation of risks which may occur in the delivery of services. Risks identified during the inspection had not been identified, assessed and mitigated by the provider. For example, there was a risk of staff providing treatments without the necessary staff immunisations in place, training and health checks.
- There was no clearly defined program of clinical audit, and therefore it was unclear how audits were being used to give assurance on the quality of care and drive improvements. The clinical audits which had been implemented were not always in line with national guidance and had not been used to drive improvements where required, for example to the recording of clinical records.

Appropriate and accurate information

The service did not always act on appropriate and accurate information.

- Patient care records were not appropriately monitored to ensure consistency. There was a risk posed to patients by the lack of accurate medical histories, allergies and recording of treatment plans and assessments.
- Patient records were stored securely and in line with national guidance.

Inadequate

Are services well-led?

- Policies and governance documentation were accessible but not always accurate. For example, the sharps injury protocol informed staff that they should attend A&E and that appropriate blood tests should be undertaken where there was a risk of infection. However, this contained no local information on where staff should access this support. The safeguarding policies did not contain information pertinent to the location such as local safeguarding referral information.

  Information was not used to identify the quality and safety of the service due to a lack of audit and review. Clinical records and other records related to the management of regulated activities were not used to drive quality improvement.

Engagement with patients, the public, staff and external partners

The service involved patients and but did not engage fully with feedback from external partners in order to support high-quality sustainable services.

- The service encouraged and listened to views and concerns from patients and acted on them where necessary.
- Staff meetings took place for nurses and support staff and they were led by the service manager. We saw a standardised agenda was in place for covering key issues. However, the clinical lead and doctors did not attend regular meetings.
- The provider had not engaged sufficiently in feedback from the CQC regarding concerns identified and reported on at the previous inspection in March 2023.

Continuous improvement and innovation

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

- There was some evidence of learning and improvement in regards to responding to patient feedback. For example, post-treatment pathways had been improved to provide clinical support over the phone when needed.
- Some relevant audit was being undertaken by the service manager. However, this was minimal and was not driven by identified local l need, neither was there a defined clinical audit program and clinical audits when performed were not always in line with relevant national guidance.

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.

Regulated activity	Regulation
Diagnostic and screening procedures Surgical procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance The provider was not operating systems to assess, monitor and improve the quality and safety of the services provided in the carrying on of the regulated activities nor did they assess, monitor and mitigate the risks relating to the health, safety and welfare of service users and others who may be at risk which arise from the carrying on of the regulated activities. The provider did not maintain securely an accurate, complete and contemporaneous record in respect of each service user, including a record of the care and treatment provided to the service user and of decisions taken in relation to the care and treatment provided. The provider did not adequately act on feedback from relevant persons in the carrying on of the regulated activities, for the purposes of continually evaluating and improving such services. **The enforcement action we took:** We issued the provider with a Warning Notice instructing them to meet the requirements of regulations by the 31 October 2023.