Laserslim Cosmetic Services Limited

Thorpe Park Medical Centre

Inspection report

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

Summary of findings

Overall summary

We rated it as good because:

- The service had enough staff to care for patients and keep them safe. Staff had training in most key skills, understood how to protect patients from abuse, and managed safety well. Medicines, infection risk and safety incidents were well managed. The service had a robust process for safety incidents and lessons learned were embedded in practice
- Staff provided good care and treatment and gave patients pain relief when they needed it. Managers monitored the effectiveness of the service and made sure staff were competent. Staff worked well together for the benefit of patients, advised them on how to lead healthier lives, supported them to make decisions about their care, and had access to useful information. They followed the two-stage consent process
- Staff treated patients with compassion and kindness, respected their privacy and dignity, took account of their individual needs, and helped them understand their conditions. They provided emotional support to patients and carers
- The service planned care to meet patients' individual needs and made it easy for people to give feedback
- Leaders ran services well using reliable information systems and supported staff to develop their skills. Staff felt respected, supported, and valued. They were focused on the needs of patients receiving care. Staff were clear about their roles and accountabilities. The service engaged well with patients to plan and manage services and all staff were committed to improving services continually

However:

- Staff completed and updated risk assessments for patients and removed or minimised risks. However, we observed that some patients risk assessments were either not completed or were not fully completed
- The surgical hand wash sink in the treatment room was not in line with best practice guidance
- Staff kept records of patients care and treatment. Records did not evidence a complete and contemporaneous record in respect of each patient. We found shortfalls in some records as not all records included a complete patient pathway
- Clearly documented care and discharge plans were not present in all patients records
- Sepsis management training was not available for clinical staff
- Baseline physiological observation checks of patients were not completed which meant there was no baseline to refer to should the patient deteriorate
- An anaphylaxis risk assessment for clinical areas was not completed for those areas which did not have anaphylaxis kits

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 the summary above for details. We rated this service as good because it was effective, caring, responsive and well led. We rated safe as requires improvement.

Summary of findings

Contents

Summary of this inspection

Background to Thorpe Park Medical Centre

Thorpe Park Medical Centre is managed by Laserslim Cosmetic Services Limited which is part of the Skinfinity Living Care Group. Skinfinity remained closed during the pandemic outbreak as per guidance of the health and beauty industry.

Thorpe Park Medical Centre in Thorpe Park, Leeds is a Doctors/GP specialising in the provision of services relating to caring for adults over 65 years, caring for adults under 65 years and surgical procedures.

Dr Stephen Feldman is the registered manager and medical director for the service. In January 2021, another cosmetic surgeon was appointed under a practicing privileges' agreement.

Skinfinity was founded in 2007 as a specialist clinic for hair restoration surgery and laser liposuction. Recently, we were informed laser liposuction and hair restoration surgery procedures are no longer provided. The provider is currently reviewing the treatments provided at Skinfinity.

Laserslim offers the following treatments:

- Silhouette Soft – known as thread-lift which gently lifts sagging facial skin to produce a smoother, more youthful appearance
- Minor operations are performed using a local anaesthetic include skin tag removal, mole removal, blepharoplasty and ear pinning otherwise known as pinnaplasty.

Skinfinity is a small service that is run on a clinician led basis. Patients get one to one care. Skinfinity operates two clinics a week which is managed by one doctor. From the 14 August 2021 Skinfinity recruited an additional nurse prescriber which increased Skinfinity activity to four clinics weekly.

In total four doctors and one patient activity coordinator work from the clinic. LaserSlim is supported by an experienced team of senior staff.

The Medical Advisory Committee (MAC) is made up of consultant user representatives at Laserslim. The MAC is responsible for monitoring the clinic's clinical performance and the quality of patient care. The service risk register includes individual risk assessments and is monitored by the senior executive team. Skinfinity's top three risks are:

- Vascular occlusions
- Use of conscious sedation
- Equipment: maintenance

The hospital is registered to provide the following regulated activity:

- Surgery

The hospital has a manager registered with the Care Quality Commission (CQC).

This is the hospitals first inspection since registration on the 03 April 2014.

Summary of this inspection

How we carried out this inspection

During the inspection visit, the inspection team:

- Visited the clinical areas, looked at the quality of the overall environment and observed how staff were caring for patients.
- Spoke with the Registered Manager, Clinical Services Manager, and the Director of People.
- Spoke with three staff members.
- Reviewed seven patient care records and treatment records.
- Attended one patient consultation.
- Reviewed 29 policies, procedures and other documents which related to the running of the service.

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 to improve:

- The service must ensure that care and treatment is provided in a safe way for service users. The service must assess, monitor and mitigate the risks which relate to the health, safety and welfare of service users and ensure that accurate, complete, and contemporaneous records are maintained in respect of each service user. Regulation 12 (1)(2)(a)(b)(i)
- The service must ensure that the ground floor treatment room surgical hand wash sink, and soap dispenser are in line with the Department of Health guidance (health building note 00-10). Regulation 15(1)

Action the service SHOULD take to improve:

- The service should dispose of named patients medicines when no longer required
- The service should ensure that a system exists for referring patients for psychological assessment before starting treatment, if necessary
- The service should ensure that the patients psychological status is reviewed and documented at initial consultation
- The service should ensure patient cooling off periods are clearly documented in patient records
- The service should ensure that staff regularly check on the patients comfort and condition during treatment and throughout the day
- The service should ensure that all patients have clearly documented care and discharge plans
- The service should ensure that all patients' GPs (General Practitioners) receive written feedback
- The service should monitor patients information on the electronic records system to ensure it is updated in a timely way so that the multidisciplinary teams involved in the patients other care needs are aware of all treatments
- The service should ensure sepsis management training is undertaken by clinical staff
- The service should formalise the sepsis management policy
- The service should introduce baseline physiological observation checks so there is a baseline to refer to should the patient deteriorate
- The service should complete an anaphylaxis risk assessment for clinical areas which do not have anaphylaxis kits
- The service should instigate surgical safety checklist audits
- The service should instigate pain management audits

Our findings

Overview of ratings

Our ratings for this location are:

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

Good

Surgery

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

Are Surgery safe?

Requires Improvement

We rated safe as requires improvement.

Mandatory training

The service did not provide mandatory training in all key skills to all staff.

Staff said sepsis training had not been provided for 2020/21. To mitigate this training shortfall sepsis training was to be included within future resuscitation training sessions. A date was not identified for the roll-out of sepsis training.

Staff told us they adhered to NICE (National Institute of Care Excellence) guidance for sepsis and that a sepsis management policy was being written. The sepsis toolkit in theatres was displayed on a clipboard.

Mandatory training statistics for 2020/21 confirmed that 100% of staff had completed training.

All staff, including medical staff on practising privileges agreements, had completed the appropriate level of adult safeguarding training and training on the Mental Capacity Act and chaperoning.

Safeguarding

Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it.

The medical director held the ultimate accountability for safeguarding for the service.

The operations director and clinical operations manager were PREVENT leads for the service.

The safeguarding lead for Skinfinity was the clinical services manager.

Good

Surgery

Contact information for the safeguarding team and Mental Capacity Act team were displayed on a poster in consultation rooms.

A safeguarding register was available, and staff knew how to escalate concerns. No safeguarding incidents had taken place.

Local safeguarding children and adults at work policies and procedures gave appropriate guidance and identified key contacts. A separate female genital mutilation policy was available.

Disciplinary policies and procedures were in place.

Recruitment practices included completion of disclosure and barring (DBS) checks. DBS enhanced checks were completed on staff and those on practicing privilege's every three years.

Staff said patients were protected from discrimination including discrimination in relation to protected characteristics under the Equality Act. The Equality Act covers the same groups that were protected by existing equality legislation – age, disability, gender reassignment, race, religion or belief, sex, sexual orientation, marriage and civil partnership and pregnancy and maternity.

Staff ensured that young people were over the age of 18 years during the initial consultation.

Cleanliness, infection control and hygiene

The service did not always control infection risk well. Staff did not always use equipment and control measures to protect patients, themselves, and others from infection. However, staff kept equipment and the premises visibly clean, and used systems to identify and prevent surgical site infections.

Although most aspects of infection control were in order, we found areas that could be improved.

The treatment room surgical hand wash sink was not in line with the Department of Health guidance. The taps were not long lever action taps so staff could not do a surgical hand scrub-in properly because they could not turn off the taps without using their hands. The hand wash soap dispenser was also not in line with guidance because users could not dispense handwash without holding the container. We raised this with the service provider.

Staff did not always follow infection control principles. Although most staff followed infection control policies, audits by the service had identified some room for improvement. One member of staff was seen to be wearing jewellery and nail polish, which was a breach of the service policy. Following the inspection, we received an email dated 1 October 2021 which stated it was a disciplinary offence not to follow the company dress code.

Infection control audit outcomes identified two members of staff had been given advice about how to comply fully with infection control processes. An audit of staff hand hygiene in July 2021 found all staff complied fully with the policy. Hand hygiene guidance was displayed above sinks.

Clinical areas were visibly clean and had suitable furnishings, which were clean and well-maintained. A cleaning schedule checklist identified the areas cleaned regularly. Staff said a new cleaning contract starting in November would improve cleaning of low and high surfaces, which the service had found as an issue in a cleaning audit.

Good

Surgery

Seating in the main reception area was spaced apart to conform with COVID-19 guidance.

Staff used records to identify how well the service prevented infections. The service audited surgical site infections monthly and the one for the first six months of 2021 found none.

Staff cleaned equipment after patient contact and labelled it to show when it was last cleaned.

Staff worked effectively to prevent, identify and treat surgical site infections.

The clinical services manager was the infection, prevention, and control (IPC) lead and had identified IPC champions across all sites. The service had links with the microbiology service of a local NHS trust. Staff took microbiology samples daily and sample results came back within the week. Staff could access the local NHS trust system to obtain pathology and radiology results.

The service had adapted its IPC policy and introduced COVID-19 standard operating procedures to keep staff and patients safe. Staff followed Public Health England guidance on personal protective equipment. Before reopening after lockdown staff met and were told of the personal protective equipment changes and received training.

The service had its own waiting area in a shared building. Patients were screened for COVID-19 before their appointments, and measures to prevent the spread of infection were used at the entrance to the building and in the service's premises. The service offered virtual appointments when possible. Patients could be accompanied only by carers. The service staggered and increased appointment times to prevent overlap of patients.

The service said they did not routinely check for MRSA and Clostridium Difficile or Escherichia coli infections. Should any cases be identified, the service would implement deep cleaning of the facility.

Environment and equipment

The design, maintenance and use of facilities, premises and equipment kept people safe. Staff were trained to use them. Staff managed clinical waste well.

Not all call bells worked and until they could be fixed or replaced staff shouted for help and used an electronic alarm call that alerted staff in all areas of the building that assistance was required.

The design of the environment followed national guidance.

The clinic environment was suitable for its purpose. The operating room had a ventilation system. Air changes and daily temperature checks were completed in line with national guidance HTM (Health Technical Memorandum) 03-01. Hair transplant procedures were completed in the endoscopy theatre on the first floor as this was where the laminar flow of 15 air exchanges per hour was evidenced. The service had a service level agreement in place for maintenance of the ventilation.

Minor low-risk surgery took place in the ground floor treatment room. This was in line with guidance.

The service had enough suitable equipment to help staff care for patients safely.

Good

Surgery

Records showed that equipment was serviced regularly. Staff did daily safety checks of specialist equipment.

Staff did health and safety, infection control, and environment audits regularly and acted where needed. For example, when expired drugs were found in storage they were removed at once.

Staff checked the resuscitation trolleys on the ground floor, in endoscopy and on the first floor regularly and all were in order. Staff checked drugs were checked once a week (with expiry dates clearly highlighted on the check list). Drugs due to expire at the end of September 2021 were marked for replacement.

The theatre trolley on the ground floor had no portable appliance safety test sticker to show when it was due for service. We raised this with managers, who took the trolley out of action on the same day. The trolley has since been serviced.

A power cable led from the trolley across the floor was covered in tape, so we raised this with managers and the cable is now protected with a rubber cover.

We found one oxygen cylinder in the ground floor treatment room stored on the floor. We raised this with managers and the cylinder was secured with a hook.

The first-floor clinical room medicines fridge was on the floor, so staff were unable to clean under it in the event of a spillage. We raised this with managers, who ordered a table for the fridge to stand on.

The service monitored the fridge temperature and kept it within a range to keep medicines safe.

Staff disposed of clinical waste safely. The service had arrangements in place for waste management and collection.

Assessing and responding to patient risk

Staff completed and updated risk assessments for some patients and removed or minimised risks. However, we observed that some risk assessments were either not completed or were not fully completed. Staff had not identified patients at risk of deterioration. The service made sure patients knew who to contact to discuss complications or concerns.

Staff training records confirmed completion of resuscitation training in 2020-21.

We looked to see whether patient's consultations took account of the Royal College of Surgeon's professional Clinical Standards for Cosmetic Surgery. There were gaps in pre-operative information in some patient records. Where there were gaps, we did not see this information in other areas of some patients' records.

Staff said low risk patients accessed the service and as such veno-thromboembolism assessments and bleeding risks were not assessed for this patient group. Staff completed risk assessments for each patient as part of the initial consultation which were recorded on the patients preoperative check list and/or consultation records prior to treatment; however, this was not consistent in the seven patient notes that we reviewed.

We saw no evidence that patient's psychological status was reviewed documented in the patients notes we reviewed prior to acceptance for procedures.

Good

Surgery

Staff said patients routine baseline observations were not recorded; therefore, patients were at risk as staff were unable to identify patients who could potentially deteriorate during a surgical procedure. We were not assured that staff would recognise or respond to a deteriorating patient to keep them safe during and after a procedure.

The audit data of the cooling off period between initial consultation, consent, and procedures from January 2021 to June 2021 showed 100% compliance.

The service transfer policy had clearly defined guidance in place which staff were aware of.

Resuscitation policy guidance identified clear procedures to adopt should a patient deteriorate. There was clear guidance on who to escalate to and was dependent on the severity of the patient's condition.

In addition, Resuscitation UK (United Kingdom) guidance included an infographic for non-acute hospital settings on the resuscitation of adult Covid 19 patients. The national early warning score chart was displayed in theatre as a visual aid.

The escalation process for patients with sepsis which included red flag sepsis was identified within the serious but not immediately life-threatening pathway of the resuscitation policy escalation pathway. The senior team had instigated sepsis tool print outs in both Skinfinity clinical treatment rooms.

Guidance which related to Safety Standards for Invasive Procedures (SSIPs) was available.

Staff said that monitoring of the effectiveness of the safety standards for invasive procedures was through the learning from the incident reporting system, and information gained and reported to the specialty clinical governance meetings, endoscopy steering group and best practice meetings.

We were unable to witness the practise against surgical checklists at inspection as there were no surgical cases on the day of inspection. Compliance against the five steps to safer surgery was through monitoring of surgical checklists. We requested surgical safety checklist audit data post inspection; however, this was not provided at the time of drafting this report.

Following treatment patients were routinely followed up through a phone call within 24 hours of discharge. Where a patient identified concerns or questions, they were signposted to the clinician responsible for their care who contacted the patient by phone. Clearly documented care and discharge plans were not present in all patients records. However, we saw notes on some patient records which indicated some patients had received post-operative guidance pertinent to their treatment.

Staffing

The service had enough staff with the right qualifications, skills, training, and experience to keep patients safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed and adjusted staffing levels and skill mix and gave staff a full induction.

The clinical services manager was available to access during the clinic's operating time and had overall responsibility for safe staffing of the minor operations service. Skinfinity had either a nurse or operating department practitioner on duty three days a week. There was no on call service.

Good

Surgery

The clinic used Living Care staff when minor procedures took place in the ground floor treatment room. Each minor operations session included the clinician and an assistant. The other Skinfinity sessions were one clinician only. The staffing spreadsheet was discussed at the twice weekly senior leadership meeting.

A competency framework had been introduced which some healthcare support staff were completing. We requested information on completed competency documents as evidence, however, did not receive this evidence request.

Recruitment practices included completion of disclosure and barring (DBS) checks. DBS enhanced checks were completed on staff and those on practicing privilege's every three years.

Checks prior to practicing privileges being granted were identified within the practicing privileges policy. The service had one surgeon and nurse on practicing privileges agreements. We reviewed both clinicians personal documents and noted all checks identified by the practicing privileges policy and employment procedures were completed prior to both being awarded practicing privileges.

Staff said those clinicians on practicing privileges agreements were reviewed two yearly. The process included the clinician's completion of a self-reflective document which was reviewed by permanent medical and senior management staff in Skinfinity as part of the review process.

Medical advisory committee meetings took place three-monthly.

Records

Staff kept records of patients care and treatment. Records did not evidence a complete and contemporaneous record in respect of each patient. We found shortfalls in some of the records as not all records included a complete patient pathway. Records were stored securely and easily available to all staff providing care.

Records were stored securely.

Staff accessed the electronic records system and the NHS patient records storage system through a secure password and card. This ensured patients paper records such as consent, microbiology results and preoperative checklists were stored electronically and accessible to the wider multi-disciplinary team.

The record keeping process was not robust, the seven records reviewed did not evidence a complete and contemporaneous record in respect of each patient. We found shortfalls in some records as not all records included a complete patient pathway to evidence pre assessment, risk assessment, medical history, and photographic evidence. Not all patients records identified post-operative discharge advice.

Initial consultation notes did not always include details such as past medical history, drug history and allergies. Most of the initial consultation notes were very short and did not outline any clinical discussion with patients, for example, if the patient did or did not have any concerns.

Photographs were stored on a Skinfinity iPad which was locked away at the end of each day. Skinfinity could still access patient photographs that were over three years old, however, the staff member we spoke with was not sure of how to access the photographs which were three years or older. Photographs were for Skinfinity's use only and were not for sharing externally.

The seven records reviewed on the electronic record showed no evidence of body mapping diagrams or written information regarding exact location for procedure, for example, hair line.

Completed consent forms were in the seven patients notes we reviewed. We noted on one consent form the surgeon had not dated their signature. Confirmation of the two-week cooling off period prior to the patient's surgery was also not recorded.

Doctors sent patient information to their secretaries to scribe a letter which meant procedures and outcomes on the patient's electronic record may not be fully recorded immediately. One patient's records did not confirm the two week follow up review as stated in the original plan following their procedure in June 2021.

Monthly records audits were completed by the service. The audit data from January to June 2021 identified 100% compliance. However, we observed that the areas checked did not include all the information detailed on preoperative checklists. Some checks on the audit were on the preoperative checklist, for example, consent, allergies, post procedure verbal and written. The outcome of this audit was: 'some patient records do not have the patient's NHS number as we see all private patients in this service. Some patients may provide details which link to their GP (General Practitioner) record whereas others do not' The decision made in August 2021 was to continue to monitor patients records half yearly.

Medicines

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

A service level agreement existed with a pharmacist. There were no stock issues during the pandemic and all stock was checked for expiry dates prior to re-opening.

A medicines management policy (expiry date October 2021) was available for staff to access. The medical director was responsible for ensuring that staff followed the medicines management policy. New staff were initially introduced to this policy as part of their service induction.

No antimicrobials were prescribed as Skinfinity clinicians did not have FP10 prescription pads; the clinicians signposted patients to their GP if antimicrobials were required.

Prescription only medicines were ordered by the services prescribing team members and logged in and stored as per manufacturer instructions.

Staff followed systems and processes when safely prescribing, administering, recording, and storing medicines.

A controlled drug accountable officer was identified within the overall service; although, the service provided through Skinfinity did not use controlled drugs. If there was a need for a controlled drug prescription medical staff signposted patients to their GP. FP10 prescription pads were not held at the clinic.

The service had systems to ensure staff knew about safety alerts and incidents, so patients received their medicines safely.

The last monthly medicines checks took place on the 12 September 2021. Staff told us the drugs were checked weekly for efficacy and expiration date. We saw evidence to support this. Staff completed a daily check list to ensure drugs were in date.

The first-floor consultation room drugs cupboard stored fillers and local anaesthetic. We found a box of diazepam 5mgs in the locked cupboard prescribed for a patient and later raised this with the registered manager.

Anaphylaxis packs were available on upstairs and downstairs resuscitation trolleys. Storage of additional anaphylaxis packs were in each cubicle upstairs in endoscopy. There was no anaphylaxis kit in the first-floor consultation room. There was no risk assessment in place for this and had not been recognised on the clinic risk register.

The service did not record the patient's height and weight on the operation note or the drug calculation and maximum recommended dose. We observed height and weight for hair transplant patients was not documented to evidence calculation of bolus doses for local anaesthetic. We reviewed the providers medicines management policy to ascertain whether full process was followed and saw no guidance which stated height and weight was to be obtained preoperatively.

Incidents

The service managed patient safety incidents well. Staff recognised and reported incidents and near misses. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support. Managers ensured that actions from patient safety alerts were implemented and monitored.

An inhouse built incident reporting system was in place which was based on the local NHS trust's tools. The quality dashboard in August 2021 identified a reduction in incidents across all services provided at the Thorpe Park Medical Centre. This data was not identified by service specialities which meant it was difficult to identify whether any incidents related to the Skinfinity service.

The data provided showed clinical and non-clinical incidents were monitored and trends analysed.

All incidents are reported to the board and documented in board reports. We saw that lessons learnt were discussed with staff, at speciality clinical governance and best practice meetings. The fortnightly best practice meeting is where lessons learnt are discussed; these minutes are shared with the wider group.

The service incident reporting policy had an expiry date of 1 January 2023 and gave clear guidance on the reporting of incidents and serious untoward incidents. The service had identified no serious untoward incidents during the 12 months before this inspection. Serious incidents are events in healthcare where there is a potential for learning, or the consequences are so significant that they warrant using additional resources to mount a comprehensive response.

There were no never events reported by the service during the 12 months before inspection. Never events are serious patient-safety incidents that should not happen if healthcare providers follow national guidance on how to prevent them. Each never event type has the potential to cause serious patient harm or death, but neither need have happened for an incident to be a never event.

The incident register for 2020/21 confirmed five incidents which have since been closed since the service reopened on the 3 June 2021. Staff confirmed they had reported these incidents on the incident reporting tool. Senior managers said all incidents were reviewed daily and were discussed at the medical advisory committee and specialty clinical governance meetings for Skinfinity. We reviewed three minutes of specialty clinical governance meeting minutes and saw incidents discussed and learning identified.

Good

Surgery

Central alerting system (CAS) alerts were monitored by the operations director and clinical services manager. Relevant CAS alerts were cascaded to the relevant teams and appropriate actions were taken and confirmed. CAS alerts were also logged on the monthly board reports which were overseen by the medical director.

Are Surgery effective?

Good

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. The service met cosmetic surgery standards published by the Royal College of Surgeons.

Staff followed up-to-date policies to plan and deliver high quality care according to best practice and national guidance.

The operations director, registered manager and clinical services manager said they were informed of changing guidance and had considered publications such as the Francis and Patterson enquiry.

We saw evidence through meeting minutes that policies were being reviewed and new clinical guidance circulated to staff.

Staff said most services were minimal risk. The 'higher' risk services were governed through the company's governance matrix structure with the Living Care branch of the business.

Nutrition and hydration

Staff followed national guidelines to make sure patients fasting before surgery were not without food and drink for long periods.

A water station was in the main reception area.

Biscuits were available for patients if requested.

We also saw food dispenser machines located on the ground floor of the building.

Pain relief

Staff assessed and monitored patients regularly to see if they were in pain and gave pain relief in a timely way. They supported those unable to communicate using suitable assessment tools and gave additional pain relief to ease pain.

Staff prescribed, administered, and recorded pain relief accurately.

Patients are asked at point of local anaesthetic if they felt pain. Pain was assessed throughout the procedure. Patients were offered advice regarding pain at point of discharge.

On the day of inspection there was no surgical list; therefore, we did not see if patients were offered routine pain relief. Staff told us that patients received guidance at point of discharge regarding pain management.

Pain management audits were not completed by the service.

Patient outcomes

Staff monitored the effectiveness of care and treatment. They used the findings to make improvements and achieved good outcomes for patients.

Skinfinity did not participate in any of the services governed by patient-reported outcome measures.

Agreement was reached that the service would rather say no to patients if expectations were not going to be achieved.

Outcomes for patients were positive, consistent, and met expectations. Managers and staff used the results to improve patient outcomes. Examples of some patient outcomes are described below:

Skinfinity quarterly audit data from January 2021 until June 2021 for minor surgical procedures confirmed no unplanned readmissions to theatre.

One consultant's follow-up appointments audit data from the 22 April to the 2 September 2021 confirmed that 10 of the 14 patients required postoperative follow-up with no concerns identified at these follow-up appointments. None of the 14 patients had returned to theatre or experienced postoperative infections.

'You said we did' feedback identified how patients' outcomes had progressed and the changes instigated following patient feedback. One such change was when the provider implemented a 24-hour review call for all minor operations instigated by the clinic coordinator. This enabled patients to have a point of contact and if required the clinic coordinator would escalate to the clinical team. Staff told us this reassured patients when having the procedure.

Managers and staff carried out a comprehensive programme of repeated audits to check improvement over time. The yearly audit schedule identified monthly audits which included: record audits, surgical site infections, hand hygiene, consent, and adverse incidents. Staff said audit action plans were reviewed and staff informed of any changes or actions required to ensure that the loop was closed. These audits were reported in the monthly quality dashboard and presented at the monthly board meeting.

We were told that Skinfinity collated before and after photos of treatments. The seven patients records reviewed identified that one hair transplant patient had before treatment photographs taken. There was no reference in the patients records to post treatment photographs.

Competent staff

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

The learning and development coordinator was involved in supporting new staff. Staff had allocated buddies in addition to their line manager.

Staff attended a day long corporate Induction; in addition to this clinical staff completed a tailored clinical induction.

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

The 2020/21 appraisal data for healthcare assistants and the two clinicians on practising privileges agreements confirmed 100% compliance for completion of appraisals. Appraisal data for the senior managers was not provided as part of the evidence request.

NHS nurses who assisted Skinfinity had a yearly appraisal with the lead nurse.

The monthly reoprt in August 2021 for Skinfinity confirmed clinical staff were supported to increase their knowledge and skills through attendance at additional training sessions.

The service had identified what skill sets staff required and competency documents were held by line managers. Competency assessments were completed by some theatre healthcare assistants (HCA), and it was planned that all HCA staff would eventually complete competency-based documents. We asked to see evidence which confirmed completion of HCA and trained staff competency documents, however, this was not provided as evidence.

Staff had completed competency training sessions to enhance their skills in areas such as dermatology, minor operations, phlebotomy, and the care certificate.

Staff said other training was role dependent. Training which could be accessed included the mental health level three national vocational qualification and leadership and management training. One staff member started the leadership and management programme in September 2021.

Mental health first aid training assisted staff to support their colleagues and looked at mental health issues and conditions. Well-being action plans and well-being Wednesdays were introduced and shared with staff.

Staff received updated training which is related to people with additional needs. The training session ‘hidden disabilities’ took place in March 2020.

A virtual presentation by a mental health charity specific to managers took place and advised managers how they could support their teams. The presentation identified what mental health was and how to manage mental health.

Staff could also access fact sheets stored on the intranet under well-being resources.

Multidisciplinary working

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

All staff were invited to the quarterly directorate clinical governance as well as the fortnightly best practice meetings.

Good

Surgery

Staff said the multi-disciplinary team met monthly at governance and medical advisory committee meetings.

Monthly staff council meetings allowed staff to discuss improvements and potential changes in a safe forum.

One staff member confirmed membership of an aesthetic group.

To ensure best practice is adhered to staff worked with a dermatologist for second opinion and ongoing learning.

Evidence of multi-disciplinary team working was seen where histology reports were clear and easily accessible on the patients electronic records and all histology reports returned did not need further escalation. We saw no documented discussion by the doctor that they had discussed the histology report outcomes with the patient. We saw evidence that GPs were informed by letter of histology results which were easily accessible on the NHS electronic platform.

Seven-day services

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

The clinic ensured that all patients were aware of the limited working hours Monday to Saturday. Patients were told that should they have any concerns they must seek medical assistance by calling 111 or by attendance at the local NHS Trust emergency department.

Health promotion

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. They understood how to support patients.

Staff said surgical cosmetic procedures were completed two weeks post assessment to ensure the cooling off period. The cooling off period allowed patients time to reflect on their proposed treatment options and ask further questions so they were fully informed and in agreement with their proposed treatment plan.

We reviewed seven patient records which did not confirm that all patients had a two-week cooling off period prior to their surgery.

The provider's data identified not all procedures were subject to a two-week cooling off period prior to the procedure.

Skinfinity audit data of the cooling off period between initial consultation and procedures from January 2021 to June 2021 showed 100% compliance.

We reviewed two patient's hair transplant records and found no documented discussion for why patients wanted this intervention and the outcome that they hoped for to demonstrate appropriateness.

Consent

Staff supported patients to make informed decisions about their care and treatment. They followed national guidance and ensured that patients gave consent. They understood how to support patients.

Good

Surgery

All patients who were booked in were sent information regarding their procedure pre appointment so that they could make informed consent.

Each of the Skinfinity doctors had different consent forms for recording consent which meant that consent forms in use were not standardised.

Written consent was taken before invasive procedures. The seven patient records reviewed confirmed all patients had signed consent forms. We saw discrepancies for the level of consent obtained as some consent forms were more detailed than others. One out of seven records showed common risks within the consent form on the patient records on the electronic platform.

We observed one patient's consultation where consent was obtained and recorded in documents within the minor operations checklist. Informed consent, education and side effects were discussed during the consultation. However, the patient's records lacked the detailed discussions had during the consultation to gain consent.

The consent process was changed to ensure that patients were aware not to have filler or botulinum toxin two weeks either side of Covid–19 vaccine due to published guidance.

Staff said non-surgical activity was assessed, consented, and performed on the same day.

Staff said surgical cosmetic procedures were completed two weeks post assessment to ensure the cooling off period. The cooling off period allowed patients time to reflect on their proposed treatment options and ask further questions so they were fully informed and in agreement with their proposed treatment plan. We reviewed seven patient records which did not confirm that all patients had a two-week cooling off period prior to their surgery.

The provider's data identified all procedures were subject to a two-week cooling off period prior to the procedure. Skinfinity audit data of the cooling off period between consent and procedures from January 2021 to June 2021 showed 100% compliance.

Are Surgery caring?

Good

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.

Staff followed policy to keep patient care and treatment confidential.

We spoke with three patients who all said they had been treated with respect and felt fully informed. Patients said they understood the procedure and what to expect following their procedure. One patient also said they had felt comfortable asking the doctor questions.

Good

Surgery

We observed a patient consultation session and saw that the clinician was respectful and respected the patient's dignity.

We could not be assured that staff regularly checked on the patient's comfort and condition throughout the day as there was no care pathway in place to evidence this. During hair transplant procedures it was not evident or recorded those patients had the opportunity to have comfort breaks, to take regular drinks, use the toilet if needed and to have a meal break.

Staff understood and respected the personal, cultural, social, and religious needs of patients and how they may relate to care needs.

The 2021 staff survey scored highly in that staff felt good care was given.

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 needed.

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.

We observed a patient consultation session and saw that the clinician and patient appeared at ease. The clinician discussed potential side effects of the treatment, answered the patient's questions and was seen to reassure the patient throughout their consultation. The patient was signposted to discuss packages with another staff member following the consultation.

Understanding and involvement of patients and those close to them

Staff supported and involved patients, families, and carers to understand their condition and to make decisions about their care and treatment. They made sure patients understood the costs.

All procedures were discussed with patients before treatment with expectations being managed versus desired outcomes. The three patients we spoke with all said they understood and had felt fully involved in the discussions about their proposed treatments.

Staff talked with patients, families, and carers in a way they could understand, using communication aids where necessary.

We observed a patient consultation session where sensitive discussions about cost took place.

All patients were aware they were required to attend alone currently due to the COVID-19 regulations.

The seven records reviewed at inspection showed no evidence or indication in the patient records of any written information that the patients were provided pre and post procedure.

Good

Surgery

Patients and their families could give feedback on the service and their treatment. Following appointments, a link was sent to the patient for them to complete a feedback questionnaire. The clinic was trialling appointment cards where feedback options were included with the aim to allow patients to submit reviews across different platforms.

Are Surgery responsive?

Good

We rated it as good.

Meeting people's individual needs

The service was inclusive and took account of patients' individual needs and preferences. Staff made reasonable adjustments to help patients access services. There was not clear evidence of a system for referring patients for psychological assessment before starting treatment, if necessary.

Accessible information standards were applied to the service.

The director of people of performance, people and culture was working with a voluntary and community organisation to develop current accessible information standards (AIS) further for patients.

Provision for disabled people was available and included large corridors, disabled access and toilet facilities and the use of a lift.

Staff could access interpreters through language line to ensure effective patient involvement, communication, and involvement at their consultation.

Patients with a visual impairment could receive information in a braille format and large print information leaflets.

Patients with hearing impairments could request the use of hearing loops, whiteboards, and translucent masks.

Patients with learning disabilities could be accompanied by their carers. Staff encouraged patients to repeat information to ensure they had understood what had been said. Easy read documents could also be sent out to the patients prior to their initial consultation. Pictorial documents were being developed for patients' use.

The learning and development coordinator was due to complete the British sign language course.

We looked to see whether patient's consultations took account of the Royal College of Surgeon's professional Clinical Standards for Cosmetic Surgery and saw no evidence patient's psychological status was reviewed or documented in the seven patients notes we reviewed prior to the patient's acceptance for procedures.

We observed one patient's consultation session and noted that the clinician did not explore further the patient's mental health history and current medication.

Good

Surgery

We were not assured that post operatively patients were given a clear discharge plan regarding the care and treatment following hair transplant surgery including scalp care, pain management and the importance of taking prescribed post-operative medications and maintenance.

Access

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

No complex surgery was undertaken at Skinfinity which is a small service run on a clinician led basis. Patients were informed of the clinics working hours which were 8am to 8pm Monday to Saturday. Following treatment if patients had any concerns, they were advised to seek medical assistance by calling 111 or by attend their local NHS Trust emergency department.

Exclusion criteria for the Skinfinity business was undertaken on an individual basis which included patient expectations and mental health issues such as body dysmorphia. Staff said patient's psychological status was reviewed for minor procedures, however, we did not see evidence of these reviews in the seven patient notes we reviewed.

Staff said patient safety came first and a patients request for treatment would be declined and a full explanation given if not in the patient's best interest or if they requested multiple procedures with unrealistic expectations.

Skinfinity did not have a specific operational policy. Following the inspection, the service produced an operational policy dated 1 October 2021 which identified staff responsibilities and how the service operated.

Appointments were cancelled for patients who were isolating due to the Covid 19 pandemic. Patients who were anxious to attend had the opportunity to discuss and talk them through Covid 19 guidelines with a clinician.

Patients contacted the clinic by phone or email.

The online booking system had been reconnected to the website and appeared to be working well. The online diary synchronized with the electronic record diary on the 27 August 2021.

All patients were booked in by the patient's services team and secretaries and followed up by the same team. All patients chose their appointment times and dates.

Skinfinity operated two clinics weekly which were led by one doctor. A nurse prescriber joined the team in August 2021 which increased Skinfinity activity to four clinics a week.

All consultations were completed face to face in a private consultation room. Patients were followed up within 24 hours of their consultation by the clinic receptionist who informed the surgeons of any patient issues. The surgeon then contacted the patient to discuss issues raised.

Data from the August 2012 quality dashboard report showed an increase in referrals from NHS Trusts and GPs to Skinfinity from July 2021 to August 2021.

The August 2021 monthly report for Skinfinity confirmed 62 appointments which identified capacity booked at 92% with five to seven% of patients who did not attend.

Good

Surgery

Skinfinity quarterly audit data from January 2021 until June 2021 for minor surgical procedures confirmed no unplanned readmissions to theatre.

During our documentation review we saw inconsistent evidence of discharge letters present on the electronic patient record system. We reviewed seven patient records and saw written feedback to the patients GP was present in three records.

Learning from complaints and concerns

It was easy for people to give feedback and raise concerns about care received. The service treated concerns and complaints seriously, investigated them and shared lessons learned with all staff. The service included patients in the investigation of their complaint. The service had a system for referring unresolved complaints for independent review.

The service had a complaints policy with an expiry date of January 2022. Staff said patients were informed of the escalation process if unhappy with the outcome. Patients' complaints were also reviewed by the managing director and health ombudsman.

The clinical services manager was the complaints lead person.

Staff received complaints training on induction and had completed a refresher on complaints and incidents reporting.

Staff were encouraged to try and resolve complaints on site and where this was not possible, patients and families were directed to the clinical services manager or any other member of the executive or senior leadership team.

Information was displayed which advised patients on how to raise concerns. Staff also confirmed that they could give the patient a business card with the services NHS choices link on so that patients could raise concerns or compliments on the services NHS choices site.

A complaints register was in place.

Complaints and incidents were discussed every Tuesday and Friday with the executive team and senior leadership team. All staff could attend the Wednesday best practice meeting two-weekly.

Monthly complaints reviews took place where themes were identified. A recent theme was a lack unanswered telephone calls made by patients. The phone system was changed, and more frequently asked questions added to the website. In addition, another full-time staff member was employed to help alleviate the issue.

Are Surgery well-led?

Good

We rated it as good.

Leadership

Good

Surgery

Leaders had the skills and abilities to run the service. They understood and managed the priorities and issues the service faced. They were visible and approachable in the service for patients and staff. They supported staff to develop their skills and take on more senior roles.

Senior leaders said there had been no impact on leadership capabilities during COVID as all leaders could either work from site or home.

Board members included the medical director, managing director, non-executive directors, operations director, commercial director, and finance director.

Business continuity plans were in place and all leaders were aware of all services in case they needed to cross cover for each other in an emergency.

The clinical services manager provided daily leadership support across the centre.

The medical director and medical advisory committee advised on clinical processes and issues.

Vision and Strategy

The service had a vision for what it wanted to achieve and a strategy to turn it into action, developed with all relevant stakeholders. The vision and strategy were focused on sustainability of services. Leaders and staff understood and knew how to apply them and monitor progress.

Living Care and Skinfinity's values included: 'caring for our patients and colleagues, accomplishment and ownership of our work, reliable in what we say and do and empowering our patients and staff.'

The new vision and mission were completed in January 2019. The company involved staff through a competition where staff presented their ideas for the new vision and mission.

The company was developing a three-year business plan for the entire business. This plan included the other regulated activities not just Skinfinity. Plans included accreditations in areas such as investors in people and investors in well-being. This business plan was at review stage. Senior staff said that once ready the business plan would be shared with staff.

The Skinfinity statement of purpose was currently under review whilst the senior team decided on which treatments would continue to be offered.

Culture

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

Senior staff spoke of the mental health and well-being strategy and staff wellbeing policy. Staff wellbeing and welfare was identified as a top priority. Some activities for staff included coffee mornings, well-being Wednesdays and mental health awareness.

Good

Surgery

Senior staff said they had introduced a thriving not surviving tool kit for staff.

The service had identified a mental health first aider.

The service had introduced improvement champions and freedom to speak up guardians (FTSUG). The FTSUG is the director of people, and four champions were identified from across the business. Posters were displayed which identified who the FTSUG was. Staff could access a confidential service via email and by telephone.

The provider's quality report confirmed that freedom to speak up communications were circulated in July 2021 to prompt more staff to complete this alongside their other mandatory modules. The 2021 staff survey identified that 90% of staff identified they understood what freedom to speak up was and how to raise a concern.

Black and minority ethnic and vulnerable staff were offered risk assessments during the Covid 19 period to ensure their safety.

Staff said equality and diversity champions were identified within the service.

Senior staff described the culture as 'you said we did.'

The staff counsel was made up of staff representatives and met every eight weeks. The staff counsel encouraged staff to become involved in the business.

Governance

Leaders operated effective governance processes, throughout the service. 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.

The clinical governance director's role provided strategic direction and advised the board, clinical service manager and heads of service on patient safety, clinical effectiveness and quality of care delivered. How incidents and complaints were reported; reviews and learning formed a key part of this director's remit.

Skinfinity held quarterly medical advisory committee and clinical governance meetings that all staff were encouraged to attend.

Governance meetings and meeting minutes confirmed involvement and attendance by the multi-disciplinary team. Governance minutes were shared with the board and saved on the intranet.

The record keeping process was not robust, the seven records reviewed did not evidence a complete and contemporaneous record in respect of each patient. We found shortfalls in some records as not all records included a complete patient pathway to evidence pre assessment, risk assessment, medical history, and photographic evidence. Initial consultation notes did not always include details such as past medical history, drug history and allergies. Most of the initial consultation notes were very short and did not outline any clinical discussion with patients, for example, if the patient did or did not have any concerns. Clearly documented care and discharge plans were not present in all patients records.

Good

Surgery

Staff reported incidents through the incident reporting system and all incidents were recorded within an incident log. Incidents were investigated, and learning identified to inform future ways of working. Since the service reopened there had been five incidents, all of which were closed.

Staff were encouraged to raise concerns with their line manager and speak out when they saw something wrong.

Clinical guidance was followed, and local policies and procedures reviewed to ensure that current guidance was up to date.

The annual audit plan ensured standards were assessed, and actions identified where performance fall below accepted practice.

Staff said that clinicians with practising privileges contracts were reviewed every three years.

Senior staff said the service had taken part in the medical practitioner's assurance framework (MPAF) and the company's head of people recently did a talk on best practice with MPAF to over 200 people in the independent sector.

Staff said that all General Medical Council, Nursing Midwifery Council and Health Care Practitioners Council qualifications and revalidation dates were checked annually. When we reviewed clinical staff records, we saw this information present.

Management of risk, issues, and performance

Leaders and teams used systems to manage performance effectively. They identified and escalated relevant risks and issues and identified actions to reduce their impact. They had plans to cope with unexpected events. Staff contributed to decision-making to help avoid financial pressures compromising the quality of care.

The registered manager and medical director were the company's designated leads for risk management.

The service has identified risk, performance, business continuity and freedom to speak up policies and procedures to support the business and provide guidance for staff.

Risk was a standard agenda on all governance meetings.

A fully maintained risk register was in place which included individual risk assessments monitored by the senior executive teams. The top three risks for Skinfinity were: vascular occlusions, use of conscious sedation and equipment (maintenance)

Patients risks and psychological status were not consistently recorded within their notes. Patients routine baseline observations were not recorded; therefore, patients were at risk as staff were unable to identify patients who could potentially deteriorate during a surgical procedure. We were not assured that staff would recognise or respond to a deteriorating patient to keep them safe during and after a procedure.

Quality dashboards were submitted monthly to the board by the team.

We were told there had been quality walk rounds in clinic by the executive teams and observations shared, however, we did not see these walkarounds documented in meeting minutes.

Central alerting system (CAS) alerts were monitored by the operations director and clinical services manager. Relevant CAS alerts were cascaded to the relevant teams and appropriate actions were taken and confirmed. CAS alerts were also logged on the monthly board reports which were overseen by the medical director.

There had been no issues relating to staff performance within Skinfinity.

Staff said doctors asked if they could carry out certain procedures and these requests were discussed at governance meetings and the medical advisory committee before permission was granted.

The clinical services manager was the infection, prevention, and control (IPC) lead. Changes to IPC policy and procedure were disseminated through this group and the wider leadership teams.

Living Care said they had the following insurance policies in place: public liability, crown medical insurance, business continuity insurance, cyber fraud insurance, employers' liability, and directors' insurance.

Doctors and nurses who worked in a private capacity provided their own medical defence union cover and human resources kept a record of this on file. This was requested yearly as part of the practising privileges policy. We reviewed the personal records of the two clinicians working under practising privileges agreements and saw that the relevant insurance was in place.

Information Management

The service collected reliable data and analysed it. Staff could find the data they needed, in easily accessible formats, to understand performance, make decisions and improvements. The information systems were integrated and secure. Data or notifications were consistently submitted to external organisations as required.

All staff could access the electronic patient record system which is a GP shared record via secure smart card access. This was where Skinfinity recorded all procedures. Consent forms included a note telling patients their details are shared on their GP record.

The registered manager was the clinics Caldicott guardian.

The senior information risk owner was one of the executive team.

No data protection or information governance issues were identified at the specialist clinical governance meeting held on the 5 August 2021.

Patient information was encrypted and sent using a secure account.

Engagement

Leaders and staff actively and openly engaged with patients to plan and manage services. The service said they held coffee mornings with patients prior to Covid 19 pandemic.

A patient follow-up service asked patients for feedback following their treatment. This information was discussed at the medical advisory committee and at twice weekly operations calls.

Good

Surgery

The 2021 patient survey feedback confirmed a rating of 4.91 which related to likely and extremely likely responses against the question, 'Count of how likely you are to recommend us to somebody you know.' Seven patient comments were identified and related to payment plans, cost of treatment, telephone answer times and building signage. In response to the telephone answer times additional staff had been trained to answer enquiries and book appointments. The online booking facility had also been reinstated.

Friends and family test results for August 2021 for the Thorpe Park clinical centre identified that 92% of patients would recommend services provided at this site.

The 2021 staff survey was completed by 84 individuals from all departments which accounted for 76% of the current Living Care population. The 2021 staff survey identified changes in ways of working and management team visibility was low in the staff survey. As a result, senior managers and the executive team resumed site tours, now dial into inductions and three of the executive team attended the 7 September 2021 staff counsel to meet staff. The staff survey presentation was shared with all permanent staff by email and via Facebook and discussed at the staff counsel on the 8 June 2021.

The staff counsel was made up of staff representatives and met every eight weeks. The staff counsel encouraged staff to become involved and discussions included culture and engagement.

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	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment • The service must ensure that care and treatment is provided in a safe way for service users. The service must assess, monitor and mitigate the risks which relate to the health, safety and welfare of service users and ensure that accurate, complete, and contemporaneous records are maintained in respect of each service user. Regulation 12 (1)(2)(a)(b)(i)

Regulated activity	Regulation
Surgical procedures	Regulation 15 HSCA (RA) Regulations 2014 Premises and equipment • The service must ensure that the ground floor treatment room surgical hand wash sink, and soap dispenser are in line with the Department of Health guidance (health building note 00-10). Regulation 15(1)