Sk:n - Esher High Street

Inspection report

101A High Street
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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?	Good
Are services effective?	Good
Are services caring?	Good
Are services responsive to people's needs?	Good
Are services well-led?	Good

Overall summary

This service is rated as Good overall.

The key questions are rated as:

Are services safe? – Good

Are services effective? – Good

Are services caring? – Good

Are services responsive? – Good

Are services well-led? – Good

We carried out an announced comprehensive inspection of Sk:n - Esher High Street between 11 and 18 November 2021 under Section 60 of the Health and Social Care Act 2008. This inspection was planned to check whether the service was meeting the legal requirements and regulations associated with the Health and Social Care Act 2008. This was the provider's first inspection of the service since it registered with the Care Quality Commission (CQC).

Throughout the COVID-19 pandemic CQC has continued to regulate and respond to risk. However, taking into account the circumstances arising as a result of the pandemic, and in order to reduce risk, we have conducted our inspections differently.

This inspection was carried out in a way which enabled us to spend a minimum amount of time on site. This was with consent from the provider and in line with all data protection and information governance requirements.

This included:

- Speaking with staff in person, on the telephone and using video conferencing.
- Requesting documentary evidence from the provider.
- A site visit.

We carried out an announced site visit to the service on 15 November 2021. Prior to our visit we requested documentary evidence electronically from the provider. We spoke to staff on the telephone and using video conferencing prior to and following our site visit, between 11 and 18 November 2021.

The provider specialises in a combination of medical aesthetic treatments and anti-ageing medicine, as well as offering rejuvenation and dermatology treatments. This service provides independent doctor-led dermatology services, offering a mix of regulated skin treatments and minor surgical procedures, as well as other non-regulated aesthetic treatments.

This service is registered with CQC under the Health and Social Care Act 2008 in respect of some, but not all, of the services it provides. There are some exemptions from regulation by CQC which relate to particular types of regulated activities and services and these are set out in Schedule 1 and Schedule 2 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Sk:n – Esher High Street provides a wide range of non-surgical aesthetic interventions, for example, cosmetic Botox injections, dermal fillers and thread vein treatments, which are not within CQC scope of registration. Therefore, we did not inspect or report on these services.

Overall summary

Sk:n – Esher High Street is registered with the Care Quality Commission to provide the following regulated activities: Treatment of disease, disorder or injury, Diagnostic and screening procedures and Surgical procedures.

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

Our key findings were:

- Staff had received training in key areas. There was a clear plan of training for staff. There was some monitoring of training undertaken by clinical staff employed on a sessional basis, but some current gaps in training had not been identified.
- There were processes in place for performance review and monitoring/oversight of clinical staff employed on a sessional basis. Staff employed by the service had undergone appraisal and regular one to one review.
- There were effective systems and processes to assess the risk of, and prevent, detect and control the spread of infection. There were processes for auditing of infection prevention control arrangements.
- The monitoring of staff immunisations did not reflect current Public Health England guidance.
- There were safeguarding systems and processes to keep people safe. Staff were clear who the safeguarding lead was and what procedures they would follow if they had a safeguarding concern. Staff had received training in the safeguarding of adults and children.
- Arrangements for chaperoning were effectively managed. Staff had received chaperone training and had been subject to Disclosure and Barring Service checks.
- There were appropriate arrangements to manage medical emergencies and suitable emergency medicines and equipment in place.
- Fire safety processes were in place. Staff had participated in fire drills and had received fire safety training.
- There were comprehensive health and safety and premises risk assessments in place.
- Clinical record keeping was clear, comprehensive and complete.
- There was evidence of clinical audit and regular auditing of clinical record keeping processes.
- There were clear and effective governance and monitoring processes to provide assurance to leaders that systems were operating as intended. Risks were promptly identified and responded to.
- Best practice guidance was followed in providing treatment to patients. For example, excised lesions were routinely sent for histological review.
- There were records to demonstrate that recruitment checks had been carried out in accordance with regulations, including for staff employed on a sessional basis. However, local managers did not always have oversight of those assurance checks.
- Policies and procedures were monitored, reviewed and kept up to date with relevant and sufficient information, to provide effective guidance to staff.

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

- Review processes for the monitoring of staff immunisation status to reflect current Public Health England guidance.
- Review processes for the monitoring of staff training to ensure clinical staff working under practising privileges have received up to date training in all required areas.
- Review arrangements for the storage of staff recruitment and personnel records, to facilitate ease of access and monitoring of compliance with organisational requirements by local managers.
- Store syringes and dosage instructions with needles and ampoules in emergency medicine packs, to promote ease of access.

Overall summary

Dr Rosie Benneyworth BM BS BMedSci MRCGP

Chief Inspector of Primary Medical Services and Integrated Care

Our inspection team

Our inspection team was led by a CQC lead inspector and included a GP specialist advisor.

Background to Sk:n - Esher High Street

Sk:n – Esher High Street provides independent doctor-led dermatology services, offering skin treatments such as prescribing for acne and other skin conditions, and minor surgical procedures, including the excision of moles and other skin lesions. The service also provides non-regulated aesthetic treatments, for example, cosmetic Botox injections, dermal fillers and thread vein treatments, which are not within CQC scope of registration.

The Registered Provider is Lasercare Clinics (Harrogate) Limited, who provide services from more than 50 locations across England.

Sk:n – Esher High Street is located at 101A High Street, Esher, Surrey, KT10 9QE.

The clinic opening times are:

Tuesday & Wednesday: 10am to 8pm

Thursday: 9am to 5.30pm

Friday & Saturday: 9am to 5pm

Sunday and Monday: Closed

The staff team is comprised of a clinic manager, supported by administrators and front of house staff. A doctor who specialises in dermatology provides sessional dermatology consultations and treatments on one day each week for three out of four weeks. The doctor is also employed as the medical director for the service. Staff are supported by the provider's regional and national management and governance teams.

The service is run from self-contained premises over two floors which are leased by the provider. The premises include a suite of consultation and treatment rooms, a waiting room and reception area on the ground floor. Patients are able to access toilet facilities on the ground floor. The main access to the reception and ground floor areas is via a small number of steps. Alternative access to the premises at street level, is available to patients with limited mobility.

How we inspected this service

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

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

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

Good

Are services safe?

The service had systems to keep people safe and safeguarded from abuse.

- The service had systems and processes to safeguard children and vulnerable adults from abuse. We reviewed the provider's safeguarding policies which provided appropriate guidance for staff. Staff we spoke with had a clear understanding as to who was the safeguarding lead within the service and how to raise safeguarding concerns about a patient. Our review of training records confirmed that all staff had received training in safeguarding vulnerable adults and children at a level appropriate to their role. In addition, we found that staff had received regular internal updates in the form of safeguarding policy reminder sessions.
- Treatment was offered to those aged over 18 years of age. The service asked patients to confirm they were age 18 years or over. They carried out identification checks if a patient appeared to be under the age of 25 years and recorded those checks within the clinical record. No children were treated by the service and clear guidance was provided to patients that children should not attend unless chaperoned by another adult.
- The provider carried out all required staff checks at the time of recruitment and all required ongoing monitoring, such as professional registration status and medical indemnity confirmation. However, we found omissions in the ongoing monitoring of training records held for the one clinical staff member employed by the service. We found that the provider had failed to ensure that the clinical staff member had completed up to date training in health and safety, fire safety and infection prevention and control.
- Disclosure and Barring Service (DBS) checks were undertaken for all staff. (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). All staff who acted as chaperones were trained for the role and had undergone a DBS check.
- There were mainly effective systems to manage infection prevention and control within the practice. The premises were very well maintained. Cleaning and monitoring schedules were in place. Monthly auditing of all infection prevention processes was undertaken and had last been completed on 11 November 2021. We reviewed processes for the monitoring of staff immunisations. We saw records which confirmed that the Hepatitis B status of relevant staff was monitored. However, the provider held no immunisation records relating to varicella, tetanus, polio, diphtheria and MMR (measles, mumps, rubella), for staff employed within the service, in line with current Public Health England (PHE) guidance. The provider had not assessed the risks to staff and patients associated with a failure to hold those immunisation records. There was no documented staff immunisation policy or statement in place which set out the provider's rationale for this approach.
- There were systems for safely managing healthcare waste, including sharp items. We saw that clinical waste disposal was available in clinical rooms. Bins used to dispose of sharps items were signed, dated and not over-filled. External, lockable bins were used to store healthcare waste awaiting collection by a waste management company.
- The service had systems to manage health and safety risks within the premises, such as fire safety and legionella. Legionella risk assessments were carried out and resulting actions had been completed. (Legionella is a particular bacterium which can contaminate water systems in buildings). We noted that staff undertook weekly flushing of taps in infrequently used consulting rooms in order to reduce the risk of Legionella occurring. Testing of water samples had last been undertaken in June 2021. There was guidance and information, including risk assessments, available to staff to support the control of substances hazardous to health (COSHH). There were documented risk assessments in place to manage risks associated with the premises and general environment which had been last reviewed in September 2021. There was a documented fire evacuation plan and major incident plan in place. The provider had developed a comprehensive COVID 19 safety policy and associated local risk assessments.
- The provider had carried out regular fire safety risk assessments. Staff had recently participated in a fire drill. There was appropriate fire-fighting equipment located within the premises which was regularly serviced and maintained. We noted that the fire alarm had last been serviced in July 2021. Fire extinguishers had been serviced in November 2020.The practice had designated staff who were trained as fire marshals and staff had undertaken fire safety training.

Good

Are services safe?

- The provider ensured that facilities and equipment were safe, and that equipment was maintained according to manufacturers' instructions. We reviewed records to confirm that electrical equipment had undergone portable appliance testing in August 2021.

Risks to patients

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

- There were arrangements for planning and monitoring the number and mix of staff required to meet patient needs. Clinical staff working on a sessional basis were scheduled according to patient demand.
- There were planned induction processes in place and a plan of required training for staff to complete as part of the induction process.
- There was an established process for sending samples for histology and receiving results for review. Staff recorded samples in the histology log and the minor operations book, and all samples were tracked when dispatched. The medical director contacted patients if there was a cause for concern and made onward referrals if necessary. If there were no concerns, clinic staff phoned and sent patients copies of their results.
- All patients undergoing minor surgical procedures were discharged with a direct telephone number for the medical director in case of complications. The medical director was available to offer advice and support to patients outside of opening hours.
- The provider's national contact centre implemented a triage system for patients which automatically recognised an existing patient's telephone number. Outside of opening hours this facility enabled the caller to access immediate medical advice from the service, triggering the provider's adverse reaction process. Callers were responded to by a manager or senior advisor who referred the call to a nurse for further medical advice where required.
- The service implemented inclusive pricing which meant that patients who were required to attend for follow up appointments for removal of sutures or review of a wound, were not charged for follow up appointments. This encouraged patients to attend for review and ensured effective wound care management following treatment.
- We reviewed arrangements within the service to respond to medical emergencies. We found there were appropriate supplies of emergency medicines available to staff in the event of a medical emergency, for example anaphylaxis. There was a comprehensive documented risk assessment in place to assess the level of risk to patients in the event of a medical emergency which included rationale for the emergency medicines held. The service held adequate supplies of 'Epipen' auto-injectable devices to treat patients in the event of anaphylaxis. In addition, ampoules of adrenaline to treat anaphylaxis, were stored within an alternative emergency kit within the clinical treatment room. We noted that there were needles, but no syringes or dosage instructions stored within the box alongside the ampoules, which may have delayed administration of the medicine in an emergency if that supply of emergency medicines was used. Staff told us that syringes were stored separately. There was a defibrillator and oxygen available on the premises. The defibrillator pads, battery and the oxygen were all in date and the oxygen cylinder was full.
- Staff understood their responsibilities to manage emergencies and to recognise those in need of urgent medical attention.
- Staff had received basic life support training which was annually updated.
- The service had a first aid kit in place which was appropriately stocked, and its' contents were regularly checked.
- There were appropriate professional indemnity arrangements in place for clinical staff.
- The provider had in place public and employer's liability insurance policies effective until May 2022.

Information to deliver safe care and treatment

Staff had the information they needed to deliver safe care and treatment to patients.

Good

Are services safe?

- We reviewed clinical records relating to 10 patients who had received treatment within the service. Clinical records were stored on a secure, password-protected, electronic system. Hand-written records were stored securely in locked cupboards.
- Individual care records were written and managed in a way that kept patients safe. The care records we saw showed that information needed to deliver safe care and treatment was available to relevant staff in an accessible way. Clear, accurate and contemporaneous patient records were kept. Treatment planning and information were fully documented.
- There was a documented consent policy. Consent processes were comprehensive and consistently applied. Patient records clearly documented the consent process and discussions between the practitioner and patient.
- Patients attended the clinic for assessment and treatment of skin lesions such as moles, lipomas and cysts. Clinical staff providing dermatology services had received specialist dermatology training and followed best practice guidance, such as that provided by the British Association of Dermatologists (BAD). For example, screening of moles and other lesions included the use of a dermatoscope and removed lesions were routinely sent for histological examination. (A dermatoscope is a hand-held visual aid device used to examine and diagnose skin lesions and diseases).
- The service had systems for sharing information with staff and other agencies, for example, the patient's NHS GP, to enable them to deliver safe care and treatment.
- Clinicians made appropriate and timely referrals in line with protocols and up to date evidence-based guidance. For example, for patients requiring onward referral to secondary care services for skin cancer treatment. Staff told us if a lesion appeared suspicious, they would immediately refer the patient back to their registered GP or directly onto a secondary care pathway.
- The service had a system in place to retain medical records in line with Department of Health and Social Care (DHSC) guidance in the event that they cease trading.

Safe and appropriate use of medicines

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

- There were systems and arrangements for managing the safe handling of medicines and prescribing practices in a way which minimised risks to patients. The service kept prescription stationery securely and monitored its use.
- Our review of clinical records confirmed that staff prescribed and administered medicines to patients, and gave advice on medicines, in line with legal requirements and current national guidance.
- Appropriate processes were in place for the ordering, receipt and monitoring of stock medicines held and staff kept accurate records of those medicines.
- Emergency medicines were readily available and in date and supplies were regularly checked. There were documented records of those checks.
- Medicines were stored securely in a locked cupboard in the consulting room. Medicines requiring refrigeration were stored in a refrigerator which was monitored to ensure it maintained the correct temperature range for safe storage. All temperatures recorded had been within the range for safe storage.
- The service monitored prescribing to ensure it was in line with best practice guidelines for safe prescribing.

Track record on safety and incidents

- There were comprehensive risk assessments in relation to safety issues and to support the management of health and safety within the premises.
- The provider had developed comprehensive monitoring processes which provided a clear, accurate and current picture to local and national leaders which led to safety improvements. Central medical advisory and clinical governance committees ensured local and group oversight, and prompt intervention when required.

Good

Are services safe?

- The provider had established monitoring and auditing processes to provide assurance to leaders that systems were operating as intended. Some of those processes were implemented by regional and national support roles who worked closely with local managers to identify risks and implement improvements. For example, regional audit staff worked with local managers to undertake six-monthly auditing of all aspects of service delivery, including for example, premises safety, a review of a sample of clinical records, medicines management and infection prevention and control.

Lessons learned and improvements made

The service had systems to ensure they learned when things went wrong.

- There was a system for recording and acting on significant events. Staff understood their duty to raise concerns and report incidents and near misses. Local and national leaders supported them when they did so. There had been no serious incidents recorded within the past 12 months.
- There were appropriate systems for reviewing and investigating when things went wrong. The service learned, and shared lessons, identified themes and took action to improve safety in the service. For example, we reviewed the records relating to one patient who had developed a skin infection following treatment which was related to activities they had been undertaking. The service had reviewed and revised the advice and guidance they provided to patients following this treatment, in response to the incident.
- The provider was aware of and complied with the requirements of the Duty of Candour. The provider encouraged a culture of openness and honesty.
- The service had systems in place for knowing about notifiable safety incidents. The service acted on and learned from external safety events as well as patient and medicine safety alerts. For example, the provider had developed additional guidance for staff in response to a safety alert issued in July 2021, with regard to the monitoring requirements of patients prescribed a particular medicine to treat acne. Safety alert information and other organisational messaging, for example protocol changes, were cascaded effectively to staff within local services via update bulletins issued by central teams and reinforced by local managers.

Good

Are services effective?

Effective needs assessment, care and treatment

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

- Clinicians employed by the service had high levels of skills, knowledge and experience to deliver the care and treatment offered by the service.
- Clinicians kept up to date with current evidence-based practice. We found that clinicians assessed needs and delivered care and treatment in line with relevant current legislation, standards and guidance. These included the National Institute for Health and Care Excellence (NICE) and British Association of Dermatologists (BAD) best practice guidelines. Current, evidence-based practice guidelines were implemented in the treatment of specific conditions.
- We reviewed clinical records relating to 10 patients who had received treatment within the service. We found there was a consistent approach to clinical record keeping and risks to the patient were comprehensively assessed, discussed and documented. Clear, accurate and contemporaneous clinical records were kept. Treatment planning and information were fully documented.
- The service ensured they provided information to support patients' understanding of their treatment, including pre- and post-treatment advice and support. Staff within the service provide a telephone call prior to and following treatment. Patients were able to access post treatment support via follow up appointments and also on the telephone.
- Staff assessed and managed patients' pain where appropriate. Patients were prescribed local anaesthetic medicines prior to some procedures, where appropriate.
- We saw no evidence of discrimination when making care and treatment decisions.

Monitoring care and treatment

The service was able to demonstrate quality improvement activity.

- The service used information about care and treatment to assess the need to make improvements.
- The service carried out a regular series of audits of patient records to review compliance with the provider's expected standards of record keeping. For example, we saw records of clinical notes audits which had been undertaken every six months. Regional audit staff worked with local managers to undertake six-monthly auditing of all aspects of service delivery, including for example, premises safety, policy and procedural management, infection prevention and control and medicines management. Auditing processes included staff interviews to confirm their level of knowledge and understanding. Service locations received a score and rating which reflected the level of risk identified by the audit. Action points arising from the audits were identified and closely monitored until completion. Audit activity frequency was increased where there were identified risks or ongoing concerns.
- Staff employed on a sessional basis were subject to review of their performance within the service and monitoring of their clinical decision making and patient treatment outcomes. Medical advisory and clinical governance committees provided a central structure under which patient treatment outcomes were monitored.

Effective staffing

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

- Staff had the appropriate skills and training to carry out their roles. There were planned induction processes in place. There was a clear plan of required training for staff to complete as part of the induction process.
- The provider understood the learning needs of staff and provided protected time and training to meet them. Up to date records of skills, qualifications and training were generally maintained. However, we found that one clinical staff member had not completed up to date training in health and safety, fire safety and infection prevention and control.

Good

Are services effective?

- The service held records which confirmed medical professionals were registered with the General Medical Council (GMC) and were up to date with revalidation. There were no nurses employed within the service.
- There was a clear approach to staff appraisal and regular review of individual performance. Staff underwent monthly one-to-one review meetings with the service manager and annual appraisal of all aspects of their role. Clinical staff employed on a sessional basis provided evidence of their professional external appraisal summary to the provider and also participated in monthly one-to-one review meetings. Those clinical staff employed on a sessional basis were subject to a review of their performance within the service via auditing of their clinical decision making and patient treatment outcomes.

Coordinating patient care and information sharing

- Patients who used the service received coordinated and person-centred care. 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, previous medical and medicines history. We saw examples of patients being signposted to more suitable sources of treatment where this information was not available to ensure safe care and treatment.
- All patients were asked for consent to share details of their consultation and any medicines prescribed, with their registered GP when they registered with the service.
- Patient information was shared appropriately, and the information needed to plan and deliver care and treatment was available to relevant staff in a timely and accessible way. There were clear and effective arrangements for following up on patients where their care involved other services, for example there were rigorous processes for tracking histology results following lesion excision.

Supporting patients to live healthier lives

- Patients were provided with information about procedures, including the benefits and risks of treatments provided. The service provided pre- and post-treatment advice and support to patients. All patients received a support telephone call in the days preceding their initial consultation and following their treatment.
- In the event that patients presented with deteriorating skin conditions post procedure, the service had access to advice and support from nurses from across the organisation, as well as a group medical standards team for advice, triage and support.
- Where patients' needs could not be met by the service, staff told us they redirected them to the appropriate service for their needs. For example, the service offered screening and removal of moles and other lesions. Staff told us that if they were concerned about a suspicious lesion, they would decline to treat the patient and would refer the patient back to their GP or directly onto a secondary care pathway.
- Where lesions were removed or treated within the service, samples were routinely sent for histology. Rigorous processes were in place to ensure the recording and tracking of samples sent for histological review. The treating clinician reviewed all results prior to patients being notified of the outcome.

Consent to care and treatment

The service had processes to ensure consent to care and treatment was obtained in line with legislation and guidance.

- Staff we spoke with understood the requirements of legislation and guidance when considering consent and decision making. Staff described processes for the assessment of patients' suitability for treatment which included their psychological well-being, mental capacity and vulnerability. Staff told us they would not agree to treat patients about whom they had any concerns.

Good

Are services effective?

- There was a documented consent policy. Consent processes were comprehensive and consistently applied. Patient records we reviewed clearly documented the consent process and discussions between the practitioner and patient.

Good

Are services caring?

Kindness, respect and compassion

Staff treated patients with kindness, respect and compassion.

- The service actively invited feedback on the quality of care patients received. The provider implemented an online service for all patients which enabled them to provide feedback after every appointment in the form of a score from one to ten. This feedback system also allowed patients to provide comments, whether positive or negative. Clinic managers responded to all comments and contacted patients who provided a score of seven or below to identify their concerns and explore how they felt improvements to the service could be made. We noted that the service had responded directly to feedback regarding the ability to make direct contact with the service to amend appointments, for example, without having to go via the provider's central contact team. As a result, the service was provided with a direct line to enable patients to contact them directly.
- Prior to our inspection we reviewed publicly available information regarding patient experiences at the service. At the time of our review we saw there were 16 reviews on Google, which rated the service as 4.3 out of 5 stars. All 4 reviews left within the last 12 months rated the service as 5 out of 5 stars. The positive comments included: 'friendly, professional and attentive staff'; 'fantastic and knowledgeable team'. The service also encouraged patients to use Trustpilot to review and rate their experience. The provider's website included a direct link to all Trustpilot reviews. We saw that Trustpilot showed the service was rated as 3.5 out of 5 stars. 5 reviews had been left within the 12 last months. All reviews had been responded to by the provider. Positive comments included: 'staff polite, friendly and professional'; 'procedure carried out very well'. Negative comments included: 'disappointed with contact centre customer service'.
- Staff understood patients' personal, cultural, social and religious needs. They displayed an understanding and non-judgmental attitude to all patients.
- The service gave patients timely support and information in relation to their care and treatment.

Involvement in decisions about care and treatment

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

- The service ensured that patients were provided with all the information they required to make decisions about their treatment prior to treatment commencing. Information about pricing was available to patients on the service's website and within the service. Patients were provided with individual quotations for their treatment following their first consultation.
- We saw that the service provided a patient information folder located within the reception and waiting area. This provided information which included the provider's statement of purpose, governance structure, terms of business, complaints policy, data security, General Medical Council guidance on cosmetic procedures and the service's COVID-19 risk assessment.
- Interpretation services were available for patients who did not have English as a first language. The service had a hearing loop installed.

Privacy and Dignity

The service respected patients' privacy and dignity.

- Staff recognised the importance of people's dignity and respect. Consultations and treatments took place behind closed doors and conversations could not be overheard.
- Patients were collected from the waiting area by the clinician and escorted into the consultation room.
- Front of house staff were aware that if patients wanted to discuss sensitive issues or appeared distressed, they could offer them a private room to discuss their needs.

Good

Are services caring?

- Chaperones were available should a patient choose to have one. All staff who provided chaperoning services had undergone required employment checks and received training to carry out the role.
- Staff complied with the service's information governance arrangements. Processes ensured that all confidential electronic information was stored securely on computers. All patient records and information kept as hard copies was stored in locked cupboards within a locked room. Staff working in the reception area told us that they operated a clear desk policy and hard copy documents were promptly locked away.

Good

Are services responsive to people's needs?

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 arranged services in response to those needs. Doctor-led dermatology services were provided on one day each week and according to patient need.
- The facilities and premises were maintained to a high standard and were appropriate for the services and treatments delivered. All consulting rooms were located on the ground floor. The main access to the reception and ground floor areas was via a small number of steps. Alternative access to the premises at street level, was available to patients with limited mobility.
- Reasonable adjustments had been made so that people in vulnerable circumstances could access and use services on an equal basis to others. For example, there was a hearing loop and translation support 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.

- Appointments could be booked in person or by telephone. Patients usually had appointments within a short time from their request. Evening and weekend appointments were available. Patients were able to register their interest in booking an appointment via the provider's website and this was followed up by a central contact centre.
- Waiting times, delays and cancellations were minimal and managed appropriately.
- Referrals to other services were undertaken in a timely way and were managed appropriately. For example, for patients requiring onward referral to secondary care services for skin cancer treatment.

Listening and learning from concerns and complaints

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

- Information about how to make a complaint or raise concerns was readily available to patients. We saw that the service's complaints procedure was displayed within the reception/waiting area. Staff treated patients who made complaints compassionately.
- The service had received four complaints within the previous 12 months and was able to demonstrate how appropriate and timely actions were taken in response to a complaint.
- The service clearly informed patients of further action that may be available to them should they not be satisfied with the response to their complaint. The service's written complaints policy included up to date information to support patients should their complaint remained unresolved. For example, there was reference within the policy to the Independent Sector Complaints Adjudication Service from whom additional advice and support may be sought.
- There was evidence that complaints had been discussed and the learning shared amongst the team. We reviewed documented evidence of staff meetings where complaints had been discussed.

Good

Are services well-led?

Leadership capacity and capability:

Leaders demonstrated the capacity and skills to deliver high-quality, sustainable care.

- Leaders demonstrated the capacity to implement systems and processes to support the delivery of high-quality care. Leaders were knowledgeable about issues and priorities relating to the quality and future of services. They understood the challenges and had developed clinical strategies focused upon areas including clinical governance, risk management, and the use of technology
- Leaders at all levels within the service were visible and approachable. They worked closely with the small team of staff to make sure they prioritised compassionate and inclusive leadership.
- There was a clear local, regional and national staffing structure in place across the organisation and staff were aware of their individual roles and responsibilities. The provider had identified individual members of staff to assume lead roles in key areas. For example, safeguarding and infection prevention and control.
- There were open lines of communication between staff based within the service and those working at a regional and national level and also those employed by the service on a sessional basis. Staff we spoke with felt well supported and described leaders within the service as approachable. Staff told us they had regular formal and informal one-to-one interaction with managers. Staff spoke of regular team meetings they had attended, and we saw records of those meetings.

Vision and strategy

- There was a clear vision and set of values. The provider had set out clear brand values which were to be accessible, approachable, expert and responsible. The company values focused upon brand reputation, customer experience and customer loyalty.
- Staff were aware of and understood the vision, values and strategy and their role in achieving them.
- The service monitored progress against delivery of the strategy. It carried out 'mock' CQC audits to assess the quality of care provided.

Culture

There were systems and processes to support a culture of high-quality sustainable care.

- Staff felt respected, supported and valued. The service focused on the needs of patients.
- Leaders and managers encouraged behaviour and performance consistent with the vision and values.
- Openness, honesty and transparency were demonstrated when responding to incidents and complaints. There had been no serious incidents in the past 12 months relating to the regulated activities carried out by the service. The provider was aware of and had systems to ensure compliance with the requirements of the duty of candour, and these were embedded in corporate policies.
- Staff told us they could raise concerns and were encouraged to do so. They had confidence that these would be addressed.
- There were processes for providing all staff with the development they needed. Staff had received regular annual appraisals in the last year. Staff were supported to meet the requirements of professional revalidation where necessary.
- There was a strong emphasis on the safety and well-being of all staff. We saw records which confirmed all staff had participated in monthly one-to-one review meetings with their line manager.
- The service actively promoted equality and diversity. Staff had received equality and diversity training. Staff felt they were treated equally.

Good

Are services well-led?

- There were positive relationships between staff and prompt and effective communications across the staff team. Staff meetings were held regularly. Organisational communications were shared effectively across the group, for example, in the form of regular bulletins which staff within local services were required to sign to confirm their receipt and understanding.

Governance arrangements

There were clear responsibilities, roles and systems of accountability to support good governance and management.

- Structures, processes and systems to support good governance and management were clearly set out and understood. Regional and national structures and processes implemented by the provider ensured appropriate levels of support to local teams to ensure consistent and effective governance arrangements.
- Leaders had established appropriate policies, procedures and activities to ensure safety and assured themselves that they were operating as intended, including clear escalation procedures and a medical standards team. However, we noted that there was no staff immunisation policy and staff immunisations had not been monitored in line with current PHE guidance.
- The clinic manager had regular update meetings with the medical director, to highlight any changes and to discuss patients' specific needs.
- Staff understood their individual roles and responsibilities.
- The service used performance information, which was reported and monitored, and management and staff were held to account.
- The service submitted data or notifications to external organisations as required.
- There were arrangements in line with data security standards for the availability, integrity and confidentiality of patient identifiable data, records and data management systems.

Managing risks, issues and performance

There were clear and effective processes for managing risks, issues and performance.

- There were effective governance processes to ensure leaders were able to identify, understand, monitor and address current and future risks, including risks to patient safety.
- The service had processes to manage current and future performance. Performance of clinical staff could be demonstrated through audit of their consultations and patient treatment outcomes.
- Leaders had oversight of safety alerts, incidents, and complaints. There was a system for recording and acting upon significant events. Staff understood their duty to raise concerns and report incidents and near misses. Leaders and managers supported them when they did so.
- Clinical audit had a positive impact on the quality of care and treatment outcomes for patients. There was clear evidence of action taken to change services to improve quality.
- Auditing of patient records was undertaken to review compliance with the provider's expected standards of clinical record keeping.
- The provider had plans in place and had trained staff to respond to major incidents.

Appropriate and accurate information

The service acted upon appropriate and accurate information.

- Quality and operational information was used to monitor performance and drive improvement.

Good

Are services well-led?

- The provider carried out all required staff checks at the time of recruitment and all required ongoing monitoring, such as professional registration status and medical indemnity confirmation. However, storage of monitoring information in relation to clinical staff, who worked on a sessional basis under practising privileges, did not promote ease of access to that information for some local managers. We found that records were not readily accessible to local managers if a clinician worked at multiple sites. This limited managers' oversight of compliance with organisational requirements in some instances. We found omissions in the monitoring of training records held for the one clinical staff member who was employed by the service under practising privileges. We found that the provider had failed to ensure that the staff member had completed up to date training in health and safety, fire safety and infection prevention and control.
- Individual care records were written and managed in a way that kept patients safe. The care records we saw showed that information needed to deliver safe care and treatment was available to relevant staff in an accessible way. Clear, accurate and contemporaneous patient records were kept. Treatment planning and treatment records were fully documented.
- Staff told us they had attended regular staff meetings. We saw documented evidence of staff meetings, where for example, updates, incidents and complaints had been discussed and outcomes and learning from the meetings cascaded to staff.
- Processes ensured that confidential electronic information was stored securely on computers. All patient information kept as hard copies was stored in locked cupboards within a locked room. Staff demonstrated a good understanding of information governance processes.
- The service used feedback from patients combined with performance information, to drive improvement.

Engagement with patients, the public, staff and external partners

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

- The service encouraged and heard views and concerns from the public, patients, staff and external partners and acted on them to shape services and organisational culture.
- All patients were asked to provide feedback following their treatment at the clinic. Concerns raised were acknowledged and responded to promptly.
- Where necessary a further follow up telephone call or appointment took place in order to resolve concerns.
- Staff felt confident in providing feedback to managers. The provider had identified a freedom to speak up guardian to provide additional support to staff.
- The provider offered staff the use of an online well-being and rewards platform.

Continuous improvement and innovation

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

- There was a focus on continuous learning and improvement.
- The service made use of internal and external reviews of incidents and complaints. Learning was shared and used to make improvements.
- Leaders and managers encouraged staff to review individual and team objectives, processes and performance.
- There were systems to support improvement and innovation, including a focus on the use of digital technology to drive improvement.
- The provider told us they were working in partnership with the Joint Council for Cosmetic Practitioners in raising standards relating to patient safety, disseminating best practice and identifying emerging trends and themes across the sector.