Shropshire Skin Clinic

Inspection report

The Lodge
Farley Road
Much Wenlock
Shropshire
TF13 6NB
Tel: 01743 590010
www.stmichaelsclinic.co.uk

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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?	Good
Are services well-led?	Good

Overall summary

This service is rated as Good **overall.** The service had previously been inspected in January 2014, but was not rated at this time.

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 at Shropshire Skin Clinic as part of our inspection programme and to provide the service with a rating. 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.

Shropshire Skin Clinic is based in Much Wenlock, Shropshire and provides a dermatology service to NHS patients within Telford and Wrekin, Shropshire and Powys. The Clinic provides services from The Lodge, Farley Road, Much Wenlock, Shropshire TF13 6NB and also has another registered location known as St Michaels Clinic in Shrewsbury, Shropshire.

The 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 and of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Shropshire Skin Clinic provides a limited range of non-surgical cosmetic interventions, for example botulinum toxin injections which are not within CQC scope of registration. Therefore, we did not inspect or report on these services.

As a provider of Independent Healthcare, the service is able to offer a private dermatological service to patients within those areas offered to the NHS and beyond those geographical boundaries.

The service is managed from the provider's main site at St Michael's Skin Clinic, in Shrewsbury, Shropshire. The directors of the company are Dr Stephen Murdoch and Mrs Alison Murdoch.

Dr Stephen Murdoch 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.

In preparation for the inspection, the service had been sent comment cards and a collection box from CQC and had encouraged patients to fill these in prior to the inspection. We received a total of 14 completed comment cards which, included patients who had received diagnosis or treatment. Following the inspection and with the consent of patients, we also telephoned and spoke with two patients and a close relative that had accompanied their family member at the clinic for diagnosis and treatment. Feedback from comment cards and telephone discussions were very complimentary about the service and the care and treatment received. Patients spoke highly of the service and described staff as professional, attentive, friendly, caring, thoughtful and efficient.

Our key findings were :

- The service had clearly defined processes and systems in place to keep people safe and safeguarded from abuse.
- There was an open and transparent approach to safety and a system in place for recording, reporting and learning from significant events, incidents and complaints.
- There were effective arrangements in place for monitoring and managing risk.
- Staff had received essential training in safe working practices.
- The provider had effective recruitment procedures in place to ensure staff were suitable for their role.
- Patients received effective care that met their needs, kept them safe and protected them from avoidable harm.
- The premises were clean, well maintained and well equipped to treat patients and meet their needs.
- Patients were provided with detailed information about any proposed treatment and costs where applicable, which enabled them to make an informed decision.
- Patients were offered convenient, timely and flexible appointments.

Overall summary

- Patients told us staff involved them in their care and treatment and treated them with compassion, kindness, dignity and respect.
- Written arrangements were in place between the service and the local hospital for transferring the care of patients with a cancer diagnosis.
- The service reviewed the effectiveness and appropriateness of the care provided.
- There were clear responsibilities, roles and systems for accountability to support good governance and management that assured the delivery of high-quality care and treatment.

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

- Consider developing a lone working policy and risk assessment.
- Ensure safety checks carried out on the defibrillator also include checks on expiry dates of defibrillator pads.
- Improve the monitoring of vaccine fridge temperature checks.
- Develop a structured programme of structured quality improvement activity.

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. The team included a CQC specialist advisor.

Background to Shropshire Skin Clinic

Shropshire Skin Clinic is based at The Lodge, Farley Road, Much Wenlock, Shropshire TF13 6NB. The clinic is registered with CQC for diagnostic and screening procedures; treatment of disease, disorder or injury; surgical procedures and is an Independent Healthcare Company.

Shropshire Skin Clinic provides a small range of medical aesthetic treatments. These are performed by a consultant dermatologist and their team who specialise in aesthetic treatments and skin disease. The clinic provides services to NHS and private paying patients. A wider range of treatments are available at the provider's other registered location situated approximately 17 miles away in Shrewsbury, Shropshire and was not inspected as part of this inspection.

The service is led by a director partnership who own the business and the Much Wenlock and Shrewsbury premises, from which they provide services.

In addition to the Director and Consultant Dermatologist, Dr Stephen Murdoch, one speciality doctor, two GPs with a special interest, one clinical assistant, one nurse, one health care assistant and a receptionist work at the Shropshire Skin Clinic. The provider employs other clinicians on an arranged sessional basis supported by a team of 21 administrative staff and a business manager based at their main site in Shrewsbury, Shropshire.

The clinic opened in 2004 and offers a dermatology service to adults and children over 12 years of age. The clinic functions as an independent provider to the NHS for 87% of its work. The service is commissioned by three Clinical Commissioning Groups (CCG's) which are either in or on the border of Shropshire, Powys, and Telford and Wrekin. They also take out of area referrals in line with NHS Tariff. On average, the clinic sees 800 NHS and 800 private episodes per year. Some patients were seen more than once. Only 1% of children aged 12 and over were currently treated at this clinic

The clinic's current core opening times are between 9am and 5pm Monday to Wednesday, although this is flexible and dependent on consultant availability. Patients are also able to access care and treatment provided at the provider's main site in Shrewsbury, which is open Monday to Thursday between 9am and 8pm and Friday between 9am and 5pm. Services at the clinic are offered on a booked appointment only basis and can be made by using the provider's central telephone number.

Further details about the clinic can be found on their website: www.stmichaelsclinic.co.uk

How we inspected this service

We reviewed information about the service in advance of our inspection visit. This included:

- Information we held about the service.
- Material we requested and received directly from the service ahead of the inspection. This included information about the complaints they had received in the last 12 months and the details of their staff members, their qualifications and training.
- Information reviewed on the day of the inspection including some policies, a sample of staff recruitment files, patient records, audits and records held at the practice.
- Information available on the service's website.
- Patient feedback in surveys, CQC comment cards and telephone discussions.

We inspected Shropshire Skin Clinic on 20 January 2020 as part of our inspection programme. During the inspection we spoke with the Director, Practice Manager Director and Business Manager. There were no clinics held on the day of the inspection. Therefore following the inspection we spoke with two patients and a close relative that had accompanied their family member at the clinic for diagnosis and treatment.

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

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

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

Good

Are services safe?

We rated safe as Good because:

We found that this service was providing safe care in accordance with the relevant regulations.

Safety systems and processes

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

- The provider had effective systems in place to safeguard children and vulnerable adults from abuse. The service had a designated safeguarding lead. The provider had recently reviewed and sourced the required level of safeguarding training for all non-clinical and clinical staff. We were told 99% of staff had since completed the required level of training. Staff had access to safeguarding policies which had been regularly reviewed, however we found they did not include all categories of abuse for example, female genital mutilation (FGM). During the inspection safeguarding policies were updated.
- The service had systems in place to assure that an adult accompanying a child had parental authority.
- The provider carried out staff checks, including professional registration where relevant at the time of recruitment and on an annual basis. Disclosure and Barring Service (DBS) checks were routinely repeated every three years. (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). We reviewed the recruitment records for three staff employed in the previous two years and found all the required information had been obtained in respect of these staff.
- A clinical software system compatible with the NHS was used and had suitable data sharing protocols were in place. This enabled the provider to check the identity and details of patients on the NHS electronic database. Staff confirmed these details when they contacted patients to arrange appointments.
- The practice had a chaperone policy in place, dated May 2019. Information was displayed in the reception/ waiting area informing patients of this service. Staff who acted as chaperones were trained for the role and had received a DBS check.
- There were arrangements in place to manage infection, prevention and control (IPC). Staff had access to an infection control policy which is aligned to The Health and Social Care Act 2008 Code of Practice on the prevention and control of infections and related guidance. Staff had received training and had access to personal protective equipment where required. IPC control was discussed in meetings held. The premises were visibly clean and tidy on the day of the inspection. Feedback we gained from patients suggested they were satisfied with the cleanliness of the practice and the hygiene arrangements in place. The provider had a designated IPC lead nurse and had adopted and adapted the locally produced assessment framework 'Check to Protect' IPC audit template provided by Shropshire Clinical Commissioning Group. No IPC concerns had been identified as a result of the last audit undertaken in February 2019. The cleaning of the premise was outsourced and cleaned when the clinic was closed. Cleaning schedules were in place and safety data sheets available for the control of substances hazardous to health. There were also safe systems in place to manage healthcare waste.
- The provider ensured that their facilities and equipment were safe, and that equipment was maintained according to manufacturers' instructions. These included health and safety, fire and legionella risk assessments. Issues identified in the fire risk assessment in April 2019 had since been met. All electrical equipment was checked to ensure that it was safe to use, and clinical equipment was checked to ensure it was working properly. Checks to the fire system and emergency lighting were carried out at regular intervals and the fire evacuation procedure was displayed on entry to the clinic.
- Environmental risks had been assessed and regularly reviewed. However, a risk assessment or lone working policy was not in place at the time of the inspection for the occasions when a member of staff was on their own in the clinic.
- Clinics were carried out in a number of buildings that were not owned or managed by the provider. When we inspected the St Michaels Clinic in Shrewsbury in December 2019, we saw there were comprehensive arrangements and written agreements in place to ensure staff working at these sites had access to all emergency equipment and medicines if required. The cleaning and stocking arrangements for the rooms used were also specified.

Good

Are services safe?

- Appropriate processes were in place for receiving, managing and responding to alerts, including those received from the MHRA (Medicines and Healthcare products Regulatory Agency). We saw MHRA alerts were discussed in clinical governance meetings held.

Risks to patients

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

- There were arrangements for planning and monitoring the number and skill mix of staff. The provider ensured adequate staffing arrangements were maintained and enough staff were available to meet the demand for the service. The provider had their own bank staff to cover staff absence and permanent staff were able to work across sites. Agency staff were not used.
- Staff completed training in basic life support and clinical staff completed advanced training to ensure they were able to respond appropriately to any changing risks to patients' health and wellbeing during their treatment.
- There were appropriate indemnity arrangements in place to cover all potential liabilities.
- Emergency medicines, oxygen, pulse oximeter and an automated external defibrillator (AED) were available. An AED is a portable device used to deliver a dose of electric current to the heart to help people having sudden cardiac arrest. However, the AED pads had exceeded their expiry date in August 2018. Replacement pads were ordered during the inspection. The practice did not stock all the suggested emergency medicines we would expect however, a risk assessment had been carried out to determine the range of medicines held.
- The service had a business continuity plan in place for major incidents such as power failure or building damage. In the event of a major incident patients booked for appointments would be directed to other local clinic sites if needed. A copy of the plan was kept off site. The provider advised that in April 2019 they carried out a table top exercise where eight staff attended and discussed a range of scenarios to help prepare staff in the event of a major incident. Staff could keep personal mobile phones with them, for emergency use only.
- The provider had written arrangements in place with the local hospital for transferring the care of patients with a cancer diagnosis. Clinicians attended the local skin cancer multidisciplinary meetings held. Written transfer agreements were also in place with the emergency services to ensure that should a patient at the clinic require urgent transfer to hospital they were responded to.
- Clinicians made appropriate and timely referrals in line with protocols and up to date evidence-based guidance.
- The service had systems for sharing information with staff and other agencies to enable them to deliver safe care and treatment.
- 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.
- Staffing levels and the skill mix of staff were planned and reviewed to ensure patients received safe care and treatment. Each clinic was colour coded and the skill mix of staff required was then matched accordingly. The record was available on the shared computer system so that all staff had access to it. The clinic had its own bank staff should they require an additional member of staff for any reason. Arrangements were in place to cover holidays.
- Professional indemnity arrangements were in place for the clinical staff and arrangements were in place to ensure they were up to date with their professional registration and revalidation.

Information to deliver safe care and treatment

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

- The service received completed referral forms for each NHS and some private patients from other healthcare professionals. When patients had self referred the practice sought suitable consent to contact their GP.
- The service maintained electronic records for patients. We reviewed five sets of patient records. These showed that information needed to deliver safe care and treatment was appropriately available and accessible to staff. They were written and managed in a way that kept patients safe.
- Any medicine administered was only done with an accompanying prescription by a doctor.
- The service shared information with the patient's GP by receiving referral letters detailing the patient's condition and personal circumstances and liaising with them following a procedure. Consent was obtained from non-NHS referred patients to contact their GP and share

information about their diagnosis and treatment. This was confirmed by patients we spoke with. The service recorded information electronically on a clinical software system compatible with that of the local GPs.

Safe and appropriate use of medicines

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

- The service had a comprehensive medicines policy in place.
- Patients who were prescribed medicines for acne were reviewed every four weeks. All teenage patients had their treatment schedule explained prior to the commencement of their treatment and were asked to commit to the number of appointments over the time period required. This was confirmed by a close relative of a patient we spoke with whose family member had received a course of treatment at the clinic.
- The procedure for managing contact allergens had recently been reviewed and updated.
- When psychological support was required for patients whose conditions had impacted adversely on their mental health; GPs were contacted and requested to make onward psychological referrals.
- Prescription stationery was held securely, and its use monitored.
- Staff prescribed, administered or supplied medicines to patients and gave advice on medicines in line with legal requirements and current national guidance. Processes were in place for checking medicines and staff maintained accurate records of medicines held.
- There were effective protocols for verifying the identity of patients including children.
- Vaccines were securely stored, and a log of fridge temperatures checks was held. However, staff were not checking and recording fridge temperatures at the required frequency to ensure vaccines were stored within the recommended range.

Track record on safety

The service had a good safety record.

- There were comprehensive risk assessments in relation to safety issues, which included written requirements for multi-disciplinary team meetings (MDT) at the hospital and handover arrangements for patients with cancer diagnoses.
- The provider monitored and reviewed activity. This helped leaders to understand risks and gave a clear, accurate and current picture that led to safety improvements.
- The provider had an effective system in place for reviewing and acting upon patient safety alerts.
- There were risk assessments in relation to safety issues, for example environmental risks, including fire risks.

Lessons learned and improvements made

The service learned and made improvements when things went wrong.

- The provider had recently reviewed and improved their system, policy and procedure for recording and acting on significant events and incidents and maintaining a log of all significant events to apply learning and to monitor any trends over time. This included assessing the need to undertake a root cause analysis where identified.
- Staff had access to a policy and a standard form to record and report adverse incidents and events. These had recently been reviewed and updated.
- No significant events had occurred at this clinic in the previous 12 months. The provider had a dedicated significant event team in place, which included a doctor, nurse, practice manager, business manager and an administrator who attended meetings held quarterly to review significant events. Meetings were recorded and shared to ensure staff were kept informed of significant events and outcomes.
- The provider was aware of and complied with the requirements of the Duty of Candour and encouraged a culture of openness and honesty. A duty of candour policy was in place and staff were required to sign to confirm they had read and understood the policy.

Good

Are services effective?

We rated effective as Good because:

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

Effective needs assessment, care and treatment

- We saw evidence that clinicians assessed needs and delivered care and treatment in line with current legislation, standards and guidance including guidance from the National Institute for Clinical Evidence (NICE) and the British Association of Dermatologists (BAD). New guidance was discussed in clinical governance meetings held.
- Patients' immediate and ongoing needs were fully assessed. Where appropriate this included their clinical needs and their mental and physical wellbeing.
- Clinicians had sufficient information to make or confirm a diagnosis.
- We saw no evidence of discrimination when making care and treatment decisions.

Monitoring care and treatment

The service was actively involved in quality improvement activity.

- There were effective systems in place to monitor and assess the quality of the service including the care and treatment provided to patients.
- Information obtained was used to make improvements. For example, young patients attending for a specific acne treatment were required to commit to attending a course of treatment over a period of time prior to being offered a specific treatment. Those who were unable to make this commitment were considered for alternative treatment.
- The service made improvements through the use of audits. There was evidence of action to resolve concerns and improve quality. Audits undertaken included an audit of the cutaneous allergy service (CAS) and a surgical site infection (SSI) audit. The SSI audit had been completed and presented to the clinical governance meeting held in October 2019. Previous SSI audits were undertaken in 2014 and 2016. Following the results the provider reviewed the guidance on SSI prevention, including antibiotic prophylaxis. The criteria for the audit was patients who had skin lesion excised surgically 95% of patients met the standard. Patients were requested to complete a wound healing audit one month post their procedure and return it. Eighty-seven per cent of patients completed the survey in 2014. Of the 46 patients identified, 8.7% had a SSI. In 2016 3.5% of the 115 patients had an SSI and in 2019, 12.8% of the 163 patients had an SSI. The initial reading of the data showed a high infection rate (12.8%), however on better analysis of cases this reduced to 4.9% – 6.4%. A number of patients showed lack of understanding in filling in the questionnaire. It was concluded that the SSI rates compared favourably with published data and had not changed significantly since 2016, the practice had reviewed how to make further improvements. For example, a telephone follow up was required and a redesign of the questionnaire was considered plus better education of clinicians. The provider told us they were formalising a structured audit plan going forward.
- Having participated in a recent national bullous pemphigoid audit, the team had recognised that the documentation of important aspects of care could be optimised. To safeguard patient care, they had developed an electronic template for bullous pemphoid that automatically loads on the electronic notes to ensure salient clinical observations were captured for every patient with bullous pemphigoid.
- The practice reported to its commissioners every quarter and included patient experience, waiting times, significant events, complaints, issue of discharge letters, number of referrals and finance.

Effective staffing

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

- The provider understood the learning needs of staff which were identified through a system of induction, annual appraisal, meetings and reviews.
- There was an effective induction system for new staff tailored to their role. On commencement of employment new staff were issued with a copy of the bullying and harassment policy, and health and safety policy. There were also issued with a staff handbook, given a tour of the premise and provided with information on the fire evacuation procedure. Staff were required to sign a confidentiality agreement in addition to a health statement.
- Administrative staff were allocated a buddy as part of their induction and shadowed existing staff until they felt confident and comfortable in their work.

Good

Are services effective?

- Staff were supported to complete a variety of training appropriate to their role and were encouraged and provided with opportunities to develop. For example, a former IT assistant had been promoted to an IT manager and a former receptionist had requested to change roles and was now an administrator.
- Essential training included safeguarding and Prevent, data security awareness, fire safety, infection prevention and control, health and safety, equality and diversity, duty of candour, basic life support and information governance.
- There were effective systems in place to ensure all staff were up to date with their training and appropriately qualified. All doctors interested in working for the provider were required to have a minimum additional qualification of a diploma in dermatology and received 10 days study leave. The provider told us they employed the best GPs and further developed their skill-set. These clinicians were supervised by the director/consultant dermatologist until they were competent and confident in their work.
- Medical and nursing staff were registered with a professional Body, for example the General Medical Council (GMC) and Nursing and Midwifery Council (NMC). Effective systems were in place to ensure their registration was checked on an annual basis and to ensure they were up to date with their revalidation.
- Since the last inspection the provider had employed a Business Manager with a NHS background and dedicated commissioning experience to focus on NHS contracts and information governance.

Coordinating patient care and information sharing

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

- Patients received coordinated and person-centred care. Patients were asked for consent to share details of their consultation and any medicines prescribed with their registered GP. This was confirmed during discussions held with patients and a patient representative.
- Staff referred to and communicated effectively with other services when appropriate. For example, local hospitals and NHS GPs.
- Multi-disciplinary team (MDT) meetings were held weekly where approximately 12 cases were discussed. The Director/Consultant Dermatologist was present at these meetings held.
- Prior to patients receiving treatment, doctors at the service ensured they had adequate knowledge of the patient's health, any relevant test results and their medicines history.
- The provider had risk assessed the treatments they offered. Where patients agreed to share their information, we saw evidence of letters sent to their registered GP in line with GMC guidance.
- Patient information was shared appropriately (this included when patients moved to other professional services), 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 people who had been referred to other services.

Supporting patients to live healthier lives

Staff were consistent and proactive in empowering patients and supporting them to manage their own health and maximise their independence.

- Where appropriate, staff gave patients advice, so they could self-care. For example, advice on sun protection, skin cancer monitoring and attended skin cancer screening roadshows to provide advice to the public on checking their skin for signs and symptoms of cancer.
- The service offered health promotion on a range of topics such as smoking, and alcohol consumption, and focused on these activities affected skin.

Consent to care and treatment

The service obtained consent to care and treatment in line with legislation and guidance .

- Staff understood the requirements of legislation and guidance when considering consent and decision making.
- Staff supported patients to make decisions. Where appropriate, they assessed and recorded a patient's mental capacity to decide.
- We saw consent was documented in patient records for skin biopsy, a technique in which a skin lesion is removed to be sent to a pathologist for diagnosis and for cryotherapy, used to treat a variety of tissue lesions.

Good

Are services caring?

We rated caring as Good because:

Patients were treated with kindness and respect and involved them in decisions about their care.

Kindness, respect and compassion

Staff treated treat patients with kindness, respect and compassion.

- The provider sought feedback on the quality of clinical care patients received through ongoing patient surveys. Feedback was reviewed, analysed and published monthly and made available in the clinic waiting area. Comments following the most recent published survey included that staff were very friendly and helped relax patients and understood a patient's condition in a very caring way and staff were welcoming and friendly.
- We received 14 completed Care Quality Commission (CQC) comment cards and following the inspection we spoke with two patients and a patient representative. Feedback was positive about the way staff treated them. Patients told us they were treated with kindness and respect and staff were described as professional, attentive, friendly, caring, thoughtful and efficient.
- Staff understood patients' personal, cultural, social and religious needs. They displayed an understanding and non-judgmental attitude to all patients.
- Patients were provided with timely support and information.
- The provider had a continuous patient satisfaction survey. The most recent published survey dated 27 January 2020 showed 98.2% of respondents rated staff as good, very good or excellent for their helpfulness during their clinic visit.

Involvement in decisions about care and treatment

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

- Interpretation services and longer appointments were available for patients who did not have English as a first language. The provider advised they had two Welsh staff on the team that were able to support Welsh speaking patients.
- Leaflets could be made available in different formats on request to help patients be involved in decisions about their care.
- Patients told us that they felt listened to and had sufficient time during their consultations to make an informed decision about the choice of treatment available to them. There was opportunity for patients to consider any proposed treatment and costs, where applicable, prior to receiving treatment.

Privacy and Dignity

The service respected patients' privacy and dignity.

- Staff recognised the importance of people's dignity and respect.
- The clinic had two consulting rooms in addition to one treatment room. Only two rooms were used at a time due to the limited capacity of the waiting area.
- Staff knew that if patients wanted to discuss sensitive issues or appeared distressed they could offer them a private room to discuss their needs.
- The provider had eight staff, including both clinical and non-clinical staff, who were designated dignity champions. Their role was to promote the use of patients being treated with privacy and dignity. Leaders told us the ethos of the organisation was for staff to treat patients as they would like to be treated. Leaders were able to share an example of how they had promoted confidentiality and privacy in an extreme circumstance when two patients had attended the clinic for treatment.
- Private paying patients were offered the facility to pay for their treatment privately away from the small waiting room.

Good

Are services responsive to people's needs?

We rated responsive as Good because:

Patients received a responsive service that took into account their individual needs and preferences.

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 and provided care and treatment in a timely way.

- The provider understood the needs of their patients and improved services in response to those needs. The service demonstrated that it offered timely appointments for NHS patients compared to an appointment in a secondary care dermatology clinic which involved a longer wait.
- The facilities and premises were appropriate for the services delivered. A ramp at the rear of the premise was available to assist disabled patients. The premises did not have a passenger lift and patients were asked at the time of the booking if they required to be seen in a ground floor consultation room. If a ground floor room was required a note was placed on the patient record and the clinician advised in advance of the appointment. Alternatively patients could access the provider's main site in Shrewsbury where additional facilities were available. A disabled toilet was available.
- Staff were provided with training in equality and diversity.

Timely access to the service

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

- The clinic's current core opening times are between 9am and 5pm Monday to Wednesday, although this is flexible and dependent on consultant availability. Patients were also able to access care and treatment provided at the provider's main site in Shrewsbury Monday to Friday, at a time convenient for them, including late appointments until 8pm four evenings per week.
- Patients had timely access to initial assessment, test results, diagnosis and treatment.
- Waiting times, delays and cancellations were minimal and managed appropriately.
- Patients with the most urgent needs had their care and treatment prioritised.
- Patients reported that the appointment system was easy to use.
- Longer appointments were available for those who needed them.
- Referrals and transfers to other services were undertaken in a timely way. The service had written protocols and arrangements in place for onward referral.

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.

- The provider had complaint policy and procedure in place and welcomed all comments and feedback and encouraged patients and their families to talk with staff about any issues or concerns they have about their care and treatment.
- The Business Manager was the designated complaints officer for dealing with all complaints.
- Information about how to make a complaint or raise concerns was available. This included further action that may be available to them should they not be satisfied with the response to their complaint for both NHS and private patients. An example of a complaint was included in the patient complaints leaflet and also included information for representatives acting on behalf of a patient.
- No complaints had been received about this clinic in the previous 12 months. However, leaders shared an example of the most recent complaint they had received in relation to their Shrewsbury Clinic and the action they had taken in response to it.
- The provider had recently introduced a procedure for documenting informal concerns received to identify any common trends and themes and further inform the quality of care provided.
- None of the people we spoke with were aware of the complaint's procedure, although told us they had not had cause to make a complaint about the care and treatment they or a close family member had received from the clinic.
- The provider was required to report any complaint received in quarterly reports produced for the local Clinical Commissioning Groups (CCGs).

Good

Are services well-led?

We rated well-led as Good because:

There was compassionate, inclusive and effective leadership at all levels.

Leadership capacity and capability

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

- Leaders were knowledgeable about issues and priorities relating to the quality of services, including the ongoing and future delivery of these services.
- Leaders at all levels were visible and approachable. They worked closely with staff and others to make sure they prioritised compassionate and inclusive leadership.
- The provider had effective processes to develop leadership capacity and skills. We saw evidence of effective governance arrangements in place to confirm monitoring, continuous learning and improved processes.
- Feedback gained from CQC comment cards were positive inn relation to how the service was managed. Patients commented they had confidence in all aspects of the service and they could not recommend the service highly enough.

Vision and strategy

There was a clear vision and credible strategy to deliver high quality care and promote good outcomes for patients.

- The provider had a clear vision and set of values and these were shared with us. They told us they did not publish a 'punchline' because all staff employed live the same values. Their complete ethos and focus was on outcomes for patients and making the whole experience and patient journey better.
- The service monitored progress against delivery of the strategy.

Culture

The service had culture of high-quality sustainable care.

- The provider promoted a culture where staff felt respected, supported and valued and proud of their work. Leaders told us all staff were key to the successful running of the business and they placed a high level of value on what they say, and communication was very important.
- The service focused on the needs of patients. NHS patients were treated the same as private paying patients. Leaders told us the organisation ethos was to make sure every patient mattered.
- Leaders and managers acted on behaviour and performance inconsistent with the vision and values.
- Openness, honesty and transparency were demonstrated when responding to incidents and the provider was aware of and had systems to ensure compliance with the requirements of the duty of candour.
- There were processes for providing all staff with ongoing development. This included appraisal and career development conversations. Staff were supported to meet the requirements of professional revalidation where necessary and received regular supervision, mentorship and appraisal. Clinical staff were considered valued members of the team and given protected time for professional development and evaluation of their clinical work. For example, doctors received 10 days study leave per year.
- There was a strong emphasis on the safety and well-being of all staff. Staff retention was high with staff leaving the service mainly due to retirement.
- The service actively promoted equality and diversity, and this was considered essential training for all staff.
- There were positive relationships between staff and teams.

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, understood and effective. The provider ensured standards were achieved through audit and feedback received from patients following their care and treatment.
- The governance and management of partnerships, joint working arrangements and shared services promoted an interactive and co-ordinated approach which ensured patients were at the centre of their care.
- Staff had access to a suite of policies and procedures that governed activity to ensure safety and assured themselves that they were operating as intended. These were easily accessible to staff, regularly reviewed and

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updated. We saw the provider responded promptly when policies did not reflect current guidance. For example, safeguarding policies were updated during the inspection.
- There was a clear organisational structure, with clear lines of accountability and staff were aware of their own roles and responsibilities.
- A range of regular meetings were held to support governance systems. For example clinical governance meetings were held monthly, excluding August and December, and all staff were encouraged to attend and contribute ideas to improve the services provided. Other meetings held included senior staff, nurse, surgical, GP specialist interest, administrative and significant event analysis meetings.

Managing risks, issues and performance

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

- There was an effective, process 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, prescribing and referral decisions. Leaders had oversight of safety alerts, incidents, and complaints.
- Clinical audit had a positive impact on quality of care and outcomes for patients. There was clear evidence of action to change services to improve quality. For example, changes to the protocol for acne treatment had improved the compliance of young people with the treatment programme, resulting in better outcomes for young people.
- The provider advised that the local Clinical Commissioning Group (CCG) had undertaken a quality visit last year to review infection, prevention and control procedures and quality.

Appropriate and accurate information

The service acted on appropriate and accurate information.

- Quality and operational information was used to ensure and improve performance. Performance information was combined with the views of patients.
- Quality and sustainability were discussed in relevant meetings where all staff had sufficient access to information.
- The service used performance information which was reported and monitored, and management and staff were held to account.
- The information used to monitor performance and the delivery of quality care was accurate and useful. There were plans to address any identified weaknesses.
- The provider submitted data or notifications to external organisations as required. These included quarterly reports produced to the local Clinical Commissioning Groups (CCGs) on performance including any complaints received.
- There were effective arrangements in line with data security standards for the availability, integrity and confidentiality of patient identifiable data, records and data management systems. Some patient paper records were retained from the previous year, but these were securely held, and electronic notes were accessible to staff.

Engagement with patients, the public, staff and external partners

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

- The provider welcomed and took on board the views of patients and staff and used feedback to improve the quality of services. The provider had a continuous patient satisfaction survey. Results across all clinics were reviewed, analysed and published on a bi-monthly basis and made available to patients in waiting areas and shared with staff to inform the practices service and culture. We saw 114 patient surveys had been completed from 1 November to 31 December 2019. Results showed 98.2% of respondents that completed the survey said they would recommend the clinic to their friends and family. A further 99.1% of respondents rated the quality of the consultation they had received as good, very good or excellent. Comments were very complimentary about the care and treatment received.
- Information about how to make a complaint was available and staff encouraged patients to discuss any immediate concerns at the time of their consultation or treatment. Staff were encouraged to speak out if they had concerns.

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- The service was transparent, collaborative and open with stakeholders about performance. For example, the provider had quarterly meetings with its NHS commissioners. Quality visits were undertaken by the local Clinical Commissioning Group (CCG). Areas assesses included clinical effectiveness, patient experience, patient safety, clinical areas and general comments.

Continuous improvement and innovation

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

- There was a focus on continuous learning and improvement. For example, clinicians without experience in dermatology were provided with training as part of their career development and progression.
- The provider made use of internal and external reviews of incidents and complaints. Learning was shared with staff and used to make improvements.
- Leaders and managers encouraged staff to take time out to review individual and team objectives, processes and performance.
- Future aspirations were shared with us which included the accreditation of GPs with Extended Roles (GPwER) in dermatology and skin surgery. The clinic also hoped to provide a teledermotology service as part of the Clinical Commissioning Group (CCG) contract to transfer medical information over varying distances through audio, visual and data communication.