RejuvaMed Skin Clinic & Vein Centre Ltd.

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Inspection report

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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

Summary of findings

Overall summary

RejuvaMed Skin Clinic & Vein Centre Ltd provide cosmetic surgery procedures that include treatment for varicose veins, gastric balloon insertion, 3D Vjuve treatment (carbon dioxide laser to vulvar area) and upper blepharoplasty (Upper blepharoplasty is a procedure that involves resection of redundant skin and/or musculature of the upper eyelid.).

Since starting with the service in August 2022, the vascular surgeon had consulted 103 patients which meant a total of 114 treatments or reviews. Between June 2021 and June 2922, the women's health doctor consulted with 29 patients and carried out 115 appointments. For the same time period the oculoplastic surgeon consulted with 21 patients, completed 12 procedures and 19 reviews. The medical director had carried out 19 gastric balloon procedures at a neighbouring independent hospital over the same time period as well as 54 treatments for hyperhidrosis (excessive sweating).

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Surgery	Good	We rated it as good because: • The service had enough staff to care for patients and keep them safe. Staff had training in key skills, understood how to protect patients from abuse, and managed safety well. The service controlled infection risk well. Staff assessed risks to patients and kept good care records. The service managed safety incidents well and learned lessons from them. • Staff provided good care and treatment. Managers monitored the effectiveness of the service and made sure staff were competent. Staff worked well together for the benefit of patients, supported them to make decisions about their care, and had access to good information. • Staff treated patients with compassion and kindness, respected their privacy and dignity and took account of their individual needs. • The service considered patients' individual needs, and made it easy for people to give feedback. People could access the service when they needed it and did not have to wait too long for treatment. • Leaders ran services well using reliable information systems and supported staff to develop their skills. Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. Staff were clear about their roles and accountabilities. The service engaged well with patients and all staff were committed to improving services. However: • The service did not record environmental temperatures or minimum and maximum temperatures of fridges for areas where medicines were stored. We found some consumables, not in use, that were past their expiry dates. There was no written deteriorating patient policy and emergency grab bags were not secured with a removable tag to prevent tampering.

Summary of findings

- Written information was available in a standard format only and there was no hearing loop available. Patients with mobility issues could not access the service.
- There was no vision or strategy for the service. There was no policy for practising privileges and not all information required for the recruitment process was available to review.

Summary of findings

Contents

Summary of this inspection

Background to RejuvaMed Skin Clinic & Vein Centre Ltd

The service is available to patients, over the age of 18 years, who independently fund their treatment.

The service is registered to provide regulated activities of:

- Diagnostic and screening procedures
- Services in slimming clinics
- Surgical procedures
- Treatment of disease, disorder or injury

The service has been registered since 2019 and the registered manager has been in post since the location registered.

We have not inspected this service previous to this inspection.

How we carried out this inspection

The inspection was carried out by two inspectors. We spoke with five staff members including the registered manager who was also the medical director, the director of operations and clinic staff. We spoke with five patients. We reviewed five patient records.

You can find information about how we carry out our inspections on our website: https://www.cqc.org.uk/what-we-do/how-we-do-our-job/what-we-do-inspection.

Areas for improvement

Action the service MUST take is necessary to comply with its legal obligations. Action a service SHOULD take is because it was not doing something required by a regulation but it would be disproportionate to find a breach of the regulation overall, to prevent it failing to comply with legal requirements in future, or to improve services.

Action the service SHOULD take to improve:

- The service should ensure that medicines are monitored appropriately to include fridge ranges and environmental temperatures. (Regulation 12).
- The service should ensure that emergency grab bags are stored securely. (Regulation 12).
- The service should ensure the proposed MAC Committee is developed and embedded. (Regulation 17).
- The service should ensure that recruitment and practising privileges processes are recorded and robust with evidence maintained within staff files. (Regulation 17).
- The service should ensure that governance meetings and actions are recorded (Regulation 17)
- The service should consider developing a policy for if a patient collapses.
- The service should consider inclusivity arrangements for taking into account individual needs and preferences such as sourcing information in different formats for accessibility.
- The service should consider developing a written strategy.

Our findings

Overview of ratings

Our ratings for this location are:

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

Good

Surgery

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

Are Surgery safe?

Good

We rated it as good.

Mandatory training

The service provided mandatory training in key skills to all staff and made sure everyone completed it.

Staff received and kept up-to-date with their mandatory training. There was a clinic training policy.

The mandatory training was comprehensive and met the needs of patients and staff. Clinic staff completed an online package of modules that covered a range of areas for clinical care and treatment. The training modules were aligned to the core skills training framework (CSTF).

We were told that there was 100% compliance with requirements although managers did not monitor individual modules for staff members.

The director of operations, who shared copies of training certificates, monitored mandatory training and reviewed with staff individually when they needed to update their training.

Safeguarding

Staff understood how to protect patients from abuse. Staff had training on how to recognise and report abuse and they knew how to apply it.

Staff received training on how to recognise and report abuse. Safeguarding level two for adults and for children were part of mandatory training requirements. Two of the doctors had completed safeguarding level three training for adults and children.

Staff knew how to identify adults at risk of, or suffering, significant harm such as female genital mutilation (FGM). The service had safeguarding policies for adults and children. The policies directed staff to speak to their line manager if there was a potential concern. FGM was referenced in the services' forced marriage policy and procedure.

Good

Surgery

The service treated adults over the age of 18 years. Staff told us that if a patient came in that looked younger, they would request identification.

Staff knew how to make a safeguarding referral and who to inform if they had concerns. Staff told us they would speak with the managers if concerned.

There had been no safeguarding referrals made by the service in the 12 months prior to inspection.

Cleanliness, infection control and hygiene

The service controlled infection risk well. Staff used equipment and control measures to protect patients, themselves and others from infection. They kept equipment and the premises visibly clean.

During the COVID-19 pandemic policies were reviewed when needed in line with guidance. Activity was suspended during the initial lock-down period.

On entering the building, hand sanitiser and masks were available. Numbers of patients were restricted to help with social distancing. The reception area had wipeable chairs, tables and flooring.

Clinic areas were visibly clean and had suitable furnishings which were well-maintained. Patients we spoke with told us the clinic was clean whenever they attended.

There were areas that were decorated with wallpaper and carpets but these were not where the regulated activity took place. Regulated activity consultations and treatments were held in a dedicated clinic room. Flooring was washable and designed with curved edging which complied with national standards for infection control in the built environment.

Infection prevention and control level one was part of mandatory training requirements.

The patient couch was wipeable and in a good state of repair. Sterile equipment was stored appropriately.

Personal protective equipment (PPE) including sterile surgical gowns, gloves and packs were available.

Some items were single use; others were re-usable. These were decontaminated and autoclaved by a third party health organisation. The service did not report any surgical site infections.

There was a hand hygiene policy and procedure, although no hand hygiene audits were provided by the service.

There was a sink for pre and post treatment hand washing, however not a dedicated clinical sink. The service had completed an annual IPC audit, in July 2022. This highlighted some actions that needed to be taken forward including the replacement of the sink. The service had also identified some cracks in the wall of a clinic room and patient toilet that were being addressed with the building owner. All actions were within their target dates for completion.

There was a cleaning schedule to indicate when certain tasks were due such as requirements for a deep clean following a clinic list. Environmental cleaning was completed by clinic staff with all areas looking visibly clean. Floor mops were colour coded for different areas.

There was a locked cupboard where cleaning products were kept with information attached regarding the contents, although not a dedicated control of substances hazardous to health (COSHH) metal cupboard.

Good

Surgery

The service tested water for presence of legionella. We saw a certificate dated May 2022 that showed that no bacteria was detected in the sample tested.

Laundry was completed on site at a temperature of at least 60 degrees Celsius.

Environment and equipment

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

The clinic was located in an older two-storey property in the centre of town.

The ground floor included the entrance hall, reception area, utility room, staff room, staff toilet and a consulting room.

On the upper floor there were further consulting rooms, one of which was were regulated activity took place. There was also a patient toilet.

There was a health and safety policy with health and safety level one part of mandatory training requirements.

There was a fire policy. Fire exits were clear of clutter with signage for evacuation. Extinguishers were available in case of emergency. These had been maintained within the 12 months prior to inspection and were securely attached either with holders or wall brackets. There was no fire alarm but there were smoke alarms. Drills had taken place with evacuation to the designated meeting area.

Security cameras were at the front of the building and in the reception area for monitoring the building out of hours.

The design of the environment where regulated activity took place followed national guidance.

Staff carried out checks of specialist equipment. Equipment was maintained and serviced appropriately. We saw that all equipment had been portable appliance tested (PAT) within the 12 months prior to inspection.

The service had enough suitable equipment to help them to care for patients. Cupboards and store rooms were well organised. However, we did observe a drawer that included a number of consumable items, including syringes and needles, that were passed their expiry dates. We escalated to the managers who discarded the items.

There was a vascular stock management policy. Between July 2021 and July 2022, staff completed audits of consumable items monthly. They completed signed checklists of available sundries including the lot numbers and expiry dates.

Staff disposed of clinical waste safely. There was a sharps management policy. Sharps bins were available and not overfilled. The sharps bins were suitable for all waste sharps generated by the service.

Arrangements were in place for a third party organisation to remove the clinical waste and sharps bins. Waste bin liners were different colours to indicate if domestic or clinical waste as well as stickers to remind staff and patients.

Assessing and responding to patient risk

Staff completed and updated risk assessments for each patient. The service made sure patients knew who to contact to discuss complications or concerns.

Good

Surgery

Patients completed an electronic medical questionnaire prior to a consultation that included information such as past medical history, allergies, implants, recent treatments, exercise routine, if a smoker or any alcohol consumption. If there were any concerns highlighted, from the initial responses, such as psychological issues, we were told the procedure would not proceed. This was updated prior to each appointment including a confirmation if there had been no changes since the previous visit.

Any risks associated with the treatment were explained to the patient prior to the commencement of treatment as part of the consent process. There was no written exclusion criteria although patients were assessed individually for suitability for the treatment.

All procedures were day-case with no overnight stays. There was no written policy in the case a patient deteriorating at the location.

In the event of an emergency, first aid treatment was provided by the doctor on site and 999 was called. Posters for anaphylaxis and adult advanced life support displayed flow charts by the Resuscitation Council UK (2021) for doctors to follow. There was an additional poster for the automated external defibrillator (AED) with text and images to indicate how to perform a rescue. There was also an AED checklist policy.

All staff completed basic life support (BLS) as part of annual mandatory training requirements. The medical director and the registered nurse had completed immediate life support (ILS) as part of their substantive role within a neighbouring independent hospital. The other doctors had completed basic life support in their substantive positions. There was a defibrillator on site, with oxygen and drugs and equipment for resuscitation in grab bags. There was signage to highlight the presence of oxygen that is potentially flammable. The contents of the bags were checked and recorded weekly on checklists. The bags did not include tags to secure them, although were in a room not accessed by patients.

Treatments for leg veins and blepharoplasty (upper eye-lid surgery) and 3D Vjuve treatment (carbon dioxide laser to vulvar area) took place in dedicated clinic rooms. There was signage on the door of the room where laser procedures took place. A patch test was carried out a minimum of 72 hours prior to the procedure to ensure safe to carry out. If blood tests were indicated, the doctor managed these by securing in a blood pack and couriering to a third party laboratory for processing.

The service completed a version of the World Health Organisation (WHO) surgical safety checklist. An audit of the WHO checklist, in March 2022, for 13 patients, showed that all checklists had been completed appropriately.

The medical director carried out a gastric balloon procedure, to support weight loss, that required x-ray guidance. This was carried out at a neighbouring independent health hospital. There was a criteria that patients needed to fulfil to be accepted for the treatment. The service contracted with the independent hospital for the use of their x-ray facilities for the placement of the balloon. The service was fully responsible for the management of the patient during the procedure. In the event of a complication, arrangements were in place for patients to be referred back to the hospital for removal.

There were no venous thromboembolism (VTE) assessments for the procedures undertaken, although support stockings were applied and advice is given to all patients after leg vein treatments.

The service shared information with patients' GPs with their consent. If there was a concern that needed to be shared, the medical director told us this would be shared in the patients best interest.

Good

Surgery

Aftercare information was provided verbally to patients, and followed up with email aftercare advice. Patients were encouraged to contact the service if a concern following a treatment. In the event of an emergency patients were advised to attend their local NHS emergency department.

Staffing

The service had enough staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment.

The service had enough staff to keep patients safe. All surgery was elective with no emergency procedures. Patients were assigned to doctors available appointment lists.

Staffing was stable with no vacancies at the time of inspection. There was a clinic receptionist and two other staff members employed by the service who carried out treatments for non-regulated activities.

There were four doctors; one was an anaesthetist, one a GP, one an oculoplastic (eyes) surgeon and one a vascular (veins) surgeon. A registered theatre nurse assisted the eye surgeon. The two clinic staff members supported surgeons in a health care assistant role during treatments.

Clinic lists were completed only when doctors were available. In the event of an unexpected absence, the list was cancelled and appointments re-scheduled.

Records

Staff kept detailed records of patients' care and treatment. Records were clear, up-to-date, stored securely and easily available to all staff providing care.

Patient notes were comprehensive and all staff could access them easily. Consultations and treatment sessions were recorded on portable hand-held devices then uploaded onto the main electronic records system.

Records were stored securely. All patient records were stored electronically with a cloud back up system. The system was a clinical model rather than specifically cosmetic. In the event of a failure, paper copies of key documents were available such as consent forms and medical questionnaires. Screenshots of the following days appointments were routinely taken in preparation for clinics.

Staff were required to login to the system. There was an additional access process with personal identification numbers (PIN). Staff used portable hand-held devices when speaking with patients. Consent signatures were obtained electronically with information then being uploaded to the main system. The hand-held devices recognised who was inputting information from their own individual PIN.

Between July 2021 and May 2022, audits of randomised individual patient records were completed for different doctors. All audits showed that records had been completed appropriately.

Medicines

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

Staff followed systems and processes to prescribe and administer medicines safely. There was a medicines management policy. Medicines were purchased from an external pharmacy organisation.

Good

Surgery

Staff completed medicines records accurately and kept them up-to-date. Any medication utilised during treatments was recorded on the patients electronic record including batch numbers and expiry dates of medication used.

Staff stored and managed all medicines and prescribing documents safely. Medication was stored in locked cupboards with stock rotated so that medication close to expiry dates were utilised first.

There were no controlled drugs, general anaesthesia or sedation used. Local anaesthesia was only given by the treating doctor.

The service did not record the environmental temperature. At the time of the inspection, the room where regulated activity took place was very warm. We escalated to the provider who immediately closed the window blind and turned off the light to cool the room. There was a mobile air conditioning unit that could be utilised for periods of hot weather.

There was a fridge to store medicines at lower temperatures. We observed that there was daily recording of the temperature, however; the range was not recorded. This meant the service were not aware if the fridge temperature had been outside of the minimum and maximum recognised temperatures of two to eight degrees Celsius. This had been identified in the annual infection, prevention and control (IPC) audit and had been included in the action plan.

Staff audited medicines monthly and completed signed checklists of available medicines including the lot numbers, serial numbers and expiry dates.

In the event of a severe reaction to any medication administered, there were emergency medications available in a grab bag that could be given by the treating doctor. The bags did not include a security tag and were stored in a room that had a door with an external bolt lock. However this was not an area that was routinely accessed by the public.

Keys, to medicine cupboards were stored in a key safe that had keypad entry.

Incidents

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

The service had an incidents policy. Incidents were reported on paper and staff knew how to complete. We received a sample of incident reports; these were related mainly to minor equipment and environment issues. These were resolved promptly.

The service had no never events or serious incidents in the 12 months prior to inspection.

The medical director shared an example of a theme identified following a known complication of a treatment. The complications had not been reported as a serious incidents, however had been investigated appropriately.

Staff understood the duty of candour and there was a being open and Duty of Candour policy. Staff were open and transparent, and understood about providing patients with a full explanation if things went wrong.

Staff received feedback from investigation of incidents on a one to one basis

Good

Surgery

Staff met to discuss the feedback and look at improvements to patient care. Incidents were discussed at staff meetings.

Managers investigated incidents thoroughly. Patients were involved in these investigations.

Are Surgery effective?

Good

We rated it as good.

Evidence-based care and treatment

The service provided care and treatment based on national guidance and evidence-based practice. Managers checked to make sure staff followed guidance. The service met cosmetic surgery standards published by the Royal College of Surgeons.

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

Policies were reviewed annually, to be in line with current guidance. We were shared copies of policies and saw that all had been reviewed in the 12 months prior to inspection. Staff were required to read the updated policies and sign to confirm when completed.

The medical director monitored the other doctors in line with a practising privileges process, however there was no policy. Doctors worked in substantive posts either in the NHS or independent sector.

Pain relief

Staff monitored patients to see if they were in pain.

Local anaesthesia was administered for procedures where needed. The managing director told us that for the treatments provided, patients would not expect to experience any pain. Patients we spoke with did not express any complaints of pain during their treatments.

Patient outcomes

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

Patients were routinely reviewed after treatment. Outcomes for patients were positive, consistent and met expectations. Patients were reviewed at the clinic one week and eight weeks following eye treatments and six weeks after vein treatments.

The service did not participate in any national clinical audits although did complete internal audits.

We were shared examples of audits undertaken where information from the audits was used to improve care and treatment. Managers shared the results and made sure staff understood information from the audits.

Good

Surgery

Competent staff

The service made sure staff were competent for their roles. Managers appraised staff's work performance and provided support with development.

Managers gave all new staff a full induction tailored to their role before they started work. We observed an induction checklist that included the service's policies and procedures.

Staff were experienced, qualified and had the right skills and knowledge to meet the needs of patients. Specialist doctors undertook procedures that were within their level of expertise. An experienced registered theatre nurse assisted with designated treatments. Other staff supported in a health care assistant role for certain procedures.

Managers supported staff to develop through yearly, constructive appraisals of their work. The service retained a copy of the doctors' appraisals that they had completed with their responsible officer. We were told that the medical director routinely met with the other doctors to discuss all aspects of their practice. There was full compliance with completion of appraisals for staff.

Staff had the opportunity to discuss training needs with their line manager and were supported to develop their skills and knowledge. Staff we spoke with us told they had opportunities to complete additional courses as part of professional development.

Managers made sure staff received any specialist training for their role.Certificates, for training completion, were displayed in the reception area.

Discussions with staff took the form of either formal one to ones or small groups of two or three staff together.

We were told that one to one informal training took place with the director of operations and the medical director on a daily basis as needed.

Multidisciplinary working

Staff worked together as a team to benefit patients. They supported each other to provide good care.

Staff of all grades worked well together as a team including doctors, the nurse and assistants.

Staff told us that in the event of a patient presenting where there was concern regarding mental health then they would refer on to another professional such as safeguarding or the patients GP.

The medical director worked with a neighbouring independent hospital for gastric balloon treatments. The service also worked with an external dietician for these patients. The dietician supported patients with dietary needs before and after the treatment.

Seven-day services

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

The clinic was open on weekdays and Saturdays. Patients were given working hours telephone details to access for any queries, post treatment. The directors monitored emails and social media messages 24/7 for urgent advice.

Good

Surgery

Health promotion

Staff gave patients practical support and advice to lead healthier lives.

The service had relevant information relevant to the service provided re promoting healthy lifestyles and support.

Staff assessed each patient's health and provided support for any individual needs to live a healthier lifestyle.

There were leaflets available for treatments provided.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

Staff supported patients to make informed decisions about their care and treatment. They followed national guidance and ensured that patients gave consent in a two-stage process with a cooling off period of at least 14 days between stages. They understood how to support patients.

Staff understood how and when to assess whether a patient had the capacity to make decisions about their care.

Staff gained consent from patients for their care and treatment in line with legislation and guidance. The service had a consent policy; however it did not reference the Mental Capacity Act. Staff could describe and knew how to access the policy.

We were told that Mental Capacity Act was included in safeguarding training that was part of mandatory training requirements.

Staff understood the relevant consent and decision-making requirements of legislation and guidance, including the Mental Capacity Act 2005 and they knew who to contact for advice. Staff told us they would discuss any queries with the manager. We were told that any patient who was deemed not able to consent to treatment would not be able to proceed at the service.

Patients self-referred to the service. Staff made sure patients consented to treatment based on all the information available. The service obtained consent for taking photographs as well as treatments. Patients we spoke with told us they felt fully informed from initial consultation through to treatment and follow-up.

Staff clearly recorded consent in the patients' records. There were consent forms dependent on the treatment offered. Some forms required a declaration of being over the age of 18 years. Consent was obtained on each treatment visit using an electronic tablet that uploaded to the patient record system.

Managers monitored the consent process. They shared an example of where an audit had highlighted that one of the forms was missing some information. This was amended in line with best practice.

The doctors in the service ensure that patients were given time to review any treatments discussed at consultation. This was at least two weeks after the initial appointment. However there was no reference to a 'cooling off' period in the consent policy.

We were told that all patients had a full and thorough consultation before any treatment or procedure was carried out with all consultations being without obligation. The medical questionnaire was reviewed at each appointment with any

amendments made or recorded as no changes. The patient and doctor electronically signed the document. Patients were made aware of all advantages and disadvantages in respect of their treatment. The consent forms included possible risks and side effects of treatments. We were told that the provision of unnecessary treatment went against the ethics of the clinic and what they aimed to achieve.

After consultation patients were provided with a full breakdown of their prospective treatment(s) and the final cost discussed and any treatment or procedure they have agreed to undertake will be explained. Any risks associated with treatment were explained to the patient prior to the commencement of treatment.

In July 2022, the medical director completed an audit of the consent form for 10 patients who had undergone regulated activity treatments. He found that the consent forms did not include the side of treatment (such as left or right leg for vein treatments) although this was present on the World Health Organisation (WHO) safety checklist. The consent form was then amended in line with the WHO checklist and information shared with the other doctors.

Are Surgery caring?

Good

We rated it as good.

Compassionate care

Staff treated patients with compassion and kindness, respected their privacy and dignity, and took account of their individual needs.

Staff were discreet and responsive when caring for patients. Staff took time to interact with patients and those close to them in a respectful and considerate way. At the time of inspection, there was no regulated activity. However we observed that staff interacted and communicated respectively to those attending for non-regulated treatments.

We spoke with patients, following the on-site visit, with their consent about the care and treatment received from the service. The feedback was consistently positive. They told us that they felt relaxed and put at ease. Communication was very good from initial consultation through to treatment and follow-up care. We were told that staff were very friendly, welcoming and caring with the service being described as perfect.

We were told that induction training focused on the need to ensure that all patients were treated with dignity and respect. Working in a person-centred way level one, duty of care level one and communication level two were part of mandatory training requirements.

Patients said staff treated them well and with kindness. Patients were sent post treatment questionnaires electronically to gain feedback. Patients were encouraged to share feedback on internal platforms. We saw that feedback was very positive about treatment received for all staff who provided regulated activity.

Staff followed policy to keep patient care and treatment confidential.

Staff understood and respected the individual needs of each patient and showed understanding and a non-judgmental attitude when discussing patients with mental health needs.

Good

Surgery

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

Emotional support

Staff provided emotional support to patients, families and carers to minimise their distress. They understood patients' personal, cultural and religious needs.

Staff gave patients emotional support and advice when they needed it.

Staff understood the emotional and social impact that a person's care, treatment or condition had on their wellbeing and on those close to them.

There was a chaperone policy and they were available if preferred by the patient.

Understanding and involvement of patients and those close to them

Staff supported patients and families to understand and make decisions about their care and treatment.

Staff made sure patients understood their care and treatment.

Staff talked with patients in a way they could understand, using communication aids if necessary.

Patients could give feedback on the service and their treatment and staff supported them to do this. They gave positive feedback about the service.

Are Surgery responsive?

Good

We rated it as good.

Meeting people's individual needs

The service was not always inclusive when taking into account individual needs and preferences. Staff made some reasonable adjustments to help patients access services. There was a system for referring patients for psychological assessment before starting treatment, if necessary.

All patients self-referred to the service. Patients were generally self-funded with occasional patients from health insurance organisations or GP's.

The service was located close to the town centre and was on two levels. There was local car parking available.

The room where regulated activity took place was on the upper floor. This meant that a patient who attended with a mobility issue could not be accepted for treatment by the provider.

Good

Surgery

The reception area had magazines available that included local area information as well as features completed by the provider. There was also a television that displayed information about services or products available as well as products that could be purchased.

Staff made sure any patients suitable for treatments that were living with mental health problems, learning disabilities and dementia, received the necessary care to meet all their needs.

There was a disability policy for patients and staff. Awareness of mental health, dementia and learning disabilities level one and equality and diversity level one were part of mandatory training requirements.

For patients who presented with visual impairment, there was no information available in either Braille or an alternative larger format. There was no hearing loop for patients with hearing impairments. We were told that a signer could be sourced if needed.

For patients whose first language was not English, an interpreter could be sourced to support with explanations of information. There was a policy about how to access an interpreter.

There were leaflets available, however we did not see any in languages other than English.

Access and flow

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

Patients self-referred to the service. The provider's website include a form where patients could enquire about appointments or treatments. Emails were monitored several times daily to respond to any queries.

Vascular (vein) treatments were available Mondays, Tuesdays and one Saturday per month with eye treatments on Tuesdays and Thursdays. The medical director carried out a maximum of four gastric balloon treatments per month. These were carried out at a neighbouring independent hospital where x-ray facilities were available. On discharge, patients were given the director's personal number and contacted daily, as well as verbal and written advice, in case of an unexpected complication.

Otherwise the directors monitored emails and social media 24/7 to address any patient queries.

We were told appointments were generally available two weeks after enquiring for an initial consultation. Patients were sent pre-care information including what to expect if they decided to proceed and contact details for the clinic to book further appointments or treatments. They returned after at least two weeks before any treatment began to allow time for patients to consider their options.

Managers and staff worked to make sure patients did not stay longer than they needed to. Patients were given appointment slots either by phone or electronically with email confirmations.

When patients' appointments were cancelled, staff rearranged when possible. Between June 2021 and June 2022 there were 79 appointments for regulated activities that were cancelled ahead of the scheduled appointment. Patients appointments were rearranged due to patient choice. For the same time period, there were seven patients who did not attend for their appointment without informing the service. There was a requirement for a deposit for treatment at the time of booking.

Good

Surgery

Learning from complaints and concerns

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

Patients knew how to complain or raise concerns. Feedback could be submitted electronically on the service's website.

There was a complaints policy that had been reviewed in the 12 months prior to inspection, and staff knew how to handle them.

There had been no complaints in the 12 months prior to inspection. There had been two concerns that the service shared with us. The service had responded promptly and appropriately.

Managers shared feedback from these concerns with staff and learning was used to improve the service.

We were told that if a complaint was received and not resolved internally, they would signpost to the cosmetic redress scheme. The cosmetic redress scheme was a service where patients could be signposted to in the event of complaint not being resolved with the service.

Are Surgery well-led?

Good

We rated it as good.

Leadership

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

The service was founded by the medical director who was the registered manager (RM). The director of operations managed the administrative and governance of the service along with the RM.

Directors were supported by a clinic manager and other clinic staff. The directors worked part-time at the location but staff told us they were contactable, visible and available if and when needed.

Vision and Strategy

The service did not have a written vision or strategy for what it wanted to achieve.

We were told that their vision was: "*to work in partnership with patients and staff to provide the best medical services possible working within local and national governance, guidance and regulations.*"

Their mission statement was to improve the health, well-being and lives of those they care for.

Good

Surgery

Culture

Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. The service provided opportunities for career development.

Staff we spoke with felt supported by the directors. Staff told us there was good team spirit and they enjoyed their roles working for the service.

There was an equal opportunities policy as well as an equality, diversity and human rights policy.

Staff told us that work times had been flexible in order to accommodate other needs outside of work. They told us they felt they could raise a concern with the directors if needed.

There was time during the working day to complete any training requirements and they were encouraged to attend additional courses to support personal and professional development.

Patients were provided with terms and conditions for the treatment provided. Costs of individual consultations and treatments were clearly displayed on the services' website.

Governance

Leaders operated effective governance processes, throughout the service and with partner organisations. Staff at all levels were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service.

The medical director and director of operations managed the governance processes for the service. There was an overarching quality management policy with a range of policies in place to manage the service.

There were processes in place for the recruitment of staff including a recruitment policy. This referred to interviewing candidates and obtaining references, however; these were not available to view during the on-site inspection. Staff were required to undergo a police check. There was a disclosure and barring service (DBS) check policy. All clinical staff reviewed had enhanced DBS checks between 2020 and 2022 that had been obtained via the service either during the onsite visit or shortly afterwards. The director of operations had a standard DBS and did not participate in any clinical role.

Doctors were contracted through practising privileges, however there was no policy. There was a reliance on the doctors appraisal with their responsible officer that they were skilled and competent to undertake their role. We did observe that copies of three of the four doctors medical indemnity insurance were retained in doctors files as well as all doctors copies of annual appraisal with their responsible officers (RO). All of these had been renewed in the 12 months prior to inspection. Doctors were required to inform the service if they had been accused of disciplinary proceedings or investigation in other organisations where they practiced. We were told that In the event of this, practising privileges would be reviewed by the medical director and suspended if necessary to protect patients. Should there be an allegation made against a doctor regarding an incident within the service, the medical director would inform other organisations in which the doctor was employed.

There was a disciplinary policy in place for employed staff as well as a whistleblowing procedure, and a bullying and harassment policy.

Good

Surgery

The medical director carried out regulated activity in a neighbouring independent hospital where all the required equipment was available.

There were service level agreements (SLA) in place with third party organisations for decontamination of re-usable instruments, disposal of clinical waste and disposal of sharps bins.

There were no formal governance meetings or minutes to indicate what had been discussed and where any concerns were identified evidence of action. Any concerns were managed by the directors as needed.

Management of risk, issues and performance

Leaders used systems to manage performance effectively. They identified relevant risks and issues and identified actions to reduce their impact. They had plans to cope with unexpected events.

We were told that the medical director and director of operations monitored risk and service quality on a weekly basis. This was more frequent during the COVID-19 pandemic. Risk assessments were undertaken as needed and shared with staff.

The service had a risk register that included potential risks. There was a scoring systems, controls and mitigations recorded, however; no dates to indicate when reviewed.

There was a policy for zero tolerance on aggression and violence. We saw that arrangements were in place for staff who were lone-working. Staff were encouraged to prevent entry to persons not known to them if the sole worker at the time of an appointment.

The service received alerts from the NHS Central Alerting System (CAS) and updates from National Institute for Health and Care Excellence (NICE). Alerts were reviewed by the medical director, and any relevant information cascaded to staff.

There was a clinic continuity plan policy. In the event of a total power failure there was no back-up generator meaning regulated activity would be cancelled.

Information Management

The service collected reliable data and analysed it. The information systems were integrated and secure. Notifications would be submitted to external organisations as required.

Information governance and data security level one was part of mandatory requirements. All staff were required to complete a confidentiality agreement. There was a data protection code of practice for patients, a privacy policy, an information handling procedure, a clear desk policy and disposing of confidential waste policy.

The service had an electronic record keeping system that was password protected and backed up by a cloud system. Computers were linked to electronic tablets that included an extra PIN access. This system recognised a change in user, for example from nurse to doctor.

Information collected was utilised for audit purposes and we were shared examples of where changes had been made.

Engagement

Leaders and staff actively and openly engaged with patients and staff.

Good

Surgery

We were told that staff meetings were held quarterly and any updates would be discussed at that time. At other times staff met for informal discussions.

We reviewed minutes from the staff meeting, held in May 2022. The minutes included the date, attendees and apologies. Information was presented in the form of a list, with no formal agenda. Items discussed included appointment availabilities, any training needs, treatments and staff news items.

Staff actively encouraged feedback from patients either via the services online systems or social media platforms. The service submitted articles to local magazines; staff told us that patients had booked appointments following review of the articles.

Learning, continuous improvement and innovation

All staff were committed to continually learning and improving services.

The service were considering expanding services, however no immediate changes expected. There was no formal medical advisory committee (MAC), however prior to the inspection, the medical director had contacted the other doctors to set up a MAC with the team proposed for later this year.

The service was recruiting a new role of marketing executive but not appointed at time of inspection.

Leaders were committed to following best practice guidance and we were shared details of how learning had been shared following complications of surgery.