Stratum Clinic

Inspection report

38 Park End Street
Oxford
OX1 1JD
Tel: 01865320790

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

Overall summary

This service is rated as Requires Improvement.

The key questions are rated as:

Are services safe? – Requires improvement

Are services effective? – Requires improvement

Are services caring? – Good

Are services responsive? – Good

Are services well-led? – Requires improvement

We carried out an announced comprehensive inspection at Stratum Clinic because no inspection had been undertaken since 2014. The previous inspection in January 2014 identified no breaches of regulation and was an unrated inspection.

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

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

Our key findings were:

- The service did not always operate effective processes to ensure it provided safe care.
- Care was assessed and delivered on an individual basis. National guidance was considered by clinicians.
- Clinicians were qualified and experienced in the areas of care they provided.
- There was insufficient monitoring of clinicians' training and their individual work.
- Some clinicians did not have full pre-employment checks.
- There was a lack of care monitoring and audit processes.
- Record keeping for patient notes was not consistent with recording systems and policies. A new electronic clinical record system had been introduced but was not being utilised by clinicians.
- There were arrangements to ensure consent was sought and that patients were fully informed about their care options.
- Reasonable adjustments were made to protect people's privacy, dignity and enable access to the service where they had specific requirements.
- There were insufficient governance arrangements.
- There was not always appropriate monitoring and oversight of care and non-clinical elements of the service.

The provider **must**:

Overall summary

- Operate systems and processes to ensure services are monitored, safe and effective as part of a system of good governance.
- Ensure care and treatment is provided in a safe way to patients

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Chief Inspector of Hospitals and Interim Chief Inspector of Primary Medical Services

Our inspection team

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

Background to Stratum Clinic

- Stratum Clinic Ltd
- Cantay House, Park End Street, Oxford, OX1 1JD
- Stratum Clinic provides consultations and dermatological treatments for a variety of conditions including surgery for the treatment of skin cancers. They provide diagnostic tests and provide information and choices about potential treatments. Some medicines are prescribed by the service, where appropriate, which include treatment for acne. Cancer treatments include Mohs surgery (the removal and real time analysis of layers of skin). Some of the services are not regulated by the Care Quality Commission (CQC), such as cosmetic therapies. This report references only those services that are regulated by CQC. The service cares for approximately 5,000 patients a year. There are designated consultation and treatment rooms available.

Opening hours

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

How we inspected this service

We requested information in advance of the inspection from the provider and undertook a site visit on 28 March 2023. We reviewed care records, documents related to the management of the service, patient feedback and observed the premises. We spoke with 2 clinical members of staff.

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

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

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

Requires Improvement

Are services safe?

We rated safe as Requires improvement because:

We found there were not always appropriate systems to protect patients from the risk of harm.

Safety systems and processes

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

- The provider conducted safety risk assessments. It had policies, such as safeguarding vulnerable adults, fire safety and infection control. These were regularly reviewed and outlined clearly who to go to for further guidance. Permanent staff received induction and refresher training in areas such as safeguarding and fire safety. However, sessional staff, namely doctors and consultants, working at the service did not have their adherence to some areas of training checked.
- The provider demonstrated staff checks were completed for nurses and non-clinical staff working at the service. Disclosure and Barring Service (DBS) checks were undertaken for all staff working with patients. (DBS checks identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable). Staff vaccination records were completed and up to date. However, sessional staff (consultants who undertook surgery and other treatments) did not have references from their time of recruitment. There were no health check disclosures or questionnaires for staff to declare any health related issues which may impact on their ability to provide care safely.
- The provider ensured facilities were safe to use. However, the provider did not have a system to monitor the servicing or calibrating of equipment. We found electro-curettage equipment (a piece of medical equipment used to perform treatment of basal cell cancers and squamous cell cancers of the skin) had not been serviced or calibrated since 2021..Medical equipment such as blood pressure monitors, medical lights and weighing scales had not been calibrated since 2021. There was no system to monitor or prompt when servicing was required.
- A fire risk assessment had been undertaken in March 2022. We found 2 of the required actions had not been completed at the time of the inspection. The provider informed us 1 of the actions was due to be completed immediately following the inspection and the landlord would be contacted regarding completion of the other action.
- There were systems for safely managing healthcare waste.

Risks to patients

Systems to assess, monitor and manage risks to patient safety were not always sufficient.

- Staff understood their responsibilities to manage emergencies and to recognise those in need of urgent medical attention. The provider did not monitor that consultants had undertaken basic life support training. Nurses received this training.
- Medicines and equipment to deal with most medical emergencies were stored appropriately and checked regularly. However, we found adrenaline being stored which was out of date by 10 months and had not been replaced. The provider was aware of the out of date medicine but staff informed us they had not been able to replace it.

Information to deliver safe care and treatment

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

- The provider had implemented a new clinical record system in recent months. The new system was not being used appropriately by consultants when assessing, planning and delivering patient care. Instead, the previous paper-based

system was being utilised alongside the new clinical record system. We reviewed 2 paper patient records. Assessments and treatment plans were handwritten and there was no formula or template for completing medical histories, diagnosis or treatments. Patients had their care planned with 1 doctor. The clinical lead informed us at each appointment medical histories were being checked with the patient. However, there was a risk that patients' care records were not being reviewed and recorded consistently.

- The service had systems for sharing information with patient's registered GP to enable them to deliver safe care and treatment.
- The service had a system to retain medical records in line with Department of Health and Social Care (DHSC) guidance in the event they ceased trading.
- Clinicians made appropriate and timely referrals in line with protocols and up to date evidence-based guidance.
- Where patients may have an urgent clinical need, such as a suspected cancer, the service could fast-track them into an appointment for urgent clinical review.

Safe and appropriate use of medicines

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

- Emergency medicines were monitored frequently. Staff informed us adrenaline to be used in the case of an allergic reaction was out of date as the provider could not source a replacement. We completed checks and found it had expired in May 2022. No alternative form of adrenaline had been sourced. There was a risk that the current stock of adrenaline would not be effective if required in a medical emergency.
- Staff monitored fridge temperatures to ensure medicines were stored at the correct temperature. However, we found fridge temperature records indicated the high temperature was consistently above 8 degrees Celsius. No action or reason was noted for the high temperatures when the records were made. There was an independent thermometer in the fridge for verification that the fridge thermostat was operating accurately. However, no records were taken from this device and it was not linked to a datalogger for analysis. There was a risk medicines were being compromised by a lack of appropriate monitoring. Staff informed us they would purchase a data logger to ensure improved monitoring was implemented.
- Staff had processes to follow to ensure they prescribed, administered or supplied medicines to patients and gave advice on medicines in line with legal requirements and current national guidance. However, there were no prescribing audits.

Lessons learned and improvements made

The service learned and made when things went wrong.

- There was a system for recording and acting on significant events. No incidents or significant events had been recorded in the last 12 months. There was a standing agenda item for discussing significant events at staff meetings.
- The provider was aware of and complied with the requirements of the Duty of Candour. The provider encouraged a culture of openness and honesty. We found that, where necessary, complaints contained an apology and accountability where mistakes had been made.
- The service acted on and learned from external information such as changes in guidance as well as medicine safety alerts. The service had an effective mechanism to disseminate alerts to clinicians.

Requires Improvement

Are services effective?

We rated effective as Requires improvement because:

There was no monitoring or adequate audit of patient care. Training was not appropriately monitored for non-permanent staff who provided treatments. Patients were provided with information on their lifestyle to enable them to make informed decisions about their care.

Effective needs assessment, care and treatment

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

- The clinicians we spoke with explained that patients were assessed and their needs and care was delivered in line with relevant and current evidence based guidance. This included the National Institute for Health and Care Excellence (NICE) best practice guidelines.
- The paper patient records we reviewed showed clinical histories and diagnoses were included as well as patient treatment plans. However, these were recorded in free hand text and followed no formula to ensure all areas required were assessed and recorded.
- Once patients attended an initial consultation, diagnostic tests were undertaken as required and a full medical history was ascertained. A treatment plan letter was provided to patients and shared with their GPs with the patient's consent.
- We saw no evidence of discrimination when making care and treatment decisions.

Monitoring care and treatment

The service was not actively involved in quality improvement activity.

- There was minimal clinical audit. There were no systems to effectively monitor patient care and the individual performance of consultants undertaking surgery. We looked at a Mohs (a surgery for the treatment skin cancer) audit. The audit had no objectives and identified no areas of good practice or improvements to care. There was no audit on anti-biotic or other prescribing.
- There was no peer review of consultants' work to assess performance and ensure consistency in care. The registered manager recognised the lack of audit and clinician review from other CQC inspections of Stratum Clinics and was in the process of proposing audits and a peer review process.
- Patient feedback was used to identify potential improvements.

Effective staffing

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

- All staff were appropriately qualified and experienced in their field of care.
- The clinicians were registered with the General Medical Council (GMC) or Nursing and Midwifery Council (NMC).
- The provider identified the learning needs of staff and ensured training was maintained periodically as required. However, there were no up to date records of skills and training for sessional consultants working at the service. For example, there was no proof of training for the Mental Capacity Act (2005), fire safety, basic life support or infection prevention control on a consultant's staff record.
- The provider had an induction programme for permanent staff.

Coordinating patient care and information sharing

Requires Improvement

Are services effective?

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

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

Supporting patients to live healthier lives

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

- Where appropriate, staff gave people advice so they could self-care.
- Risk factors were identified, highlighted to patients and where appropriate highlighted to their normal care provider for additional support.
- If follow up support or advice was needed, the provider was contactable by phone 8am to 8pm Monday to Friday and 9am to 3pm on Saturdays. If necessary, there were nurses available during these hours to provide clinical advice.
- Where patient's needs could not be met by the service, staff redirected them to the appropriate service for their needs.

Consent to care and treatment

The service had systems to obtain consent to care and treatment in line with legislation and guidance.

- Staff understood the requirements of legislation and guidance when considering consent and decision making.
- Staff supported patients to make decisions.
- Staff had training in the Mental Capacity Act (2005), although this was undertaken by consultants in their NHS roles, this was not monitored by the provider.

Good

Are services caring?

We rated caring as Good because:

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

Kindness, respect and compassion

Staff treated patients with kindness, respect and compassion.

- The service sought feedback on the quality of clinical care patients received.
- Patient feedback was sought and patients reported a mix of positive and negative outcomes. Where comments indicated improvements could be made to the service, these were acted on. For example, blankets were provided to patients following treatments due to suggestions from patient feedback.
- The service gave patients timely support and information.
- A chaperone policy was in place. Patients could request a chaperone and information about chaperoning was available at reception.

Involvement in decisions about care and treatment

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

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

Privacy and Dignity

The service respected patients' privacy and dignity.

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

Good

Are services responsive to people's needs?

We rated responsive as Good because:

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

Responding to and meeting people's needs

The service organised and delivered services to meet patients' needs. It took account of patient needs and preferences.

- The provider understood the needs of their patients and improved services in response to those needs. For example, patients reported the need for more clarity post-treatment through their feedback. The provider informed us post treatment packs were introduced and a phone call was made to patients a few days after their treatment to check if they had any concerns.
- The facilities and premises were appropriate for the services delivered.
- Reasonable adjustments had been made so people in vulnerable circumstances could access and use services on an equal basis to others. For example, there was a lift for patients with limited mobility.
- Translation services were available.

Timely access to the service

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

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

Listening and learning from concerns and complaints

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

- Information about how to make a complaint or raise concerns was available. Staff treated patients who made complaints compassionately.
- The service informed patients of any further action that may be available to them should they not be satisfied with the response to their complaint.
- The service had a complaint policy.
- The provider reviewed complaints every month. Themes were analysed to identify areas where improvements may be required to the service.

Requires Improvement

Are services well-led?

We rated well-led as Requires improvement because:

The provider did not have adequate governance and quality assurance processes. Risks to patients were not always assessed and mitigated.

Leadership capacity and capability.

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

- Leaders were knowledgeable about their field of care and the services they provided.
- There was not sufficient clinical leadership to provide oversight of systems and processes and provide clinical quality assurance. For instance there were no significant events recorded in the last year and there was no effective audit.
- The provider did not ensure there were appropriate leaders across all aspects of the service. For example, there was no clear line management of the consultant doctors who worked on a sessional basis at the service.
- The registered manager was visible and available to staff. A new non-clinical manager had been appointed and was undertaking their induction at the time of the inspection.

Vision and strategy

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

- There was a clear vision and set of values. However, the provider did not have the necessary resources to develop a clear clinical strategy. For example, there was no quality assurance lead and insufficient monitoring of clinical services.

Culture

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

- Less experienced members of the team had taken on some lead roles due to a high turnover of staff. The registered manager was aware training was required to upskill staff and ensure they were knowledgeable and skilled to undertake these roles. The manager was aware some staff had been unhappy with the way the service had performed and working arrangements. One member of the team reported improvements to the culture in recent months.
- There was an incident log but this had not been used to report any incidents in the previous 12 months.
- 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 the development they needed. This included appraisal in line with the registration requirements of the clinicians. However, training was not always appropriately monitored to ensure adherence.
- The service actively promoted equality and diversity. Staff had received equality and diversity training.

Governance arrangements

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

Requires Improvement

Are services well-led?

- There were poor processes and systems for clinical governance. There was minimal oversight of the performance of individual clinicians.
- Staff were not always performing monitoring roles and accountabilities. For example, the medicine fridge was not being monitored in line with national guidance. Equipment was not always serviced in line with manufacturers recommendations.
- Policies and procedures were not always followed consistently. For example, medicines' monitoring did not follow the service's own policy and procedure.
- Policies and governance documentation was accessible to staff and updated when needed.
- The service submitted data or notifications to external organisations as required.

Managing risks, issues and performance

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

- There was not effective identification, assessment and mitigation of risks which may occur in the delivery of services. For example, the risk of staff providing treatments without the necessary references, training and health checks had not been identified and mitigated.
- The system for reporting safety incidents was not being utilised to identify potential learning events which would mitigate risks.
- Staff received major incident training and there was a major incident plan. However, some staff did not receive basic life support training and we found an emergency medicine which was 10 months out of date.

Appropriate and accurate information

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

- Patient care records were not appropriately monitored to ensure consistency. Two different means of clinical record keeping were being used at the same time due to incomplete implementation of an electronic record system.

Engagement with patients, the public, staff and external partners

The service involved patients and external partners to support high-quality sustainable services.

- The service encouraged and heard views and concerns from patients and GP practices and acted on them where necessary.
- The service was transparent, collaborative and open with stakeholders about performance.

Continuous improvement and innovation

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

- There was some evidence of continuous learning and improvement in regards to responding to patient feedback. For example, patients were given clearer directions on finding the clinic as a result of patient feedback.
- The service reviewed complaints and learning outcomes. Learning was considered from external sources such as national guidance and experts in the field of care.

Requires Improvement

Are services well-led?

- As a result of CQC inspections at other Stratum Clinics there were plans to implement greater monitoring of consultants' work and their training. There was consideration of future clinical audit to identify improvements to the service.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

The table below shows the legal requirements that were not being met. The provider must send CQC a report that says what action they are going to take to meet these requirements.

Regulated activity	Regulation
Diagnostic and screening procedures Surgical procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment The provider was not always identifying, assessing and mitigating risks to service users, including those related to; -ensuring that the equipment and premises used by the service provider for providing care or treatment to a service user is safe for such use and is used in a safe way. -ensuring that persons providing care or treatment to service users have the qualifications, competence, skills and experience to do so safely -the proper and safe use of medicines This was in breach of Regulation 12 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Regulated activity	Regulation
Diagnostic and screening procedures Surgical procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance The provider did not ensure they operated systems and processes to assess, monitor and improve the quality and safety of the services provided. The provider did not always maintain an accurate and contemporaneous record in relation to each service user or persons employed in the carrying on of the regulated activity. This was in breach of Regulation 17 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.