The Mole Clinic Limited

The Mole Clinic

Inspection report

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Overall summary

We carried out an announced comprehensive inspection of The Mole Clinic on 14 June 2018 to ask the service the following key questions; Are services safe, effective, caring, responsive and well-led?

Our findings were:

Are services safe?

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

Are services effective?

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

Are services caring?

We found that this service was providing caring services in accordance with the relevant regulations.

Are services responsive?

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

Are services well-led?

We found that this service was providing well-led care in accordance with the relevant regulations.

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the service was meeting the legal requirements and regulations associated with the Health and Social Care Act 2008.

This service was inspected in December 2012 under our previous inspection methodology and it was found at that time to be meeting all the essential standards of care.

The Mole Clinic, established in 2003, is a clinical location of the provider The Mole Clinic Limited and operates from 9 Argyll Street, London W1F 7TG, which is registered as its head office. The service also operates from a separately registered location at 7 Moorgate, London EC2R 6AF. Operational systems and processes are generic to both locations and employed staff worked across both sites. We inspected both locations on the same day with two separate inspection teams.

The service specialises in skin cancer screening, diagnosis and skin lesion removal. All services are offered from both locations. Staff from Argyll Street also provide skin cancer screening sessions at two satellite locations based within Harrods Pharmacy, Brompton Road, London SW1X 7XL and at 40 Bank Street, Canary Wharf, London E14 5NR. We did not inspect either satellite location.

The day-to-day running of the service at both Argyll Street and Moorgate is provided by the clinic manager supported by a clinic coordinator at both locations. The service also employs seven nurses, two healthcare

Summary of findings

assistants, a systems and data manager and a receptionist. Skin lesion diagnosis using digital images (tele-dermatology) is provided remotely by three sessional dermatology-specialist general practitioners. Mole removal surgery is provided on-site by five surgical consultants in the specialities of dermatology, plastic surgery and general surgery, all of whom work under practising privileges (the granting of practising privileges is a well-established process within independent healthcare whereby a medical practitioner is granted permission to work in an independent hospital or clinic, in independent private practice, or within the provision of community services).

The service offers pre-bookable face-to-face appointments for adults aged 18 and over. Patients can access appointments at this location on Monday and Wednesday from 8am to 7pm, Tuesday, Thursday and Friday from 8am to 5pm and Saturday from 10am to 4pm. Appointments at Harrods Pharmacy are available on Wednesday from 10am to 7pm and at Canary Wharf Monday to Friday from 8.30am to 5.30pm. For the period 1 June 2017 to 31 May 2018 the service has seen approximately 8,200 patients seen at Argyll Street, 300 at the Harrods Pharmacy location and 103 at its Canary Wharf location. Overall in the past year the service has seen approximately 13,000 patients at all its locations.

The provider is registered with the Care Quality Commission (CQC) for the regulated activities of Diagnostic & Screening Procedures and Surgical Procedures. After the inspection the service submitted an application to add the regulated activity Treatment of Disease, Disorder or Injury to reflect its current service provision.

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

As part of our inspection, we asked for CQC comments cards to be completed by patients prior to our inspection. Eighteen comments cards were completed, all of which were positive about the service experienced. Patients commented that the service offered a professional, caring and thorough service. Patients said staff were friendly, helpful and informative.

Our key findings were:

- There were systems in place to safeguard children and vulnerable adults from abuse and staff we spoke with knew how to identify and report safeguarding concerns. All staff had been trained to a level appropriate to their role.
- The service had systems to manage risk so that safety incidents were less likely to happen. When incidents did happen, the service learned from them and improved their processes.
- The practice carried out staff checks on recruitment, including checks of professional registration where relevant.
- Clinical staff we spoke with were aware of current evidence-based guidance and they had the skills, knowledge and experience to carry out their roles.
- There was evidence of quality improvement, including clinical audit.
- Consent procedures were in place and these were in line with legal requirements.
- Staff we spoke with were aware of their responsibility to respect people's diversity and human rights. The service was caring, person-centred and compassionate.
- Systems were in place to protect personal information about patients. The service was registered with the Information Commissioner's Office (ICO).
- Patients were able to access care and treatment from the clinic within an appropriate timescale for their needs.
- Information about services and how to complain was available.
- The service had proactively gathered feedback from patients.
- Governance arrangements were in place. There were clear responsibilities, roles and systems of accountability to support good governance and management.

There were areas where the provider could make improvements and should

Summary of findings

- Consider the infection prevention and control lead undertaking enhanced training to support them in this extended role.
- Review practice policies and procedures so they are consistently service-specific.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?

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

- There were systems and processes in place to keep patients safe and safeguarded from abuse and a patient identification system was in place.
- There was a system in place for the reporting and investigation of incidents and significant events. Lessons learnt were shared with staff.
- There were systems in place to meet health and safety legislation.
- There were arrangements in place to deal with emergencies and major incidents.
- We observed the service premises to be clean and there were systems in place to manage infection prevention and control (IPC), which included a recent IPC audit.
- The provider was aware of and complied with the requirements of the Duty of Candour and encouraged a culture of openness and honesty.

Are services effective?

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

- Clinical staff were aware of and used current evidence based guidance relevant to their areas of expertise.
- Clinical staff had been trained to provide them with the skills and knowledge to deliver effective care and treatment.
- There was evidence of quality improvement, including clinical audit, for example post-operative outcomes from minor surgical procedures.
- There were formal processes in place to ensure all members of staff received an induction and an appraisal.
- Staff sought and recorded patients' consent to care and treatment in line with legislation and guidance.

Are services caring?

We found that this service was providing caring services in accordance with the relevant regulations.

- Staff we spoke with were aware of their responsibility to respect people's diversity and human rights.
- Systems were in place to ensure that all patient information was stored and kept confidential. The service was registered with the Information Commissioner's Office (ICO).
- Patient feedback through CQC comment cards and internal surveys showed that patients felt their privacy and dignity was respected and they were shown kindness, respect and compassion.

Are services responsive to people's needs?

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

- Patients were able to access care and treatment from the clinic within an appropriate timescale for their needs.
- Staff told us that they had access to interpreting services for those patients whose first language was not English.
- There was a complaints policy which provided information about handling complaints from patients. There was a patient leaflet outlining the complaint process in line with guidance.
- Information for patients about the service was available in a patient leaflet and on the clinic's website which included the costs of services provided.

Summary of findings

Are services well-led?

We found that this service was providing well-led care in accordance with the relevant regulations.

- The management team had the capacity and skills to deliver high-quality, sustainable care.
- The service had a clear vision and credible strategy to deliver high quality care and promote good outcomes for patients.
- There were clear responsibilities, roles and systems of accountability to support good governance and management.
- The service engaged and involved patients and staff to support high-quality sustainable services.

The Mole Clinic

Detailed findings

Background to this inspection

We carried out an announced comprehensive inspection of The Mole Clinic on 14 June 2018 under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. We planned the inspection to check whether the registered provider was meeting the legal requirements within the Health and Social Care Act 2008 and associated regulations.

Our inspection team was led by CQC Lead Inspector and included a GP Specialist Advisor.

Pre-inspection information was gathered and reviewed before the inspection. On the day of the inspection we spoke with the clinic manager, compliance consultant, systems and data manager, clinic co-ordinator, screening nurses, a consultant dermatologist and a remote-working GP. We also reviewed a wide range of documentary evidence including policies, written protocols and guidelines, recruitment, induction and training records, significant event analyses, patient survey results and complaints.

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.

Are services safe?

Our findings

Safety systems and processes

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

- Arrangements for safeguarding reflected relevant legislation and local requirements. Policies were accessible to staff and we saw local contact details were displayed in all rooms.
- There was a lead for safeguarding and all staff we spoke with knew who this was. Staff demonstrated they understood their responsibilities regarding safeguarding and were able to give examples.
- We saw evidence that employed staff, the safeguarding lead and GPs and consultants working under practising privileges had received safeguarding children and adult training appropriate to their role.
- Staff who acted as chaperones were trained for the role and had received a Disclosure and Barring Service (DBS) check. 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. There was a chaperone policy and staff we spoke with who acted as a chaperone understood their role and responsibilities.
- The provider had systems in place to ensure appropriate recruitment of staff. There was a job description and person specification for each role. Shortlisting for clinical positions was undertaken by the provider's medical advisory committee which included a surgical and dermatology consultant and a dermatology specialist GP. Interview assessment notes were maintained for all interviews. The provider told us that screening nurse interviews did not currently include a screening nurse on the interview panel.
- We reviewed the personnel files of two employed clinical and one non-clinical staff member and found that the appropriate recruitment checks had been undertaken prior to employment. For example, proof of identification, written references and appropriate checks through DBS. In addition, we reviewed two files of doctors working under practising privileges and saw that they were appropriately vetted before they were allowed to work at the clinic. For example, proof of professional registration, indemnity insurance, DBS check and evidence of NHS annual appraisal.
- There was a system in place to manage infection prevention and control (IPC). There was an IPC policy and guidance was on display in all rooms. The service told us they had recently nominated a nurse as IPC lead. However, enhanced training to support them in this extended role had not been undertaken at the time of our inspection. Staff we spoke with understood good handwashing techniques, how to handle spillages and had access to bodily fluid spillage kits. The provider told us it had recently commenced quarterly IPC audits to assess and monitor IPC risks. We reviewed an audit undertaken in April 2018 which had scored 100% compliance. We saw that this included compliance with sharps handling and disposal. However, we noted that one sharps bin had been opened in 2017 which exceeded the guidance that sharps bins should be closed and disposed of three months after first use even if not full. The provider closed and disposed of the bin on the day of the inspection. We noted that sharps injury advice posters were not on display. The provider sent photographic evidence after the inspection that showed posters were now clearly displayed in all rooms.
- The practice engaged contract cleaners and we observed the premises to be clean and tidy. During our inspection we noted that the storage of colour-coded mops and buckets posed a potential risk of cross-contamination. After the inspection the provider sent evidence that it had reviewed the provision of cleaning and storage in line with guidance. We saw photographic evidence that mops and buckets were now segregated and did not pose a risk of cross-contamination.
- Arrangements for managing waste and clinical specimens kept people safe.
- There was a system in place for dealing with pathology results. Pathology specimens were sent to a professional laboratory for analysis. All specimens were collected by the laboratory directly from the service. Pathology results were accessed through a secure portal and results reviewed by the requesting consultant. The service had mechanisms in place to ensure consultants had communicated results with patients and acted upon findings. The provider told us there were effective lines of communication with the consultants and their secretaries in the management of patient results.

Risks to patients

Are services safe?

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

- The service had arrangements in place to respond to emergencies and major incidents in line with the Resuscitation Council (UK) guidelines. All staff had received annual basic life support training.
- The service had access to a defibrillator, oxygen with adult and children's masks and adrenaline. We asked the service, in relation to its provision of minor surgical procedures, if they had considered the availability of atropine, used to manage bradycardia (a slow heart rate). The service told us they had undertaken a risk assessment relative to the provision of minor surgical procedures at the premises and had concluded that their policy was to provide basic life support only which excluded the administration of atropine.
- There were no panic alarms installed in the clinical rooms to alert other staff in an emergency. Staff we spoke with told us they would call for help. We observed clinical rooms were in close proximity to the reception and waiting area and a shout for help would probably be heard.
- Doctors had professional indemnity insurance that covered the scope of their private practice.
- The clinic had a comprehensive business continuity plan in place for major incidents such as power failure or building damage which included contact details of staff.
- There were arrangements for planning and monitoring the number and mix of staff needed. Clinical and non-clinical staff rotas were prepared at least one month in advance by the clinic manager.

Information to deliver safe care and treatment

- Patients provided personal details at the time of registration which included their name, address, date of birth and contact telephone number.
- We saw that individual care records were written and managed in a way that kept patients safe. Patient records were stored securely using a bespoke electronic patient record (EPR) system. Access was password protected with restricted access dependant on role.
- The provider had systems for sharing information both internally and with other agencies to enable them to deliver safe care and treatment.
- The service had systems in place for seeking consent to share information with the patient's NHS GP, if applicable.

Safe and appropriate use of medicines

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

- There were dedicated medicines fridges and we saw daily temperature logs of maximum, minimum and current temperature were maintained and were within the recommended ranges. All medicines we reviewed were in-date. We saw that the service had not taken steps to avoid the accidental interruption of the electricity supply to the medicines fridges, for example via a hard-wire fuse or by placing cautionary notices on plugs and sockets. The provider sent photographic evidence after the inspection that notices had now been placed on the sockets.
- All private prescriptions were processed electronically and signed by the prescribing doctor.
- The provider did not hold any stocks of medicines for dispensing, including controlled drugs and did not prescribe any controlled drugs.

Track record on safety

The service had a good safety record.

- The service was operating from rented premises and maintenance and facilities management was shared by the landlord and the tenant.
- We saw evidence that the fire alarm warning system and firefighting equipment was regularly maintained by an external contractor. A weekly fire alarm warning system test was undertaken and logged. The service had nominated and trained two fire marshals. Fire evacuation tests were carried out six monthly by the landlord. All staff we spoke with knew the location of the fire evacuation assembly point and had undertaken fire awareness training. We saw fire procedure and evacuation guidance displayed in the waiting room.
- There was a health and safety poster in the kitchen which identified the health and safety leads for the location. Staff had access to a first aid kit and an accident book was available.

Are services safe?

- We saw that various risk assessments had been undertaken for the building, including health and safety, Control of Substances Hazardous to Health (COSHH), Legionella and fire. We saw evidence of annual lift maintenance.
- Portable appliance testing (PAT) had been undertaken in December 2017 and electrical wire testing in February 2018. Calibration of the medicines fridges had been undertaken in February 2018. However, we saw that a blood pressure monitor and pulse oximeter had not been included in the schedule. After the inspection the provider sent evidence that new medical equipment has been procured and all equipment would be tested as part of the annual schedule.

Lessons learned and improvements made

The service learned and made improvements when things went wrong.

- There was a system for recording and acting on significant events and incidents. There was an incident policy in place which was accessible to staff. Staff we spoke with understood their duty to raise concerns and report incidents and near misses.
- The service had recorded seven incidents in 2017 and eight to date in 2018. We saw that the service had adequately reviewed and investigated when things went wrong and took action to improve safety.
- We saw evidence from minutes of meetings that incidents had been discussed in staff meetings.
- Staff we spoke with were aware of and complied with the requirements of the Duty of Candour. They told us the service encouraged a culture of openness and honesty.
- There was a system for receiving and acting on safety alerts.

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment, care and treatment

The provider assessed needs and delivered care in line with relevant and current evidence-based guidance and standards such as the National Institute for Health and Care Excellence (NICE), the British Association of Dermatologists (BAD), the British Dermatological Nursing Group (BDNG) and the Primary Care Dermatology Society (PCDS) best practice guidelines.

- The provider captured patient information and consultation outcomes on a bespoke electronic patient record (EPR) system which included a comprehensive clinical history, patient melanoma risk assessment, screening and diagnostic data. The system was algorithm-based and required the completion of all sections in sequence before the system would allow the screening clinician to move to the next section. The provider told us this ensured all relevant clinical information was asked and recorded.
- We reviewed examples of medical records which demonstrated that patients were fully assessed and received care and treatment supported by clear clinical pathways and protocols.
- Clinical oversight of the service provision to ensure care and treatment was compliant with relevant guidelines and standards was monitored by the service's medical advisory committee which included a surgical and dermatology consultant and a dermatology specialist GP.

Monitoring care and treatment

There was evidence of quality improvement including clinical audit. For example, the service carried out ongoing monitoring of post-operative outcomes from minor surgical procedures and audit of predicted diagnosis against confirmed pathology diagnosis.

All malignant diagnoses were discussed in virtual multi-disciplinary learning groups which included screening nurses, doctor and an external pathologist. Cases were discussed from patient presenting to diagnosis to establish any learning outcomes and best practice. The service shared with us a recent case discussed.

The service had effective systems in place to monitor and follow-up on pathology results. All pathology results were saved in the patient's records.

Effective staffing

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

- We saw evidence that all clinical staff were registered with their appropriate professional body. For example, the General Medical Council (GMC) and the Nursing & Midwifery Council (NMC).
- All consultants working under practising privileges held NHS substantive positions.
- We saw evidence that all doctors engaged under practising privileges had a current responsible officer (all doctors working in the United Kingdom are required to have a responsible officer in place and required to follow a process of appraisal and revalidation to ensure their fitness to practise). All doctors were following the required appraisal and revalidation processes and were required to provide evidence to the service of an up-to-date NHS annual appraisal.
- The service had a comprehensive induction programme for all newly appointed staff, which included health and safety, fire safety awareness, information governance, infection control and incident reporting. We saw that role-specific induction was provided for staff. For example, screening nurses we spoke with told us this included theory and practical training on dermascopy and tele-dermatology, British Dermatology Nursing Group (BDNG) dermatology nursing competencies' assessment at four weeks, 12 weeks and annually thereafter by a consultant dermatologist, practical examination and shadowing by a senior screening nurse. Screening nurses had to be signed off as competent in all areas before seeing patient independently.
- There were arrangements in place for staff appraisals. All staff received a probationary appraisal review after six months and a full appraisal at 12 months.
- Staff told us clinical supervision was provided on a daily basis by the consultant team.
- The service could demonstrate role-specific training and updating for relevant staff. For example, dermascopy (a device used to examine the skin using light and magnification) training and biannual tele-dermatology (skin lesion diagnosis using digital images) training

Are services effective?

(for example, treatment is effective)

delivered by the Primary Care Dermatology Society. Nursing staff supporting consultants with minor surgical procedures had undertaken needlestick injury training and sepsis awareness.

- The service had identified mandatory training for both clinical and non-clinical staff which was completed during the probationary period and annually thereafter. For example, the nursing team were required to complete safeguarding children level one and two, safeguarding adults level one and two, basic life support, infection control fire safety awareness, health and safety, information governance and equality & diversity. We saw from training records that all staff had completed mandatory training to a level and frequency relevant to their role. Staff we spoke with told us they were allocated one hour protected time each week to undertake mandatory training updates, review any organisational policy updates and reflective practice.

Coordinating patient care and information sharing

The information needed to plan and deliver care and treatment was available to relevant staff in a timely and accessible way.

- The service had systems in place for seeking consent to share information with the patient's NHS GP, if applicable. The provider told us that if a patient declined consent to share information with their GP, but it was felt it was in the patient's best interest to share the information; a further discussion would take place at the consultation to gain consent.

Supporting patients to live healthier lives

Staff told us they were proactive in educating patients to be safe in the sun. The service had an array of patient information leaflets on a selection of skin conditions and information on their website. All patients were given a Cancer Research UK skin cancer, prevention and self-detection leaflet at the end of each screening consultation.

Consent to care and treatment

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

- All staff we spoke with understood and sought patients' consent to care and treatment in line with legislation and guidance, including the Mental Capacity Act 2005.
- The service had a consent policy and we saw documented examples of where consent had been sought for example for minor surgical procedures (under local anaesthetic).
- We were told that any treatment, including fees, was fully explained to the patient prior to the procedure and that people then made informed decisions about their care.
- There was comprehensive information on the service's website with regards the services provided and what costs applied.

Are services caring?

Our findings

We found that this service was providing caring services in accordance with the relevant regulations.

Kindness, respect and compassion

- We observed that staff treated service users with kindness, respect and compassion.
- Staff told us they respected the personal, cultural, social and religious needs of service users. We saw that employed staff had undertaken equality and diversity training.
- Arrangements were in place for a chaperone to be available if requested and we saw notices advising patients of this throughout the clinic.
- Service users were provided with timely support and information. We saw that consultants' out-of-hours contact details were provided with post-operative and wound care literature.
- We were unable to speak with patients on the day of the inspection. However, we received 18 CQC comments cards all of which were positive about the service experienced. Patients commented that the service offered a professional, caring and thorough service. Patients said staff were friendly, helpful and informative.
- The service proactively gathered feedback from patients after each consultation. Data provided for 1 June 2017 to 31 May 2018 showed that of the 403 responses received, 100% felt they were shown kindness, respect and compassion.
- Patient reviews on the service's website were all very positive about the service provided.

Involvement in decisions about care and treatment

- The service gave patients clear information to help them make informed choices which included comprehensive information on the service's website and a patient leaflet. Clear information regarding the cost of services was given on the service's website and when booking an appointment.
- Patient survey feedback from 1 June 2017 to 31 May 2018 showed that 100% (403 responses) of patients felt they were adequately involved in their care decisions and all their care questions were answered.
- We saw an array of patient information leaflets on skin conditions, preventative measures, such as how to stay safe in the sun, and guidance on skin lesion removal and post-operative wound care.
- There was an induction hearing loop available to aid those patients who were hard of hearing.
- The service had access to a formal interpreter and translation service if required. The service told us they have not needed to access this service.

Privacy and Dignity

- Staff we spoke with recognised the importance of patients' dignity and respect. It was clinic policy to ask all patients how they would like to be addressed during their consultation and we observed this during our inspection.
- Data from patient survey feedback from 1 June 2017 to 31 May 2018 showed that 100% (403 responses) of patients felt their privacy and dignity was respected.
- Curtains were provided in the consulting room to maintain patients' privacy and dignity during examinations, investigations and treatments. We observed consultation room doors to be closed during consultations and conversations could not be overheard in the waiting area.
- The service had an information governance policy in place and there were systems to ensure that all patient information was stored and kept confidential. The service employed a Systems and Data Manager who was the Information Governance Lead and responsible for oversight of the bespoke electronic patient record (EPR) system.
- We saw that employed staff had undertaken information governance training and had signed a confidentiality agreement.
- The service complied with the Data Protection Act 1998 and was registered with the Information Commissioner's Office (ICO) which is a mandatory requirement for every organisation that processes personal information.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

The service met patients' needs through the way it organised and delivered services. It took account of patient needs and preferences.

- The facilities and premises were appropriate for the services delivered. All patients were offered and had access to refreshments. The service was located on the second floor with lift access. The service told us that its location at Moorgate was on ground level so any patients with reduced mobility and or requiring assistance would be advised of the alternative location at the time of booking.
- Patient security had been considered and there was a door buzzer controlled entry system. The waiting area was visible from the reception area. All staff wore name badges.
- Information about the clinic, including services offered and fees, was on the clinic's website. A patient leaflet and information about treatments offered were available in the waiting area and consulting rooms.

Timely access to the service

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

- Appointments were available on a pre-bookable basis. The service offered pre-bookable face-to-face appointments to patients aged 18 years and over.
- Patients could access appointments on Monday and Wednesday from 8am to 7pm, Tuesday, Thursday and Friday from 8am to 5pm and Saturday from 10am to 4pm.
- We saw that the standard appointment duration for a mole check was 45 minutes and for mole removal and consultation was 40 minutes.

Listening and learning from concerns and complaints

The service had a system in place for handling complaints and concerns.

- The service had a complaints policy and there were procedures in place for handling complaints. This included timeframes for acknowledging and responding to complaints with investigation outcomes.
- There was a designated responsible person to handle all complaints. Information about how to make a complaint was available to patients in the clinic and on its website. The service subscribed to the Independent Sector Complaints Adjudication Service (ISCAS). We saw that complaint's guidance included information on how to escalate a complaint if dissatisfied with the response.
- The service had recorded 17 complaints in the last year. We found that they were satisfactorily handled in a timely way and we saw evidence of learning.
- We saw evidence from minutes of meetings that incidents had been discussed in staff meetings.

Are services well-led?

(for example, are they well-managed and do senior leaders listen, learn and take appropriate action?)

Our findings

We found that the service was providing well-led care in accordance with relevant regulations.

Leadership capacity and capability

The management team had the capacity and skills to deliver high-quality, sustainable care.

- The management and clinical team had the experience, capacity and skills to deliver the service strategy and address risks to it.
- They were knowledgeable about issues and priorities relating to the quality and future of services.
- The clinic manager was visible and approachable. They worked closely with staff and others to make sure they prioritised compassionate and inclusive leadership.

Vision and strategy

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

- The provider told us it prided itself on a highly personalised, caring journey for all its patients. The service mission, to educate the public about the importance of avoiding excessive ultraviolet exposure, was outlined on its website. The service told us its vision was to significantly reduce the mortality rate of skin cancer in the UK by increasing rates of early detection.
- There was a realistic strategy and business plan to achieve priorities.
- The service monitored its progress against delivery of the strategy.

Culture

The clinic had a culture of high-quality sustainable care.

- Staff we spoke with told us they felt respected, supported and valued. They told us they were proud to work at the service. The service focused on the needs of patients.
- All staff we interviewed spoke highly of the team spirit and commented that there was an open door policy and the management team were visible and approachable.
- The provider was aware of and had systems to ensure compliance with the requirements of the duty of candour. (The duty of candour is a set of specific legal requirements that providers of services must follow when things go wrong with care and treatment).
- Staff we spoke with told us there was a culture of openness, honesty and transparency when responding to incidents and complaints.
- There were processes for providing all staff with the development they need. This included appraisal, training and career development conversations.
- There provider told us there was an emphasis on staff wellbeing, for example it offered flexible working and funded regular social events.

Governance arrangements

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

- There was a clear management and staffing structure and staff we spoke with told us they were aware of the management structure and their own roles and accountabilities within the service. We saw staff had lead roles, for example, infection control, complaints and safeguarding.
- Clinical oversight to ensure care and treatment was compliant with relevant guidelines and standards was monitored by the service's medical advisory committee which included a surgical and dermatology consultant and a dermatology specialist GP. The group approved all appointments of doctors under a practising privileges agreement.
- Operational and Care Quality Commission compliance was overseen by the clinic manager, an independent compliance consultant and the service's board of directors.
- All staff had access to an operational handbook which outlined the mandatory systems, training and resources required to ensure the service was compliant and could demonstrate safe, effective, caring, responsive and well-led care. This handbook was underpinned by the service's policies and procedures. We reviewed several policies and noted not all were service-specific. The provider told us these were currently under review.

Managing risks, issues and performance

Are services well-led?

(for example, are they well-managed and do senior leaders listen, learn and take appropriate action?)

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

- The service carried out premises risk assessments which included health and safety and fire.
- Performance of employed clinical staff could be demonstrated through audits of their consultations and annual competency assessment and training updates.
- Clinical audit was used to monitor care and outcomes for patients.
- We saw evidence of regular clinical and staff meetings, one-to-one meetings, supervision and appraisals. There was a set range of mandatory training areas staff were required to undertake.
- The provider had plans in place to deal with major incidents.

Appropriate and accurate information

Appropriate, accurate information was effectively processed and acted upon.

- Patient consultations and treatments were recorded on a secure electronic system.
- There were robust arrangements in line with data security standards for the availability, integrity and confidentiality of patient identifiable data, records and data management systems.

Engagement with patients, the public, staff and external partners

The service engaged and involved patients and staff to support high-quality sustainable services.

- The service encouraged and valued feedback from patients and had a system in place to gather feedback from patients on an on-going basis.
- The provider actively engaged with staff through one-to-one meetings, staff meetings and appraisals. All staff had access to an intranet dashboard which was a platform for group discussion and management, human resource and operational documentation. All staff we spoke with utilised this resource.
- Staff told us the service responded to feedback from the team and some changes had been implemented which improved patient outcomes. For example, changing to a more effective post-operative water-resistant wound adhesive which enabled patients to shower more quickly post-operatively.
- Staff told us the provider funded regular social events which included an annual lunch and dinner.

Continuous improvement and innovation

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

- The practice made use of reviews of incidents and complaints. Learning was shared and used to make improvements.
- Leaders and managers encouraged staff to take time out for reflective learning to review individual and team objectives, processes, performance and training and all staff had one hour protected time each week.
- The service was technology and data-driven and further enhancements to its bespoke electronic patient record (EPR) were planned to improve patient experience and outcomes.