Inspection Report

3 July and 17 September 2025

The Belfast Skin Clinic

Type of service: Independent Hospital - Cosmetic Laser\Intense Pulsed Light and Private Doctor
Address: 18 Deramore Drive, Belfast, BT9 5JQ
Telephone number: 028 9066 7077

Information on legislation and standards underpinning inspections can be found on our website https://www.rqia.org.uk/, The Independent Health Care Regulations (Northern Ireland) 2005 and the Minimum Care Standards for Independent Healthcare Establishments (July 2014)

1.0 Service information

Organisation/Registered Provider: The Belfast Skin Clinic Ltd **Responsible Individual:** Dr Pamela McHenry	**Registered Manager:** Ms Karen Moffett **Date registered:** 16 November 2017
Person in charge at the time of inspection: Dr Pamela McHenry	
Categories of care: Independent Hospital (IH) Prescribed techniques or prescribed technology: establishments using Class 3B or Class 4 lasers PT(L); Prescribed techniques or prescribed technology: establishments using intense light sources PT(IL) and Private Doctor (PD)	
Brief description of how the service operates: The Belfast Skin Clinic is registered as an independent hospital (IH) with a private doctor, cosmetic laser and intense pulse light categories of care. The hospital provides a wide range of services and treatments, including outpatient clinics, diagnostic tests and investigations and some surgical day case procedures. The range of specialties includes dermatology, plastic surgery, rheumatology and vascular. In addition, the clinic also provides a range of aesthetic treatments. There are no overnight beds provided in The Belfast Skin Clinic.	

2.0 Inspection summary

This was an announced variation to registration inspection undertaken by two care inspectors on 3 July 2025 from 10.00 am to 4.30 pm and on 17 September 2025 from 9.30 am to 12.30 pm. An RQIA estates inspector accompanied the care inspectors on 3 July 2025 regarding matters relating to the premises.

A medicines self-assessment was completed in relation to the variation to registration application and following review by a pharmacist inspector, no further actions were identified.

The purpose of the inspection was to review the day surgical procedures undertaken in The Belfast Skin Clinic. During the inspection, the inspectors reviewed a number of policies and procedures relating to the variation to registration application. The inspectors also reviewed the clinical environment from which the day surgical procedures are performed.

Based on the findings of the inspection and discussions held with Dr McHenry, Responsible Individual and Ms Moffett, Registered Manager, the variation to registration application has now been approved from a care and estates perspective.

3.0 How we inspect

RQIA is required to inspect registered services in accordance with legislation. To do this, we gather and review the information we hold about the service, examine a variety of relevant records, meet and talk with staff and management and observe practices on the day of the inspection.

The information obtained is then considered before a determination is made on whether the practice is operating in accordance with the relevant legislation and minimum standards.

Before the inspection a range of information relevant to the registration application was reviewed. This included the following records:

- the variation to registration application
- the proposed statement of purpose
- the proposed patient guide
- current and proposed floor plans
- documents pertaining to the premises
- the previous inspection report

During the inspection the inspectors met with Dr McHenry, Ms Moffett and several staff members.

Examples of good practice were acknowledged and any areas for improvement have been discussed with the person in charge and are detailed in the quality improvement plan (QIP).

4.0 The inspection

4.1 What action has been taken to meet any areas for improvement identified at or since last inspection?

The last inspection to The Belfast Skin Clinic was undertaken on 26 March 2025; no areas for were identified.

4.2 Inspection findings

4.2.1 Has the statement of purpose been developed in keeping with Regulation 7 Schedule 1 of the regulations?

A review of the statement of purpose identified that it reflected the key areas and themes specified in Regulation 7, Schedule 1 of The Independent Health Care Regulations (NI) 2005. Ms Moffett is aware that the statement of purpose should be reviewed and updated as and when necessary.

4.2.2 Has the patient guide been developed in keeping with Regulation 8, of the regulations?

A review of the patient guide identified that it reflected the key areas and themes specified in Regulation 8 of The Independent Health Care Regulations (NI) 2005. Ms Moffett is aware that the patient guide should be reviewed and updated as and when necessary.

4.2.3 Does the hospital have appropriately qualified and skilled staff in place?

The arrangements in respect of the recruitment and selection of staff were reviewed. A recruitment and selection policy and procedure was in place, which adhered to legislation and best practice guidance.

Separate staff registers for medical, nursing and administrative staff were in place that included all information as listed in The Independent Health Care Regulations (NI) 2005.

Discussion with staff confirmed that there were sufficient staff in various roles to fulfil the needs of the hospital and patients.

Ms Moffett confirmed that several staff members had been recruited since the previous inspection. A review of a selection of newly recruited staff members' personnel files identified that all information as listed in Regulation 19, Schedule 2 of The Independent Health Care Regulations (NI) 2005 had been sought and retained.

Ms Moffett confirmed that job descriptions have been issued to new staff on commencement of employment.

It was confirmed that staff inductions had been undertaken for newly recruited staff however, a record of the inductions had not been retained in some of the personnel files reviewed. This was discussed and Ms Moffett was advised to ensure that induction records are retained on file and signed by the inductee and inductor when completed.

A review of a sample of records and discussion with staff evidenced that supervision has been completed on a regular basis and appraisals had been completed on an annual basis. Staff reported that they were well supported and fully involved in discussions about their personal and professional development.

A training matrix was in place to monitor the status of staff training requirements. It was advised that the training matrix for all grades of staff clearly identifies training undertaken in relation to both adult and child safeguarding. Ms Moffett agreed to action this following the inspection.

A review of training records evidenced that not all staff had completed mandatory training in keeping with the RQIA training guidance. Following the inspection it was confirmed that a system had been implemented to ensure that all staff have completed training in keeping with the RQIA training guidance, CPD and in accordance with their role within the hospital.

It was demonstrated that there is a robust system in place to review the registration details of all health and social care professionals with their professional bodies. Records were available for review in this regard.

Appropriate staffing levels were in place to meet the needs of patients.

As a result of the actions taken during and following the inspection it was determined that staff were suitably trained to carry out their duties.

4.2.4 Are there safe practices in place for the provision of day surgery services?

Ms Moffett submitted an email to RQIA following the inspection on 2 October 2025 to confirm the list of surgical procedures that are undertaken in The Belfast Skin Clinic.

Dr McHenry and Ms Moffett are aware that prior to The Belfast Skin Clinic offering additional surgical procedures they must consult with RQIA.

We reviewed the arrangements for the provision of day surgery in the hospital outlined under the statement of purpose. It was confirmed that the hospital provides day surgical services under local anaesthesia only, as appropriate. No procedures are undertaken using intravenous sedation or using a general anaesthetic.

The scheduling of patients for day surgery procedures is co-ordinated by the administration team with the full involvement of the consultant performing the surgical procedures and nursing staff. Scheduling takes into account individual patient requirements, staffing levels, the nature of the procedure and any associated risks.

The patient meets with the consultant for assessment and to commence the consent process in advance of the day of surgery. The patient receives information about the procedure and any preparation necessary in advance. The consent process is completed by the consultant carrying out the procedure as part of the admission process.

Ms Moffett was advised to ensure that there is an identified member of nursing staff, with relevant experience, in charge during all procedures which should be formally recorded. The Belfast Skin Clinic gave assurances on this matter. During the inspection on 17 September 2025, it was observed that a white board had been installed in the theatre which outlined salient information including details of the nurse in charge. The nurse in charge is also captured on the duty rota.

During the inspection on 3 July 2025, it was noted that a surgical safety checklist based on World Health Organisation (WHO) guidance was not formally in use, however staff confirmed its principles were adhered to in practice. The requirement to formally devise and implement a surgical safety checklist was outlined and the management and staff gave assurances on this matter. During the inspection on 17 September 2025, it was noted that a surgical safety checklist had been devised, however had not yet been implemented as management were awaiting an information technology update to the patient records.

An active discussion took place and inspectors outlined that the immediate full implementation of the surgical safety checklist must be actioned. The management confirmed that the surgical safety checklist had been included in patient records and would be implemented during the afternoon's theatre list and going forward for all surgical procedures; and that staff had been fully briefed on this matter. It was confirmed that completion of the surgical safety checklist will be routinely audited through the hospital's auditing process.

It was confirmed that patients are observed during and after the procedure by appropriately trained staff. During the inspection on 3 July 2025 it was noted that a robust discharge procedure with clear discharge criteria was not in place and there was a very limited record of the patient's

discharge in the patient record. Advice was provided on this matter and as a result during the inspection on 17 September 2025 a clear discharge procedure had been devised and a discharge checklist had been included in the patient records. However, staff confirmed that this had not been fully implemented. The inspectors outlined clearly the requirement to fully implement this procedure and update patient records as a priority. Management confirmed this matter had been addressed for patients on the afternoon theatre list and all surgical patients going forward. Staff confirmed that patients will be discharged in accordance to discharge criteria by the nursing staff directly from the theatre. It was confirmed that if there were any concerns about the patient's condition, the consultant would immediately be informed for ongoing management. Patients are provided with clear, post procedure advice, information on follow up and who to contact in the event of a post treatment emergency.

A surgical register is required to be maintained for all procedures undertaken in the hospital. Surgical registers were noted to be well completed for all surgical procedures.

Management confirmed that patient care pathway records had been reviewed in light of findings outlined during the inspection on 3 July 2025. It was confirmed that going forward they would provide a record of admission, medical history, infection status, medication, observations on admission, pre-procedure checklist, WHO surgical safety checklist, intra-procedure details, traceability details, post procedure observations and discharge record.

During the inspection on 3 July 2025, discussions on the use of a venous thromboembolism (VTE) risk assessment with management and staff noted that there was no written policy or VTE risk assessment in place. It was confirmed during the inspection on 17 September 2025 that a written VTE policy had been devised and the consultant carrying out the surgical procedure would give due consideration to individual patients on this matter and it would be recorded in the patient records.

Supplies of sterile instrument packs are obtained from an approved sterile services department under contract from a health and social care trust. There are robust measures in place to monitor the traceability of all surgical instruments used in the hospital. Clinical equipment was evidenced to be clean and fit for purpose.

During the inspection on 3 July 2025 it was noted that there were limited policies and procedures in place to support the provision of surgical services. Advice was provided on this matter and as a result during the inspection on 17 September 2025 a range of comprehensive policies and procedures had been developed to ensure that safe and effective care is provided to patients, in accordance with good practice guidelines and national standards. This included a standard operating procedure for surgical procedures, emergency transfer out policy, VTE policy, procedure on use of electro surgery, massive blood loss policy and an updated infection prevention and control (IPC) policy.

On review of IPC measures in the theatre area on 3 July 2025, it was advised that an IPC external advisor carry out a comprehensive IPC audit to assess the flow through the theatre area. An IPC audit was conducted on 21 August 2025 by an external IPC advisor for all areas of the hospital and a detailed report had been issued. It was confirmed that the deputy manager had devised an action plan to address the recommendations made by the IPC advisor to enhance and continue good IPC practices in The Belfast Skin Clinic. It was advised that management sign off the individual recommendations in the IPC report for completeness and management gave assurances on this matter.

As a result of findings on 3 July 2025 inspection, it was confirmed that nursing staff have undertaken aseptic non-touch technique training (ANTT) during August and September 2025.

There were procedures for the collection, labelling, storage, preservation, transport and administration of specimens. Staff clearly described these procedures and the procedure for reporting results to the appropriate clinical staff and the patient's General Practitioner (GP). It was confirmed there is a contract in place with an accredited pathology laboratory service. The pathology services will be subject to internal audit.

It was determined that there are safe practices in place for the provision of the surgical service.

4.2.5 Are the premises fit for the purpose of providing safe and effective care?

The documentation presented during and subsequent to the inspection confirmed that the premises, engineering services and equipment have been installed and commissioned in line with relevant legislation, approved code of practice and best practice guidance.

The fire risk assessment and legionella risk assessment documents had been reviewed and found to be acceptable.

The premises was inspected and found to be compliant with current Department of Health minimum standards.

From an estates perspective RQIA were satisfied that the premises are suitable to meet the aims and objectives, as described in the facilities statement of purpose.

4.2.6 Are robust arrangements in place regarding clinical and organisational governance?

Organisational Governance

The Belfast Skin Clinic Limited includes one director, who is Dr McHenry, Responsible Individual. Organisational governance systems were in place and there was a clear organisational structure within the hospital.

Where the business entity operating an establishment registered with us is a corporate body or partnership or an individual owner who is not in day to day management of the establishment, unannounced quality monitoring visits by the responsible individual must be undertaken and documented every six months; as required by Regulation 26 of The Independent Health Care Regulations (Northern Ireland) 2005.

Ms Moffett confirmed that as the registered manager she is in day to day charge of the clinic supported by Dr McHenry. Dr McHenry works in the clinic two or three days each week and is fully involved with the day to day management of the establishment, therefore in this case Regulation 26 unannounced quality monitoring visits are not required.

Ms Moffett discussed the arrangements in place regarding daily, weekly, quarterly and six monthly meetings that include all departments within the hospital and a selection of the meeting minutes were available to review. Ms Moffett confirmed that information is cascaded to staff at these meetings and also by email on a regular basis.

Staff working within the hospital confirmed that there were good working relationships and that management were responsive to any suggestions or concerns raised.

Policies and procedures were available for staff reference and discussion with Ms Moffett confirmed that a structure is in place to ensure that policies are being reviewed in a systematic manner. Staff reported they were aware of the policies and how to access them.

The Competition and Markets Authority (CMA) requires all hospitals and consultants offering private treatment to submit data to Private Healthcare Information Network (PHIN) as the Information Organisation for private healthcare. This enables people considering private healthcare with clear information to help them make an informed choice of which consultant and hospital is right for them. This was discussed and Dr McHenry was advised to action this as required.

Clinical and Medical Governance

The clinical team who provide the surgical procedures in The Belfast Skin Clinic include a number of specialist doctors registered with the General Medical Council (GMC), nurses who are registered with the Nursing and Midwifery Council (NMC) and they are supported by health care assistants, administration staff and management.

Ms Moffett confirmed that there is a weekly management meeting and the medical advisory committee (MAC) within the hospital meets on a quarterly basis. Clinical and medical governance within the hospital is overseen by Dr McHenry and the MAC. It was established that the MAC meetings consist of Dr McHenry, Ms Moffett and some of the medical staff. The minutes of the most recent MAC meetings, held during June and September 2025, were reviewed. We advised that the MAC terms of reference should be further developed to include a review of training undertaken by medical staff in keeping with the RQIA training guidance, CPD and in accordance with the role of the staff member. Where there are issues raised regarding staff not attending training or providing evidence of training undertaken, arrangements should be made to undertake extraordinary MAC meetings to discuss any corrective action required. During the inspection on 17 September 2025 Dr McHenry and Ms Moffett agreed to action this accordingly.

A private doctor is a medical practitioner who is not affiliated with the Health and Social Care (HSC) sector in Northern Ireland (NI) and/or is not on the General Practitioner's (GPs) performer list in NI. This was discussed with Ms Moffett and Dr McHenry. Advice and guidance was provided to ensure a system is in place to accurately reflect the number of private doctors working in The Belfast Skin Clinic.

A review of the details of a selection of private doctor records evidenced that the following had been sought:

- confirmation of identity
- current GMC registration
- qualifications in line with the surgical service provided
- ongoing professional development and continued medical education that meets the requirements of the Royal Colleges and GMC
- ongoing annual appraisal by a trained medical appraiser
- arrangements for revalidation
- professional indemnity insurance

Appraisal is a key part of revalidation and includes the appraisee providing evidence of their individual CPD activities undertaken in accordance with the GMC Good Medical Practice (2024) guidance. A review of records and discussion with Ms Moffett confirmed that the hospital retains a copy of each doctor's annual appraisal document.

In accordance with the GMC all doctors must revalidate every five years. The revalidation process requires doctors to collect examples of their work to understand what they are doing well and how they can improve. As part of the revalidation process, responsible officers (RO) make revalidation recommendations to the GMC. Where concerns are raised regarding a doctor's practice information must be shared with their RO who then has a responsibility to share this information with all relevant stakeholders in the areas of the doctor's work.

Ms Moffett confirmed that all of the doctors who work in The Belfast Skin Clinic have an appointed RO however, during the inspection on 17 September 2025 there was no evidence of the details of an appointed RO in one of the doctor's records reviewed. This was discussed and following the inspection RQIA received confirmation that the identified private doctor had an appointed RO and the details were now retained on file. Ms Moffett was advised to develop a more robust system to ensure that all medical staff who work in the hospital have an appointed RO. Arrangements should be in place to link into the wider system of RO's for doctors with practising privileges who work in other parts of the NI healthcare system or in other healthcare systems beyond NI.

Whilst it is the responsibility of GMC registrants to keep up to date with their CPD activities, the CPD learning activities may not meet with legislative mandatory training such as fire safety, safeguarding adults, children and young people, infection prevention and control and resuscitation. As previously discussed a system had been implemented to ensure that all staff have completed training in keeping with the RQIA training guidance, CPD and in accordance with their role within the hospital.

Practising Privileges

The only mechanism for a medical practitioner to work in a registered independent hospital is either under a practising privileges agreement or through direct employment by the hospital. Ms Moffett informed us that some of the medical practitioners are directly employed and have a contract of employment while others have a practising privileges agreement in place.

A policy and procedural guidance for the granting, review and withdrawal of practicing privileges agreements was in place.

It was confirmed that practising privileges can only be granted when full and satisfactory information has been sought and retained in respect of each of the records specified in Regulation 19 of The Independent Health Care Regulations (Northern Ireland) 2005, as amended. It was noted that the practising privileges application also includes a requirement to demonstrate completion of specific areas of mandatory training.

A review of a sample of medical practitioner's records evidenced that there was a written practicing privileges agreement between medical practitioners and The Belfast Skin Clinic setting out the terms and conditions which had been signed by both parties.

Discussion with Dr McHenry and Ms Moffett demonstrated that good oversight arrangements of the granting of practicing privileges agreements were in place and provided assurance of robust medical governance arrangements within the organisation.

Quality assurance

Arrangements were in place to monitor, audit and review the effectiveness and quality of care and treatment delivered to patients at appropriate intervals.
Significant incidents and themes reported are discussed at the MAC and manager's meetings.

There was a robust programme for internal audit to monitor compliance with policies and processes. Audits are completed monthly, quarterly and annually and the results are monitored by Ms Moffett. Where required, an action plan is developed to address any shortfalls identified during the audit process. Actions identified for improvement are embedded into practice.

A procedure for the dissemination and implementation of regional and national guidance, urgent communications, safety alerts and notices was in place to ensure all patient safety communications received were distributed and actioned appropriately in a timely manner.

Notifiable Events/Incidents

A policy for the management and reporting of clinical risks, incidents and near misses and a policy for the management of national safety alerts were in place.

During the inspection on 3 July 2025 the minutes of the MAC meeting were reviewed. It was identified that a notifiable incident had occurred in the hospital since the previous inspection. RQIA had not been notified in accordance with the RQIA Statutory Notification of Incidents and Deaths. Ms Moffett confirmed that the incident had been effectively documented and investigated and agreed to submit a retrospective notification to RQIA regarding this incident and to also inform the relevant appropriate bodies as required. Following the inspection on 3 July 2025 RQIA received confirmation that this had been actioned accordingly. Ms Moffett is aware that all relevant incidents that occur in the future should be reported to RQIA and other relevant organisations in accordance with legislation and RQIA Statutory Notification of Incidents and Deaths.

Ms Moffett confirmed that any learning from incidents would be discussed with staff. There was a process in place to analyse incidents and events to detect actual or potential trends or weakness in a particular area in order that a prompt and effective response can be considered at the earliest opportunity.

As previously mentioned significant incidents and themes reported are discussed at the MAC and manager's meetings.

Complaints Management

A copy of the complaints procedure was available in the hospital and was found to be in line with the relevant legislation.

Discussion with staff confirmed that a copy of the complaints procedure is made available for patients/and or their representatives on request and staff demonstrated a good awareness of complaints management.

A review of the complaints audit confirmed that a number of complaints had been received since the previous inspection and had been investigated and responded to appropriately to include details of all communications with complainant; the result of any investigation; the outcome and any action taken.

It was confirmed that any learning coming out of a complaint is disseminated across all staff groups to drive improvement in the quality of this service, which staff confirmed during the inspection.

The management of complaints is reviewed regularly, a six monthly audit of complaints is undertaken to identify trends or themes emerging at an early stage. A review of complaints is included as standing agenda item for the MAC meetings.

Risk Management

Systems were in place to support good risk management within the hospital. This ensures that the likelihood of adverse incidents, risks and complaints are minimised by effective identification, prioritisation, treatment and management.

Risks were documented, collated and tracked through the use of a risk register which provided assurance about the effective identification and management of risk.

The policies and procedures surrounding clinical and organisational governance arrangements were reviewed and discussed with Ms Moffett.

It was demonstrated that there was a clear management structure with defined lines of responsibility and accountability for the different services provided at the establishment.

5.0 Quality Improvement Plan/Areas for Improvement

This inspection resulted in no areas for improvement being identified. Findings of the inspection were discussed with Dr McHenry and Ms Moffett as part of the inspection process and can be found in the main body of the report.

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