

Inspection Report

27 May 2026



Cathedral Dermatology

Type of service: Independent Hospital (IH) – Surgical services (day cases only),
Private Doctors (PD)

Address: 1 Boucher Crescent, Belfast, BT12 6QU

Telephone number: 028 9032 2020

www.rqia.org.uk

Assurance, Challenge and Improvement in Health and Social Care

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: Cathedral Eye Ltd	Registered manager: Ms Joyce Shaw
Responsible individual: Professor Jonathan Moore	Date registered: 28 August 2025
Person in charge at the time of inspection: Ms Joyce Shaw	
Categories of care: Independent Hospital (IH): (PD) Private Doctor (AH(DS)) Acute hospitals (day surgery only)	
Brief description of how the service operates: Cathedral Dermatology is registered with the Regulation and Quality Improvement Authority (RQIA) as an independent hospital (IH) with private doctor (PD) and acute hospitals (day surgery only) AH (DS) categories of care. Cathedral Dermatology provides minor dermatology surgical services to persons over 18 year old on a day case basis provided by a private doctor. Minor surgery services are provided under local anaesthetic only. Cathedral Dermatology also provides a range of aesthetic treatments and other nurse led services. This inspection focused solely on minor surgical procedures and the private doctor service that fall within regulated activity and the categories of care for which the establishment is registered with RQIA.	

2.0 Inspection summary

A short notice announced inspection was undertaken to Cathedral Dermatology by two care inspectors on 27 May 2026 from 10.00 am to 4.00 pm. Feedback of the onsite inspection findings was delivered to Ms Shaw registered manager on the day of the inspection.

This inspection focused on three main key themes: organisational and clinical governance; the safe practice for provision of day surgery services, infection prevention and control (IPC) arrangements and staffing arrangements.

Examples of good practice were evidenced in patient safety in respect of the management of the patients' care pathway; and engagement to enhance the patients' experience.

No concerns were identified in relation to patient safety and the inspection team noted areas of strength, particularly in relation to the delivery of front line care.

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.

Prior to the inspection we reviewed a range of information relevant to the hospital. This included the following records:

- notifiable events since the previous care inspection
- the registration status of the hospital
- written and verbal communication received since the previous care inspection
- the previous care inspection report

The inspection team undertook a tour of the premises and the inspection was facilitated by Ms Shaw and the quality and clinical governance manager.

During the inspection we spoke with Ms Shaw registered manager, the quality and clinical governance manager and the lead nurse.

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

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

4.0 What people told us about the service?

Posters were issued to Cathedral Dermatology by RQIA prior to the inspection inviting patients and staff to complete an electronic questionnaire.

Seven service users submitted responses indicating that they felt the care provided was safe and effective, compassionate and that the service was well led. Six respondents indicated that they were either satisfied or very satisfied with each of these areas of care and commented on the outstanding service provided, the attentive and professional staff and that they would highly recommend this service. One respondent indicated a degree of dissatisfaction with some of these areas of care and commented that interaction could be improved.

No staff responses were submitted.

Through discussion with a number of staff who have differing roles and responsibilities it was determined that staffing levels and morale were good with evidence of good multidisciplinary team working and effective communication between staff.

5.0 The inspection

5.1 What has this service done to meet any areas for improvement identified at or since last inspection?

The last inspection to Cathedral Dermatology was undertaken on 6 August 2025; no areas for improvement were identified.

5.2 Inspection outcome

5.2.1. Organisation and clinical governance

It was demonstrated that there was a clear management structure with defined lines of responsibility and accountability. Policies and standard operating procedures were in place to support practice on the organisation's intranet that was accessible to all staff.

Cathedral Dermatology management team described an effective governance structure that provides a process and system of accountability to support the delivery of good quality service and to monitor and maintain high standards of care.

Where the business entity operating an establishment registered with RQIA 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. It was identified that the six monthly unannounced quality monitoring visits required to be completed.

This matter was discussed with Ms Shaw and following the inspection, RQIA received a copy of the report created by Professor Moore.

A joint medical advisory committee (MAC) with Cathedral Eye Clinic had been established which meet quarterly with responsibility for surgeon performance and surgery specific matters. Advice and guidance was provided to Ms Shaw to ensure that representation at these meetings included consultants from both establishments who was receptive to this advice. Ms Shaw and the internal human resource staff monitor individual consultant files, checking registration with the GMC, professional indemnity and appraisals.

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.

Practising privileges can only be granted or renewed 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.

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

A review of the private doctor records evidenced that there were written practising privileges agreements between the doctors and Cathedral Dermatology, setting out the terms and conditions which had been signed by Professor Moore. Advice and guidance was provided to Ms Shaw to ensure that the practising privileges agreements were reviewed and signed by both parties at least every two years and to ensure that the agreements were specific to Cathedral Dermatology. Following the inspection, RQIA received confirmation that these matters had been addressed.

Discussion with the Cathedral Dermatology management team demonstrated the oversight arrangements of the granting of practicing privileges agreements and providing assurance of robust medical governance arrangements are in place.

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.

This includes a range of governance meetings attended by representatives from the senior management team and clinical staff. Agenda items include clinical governance, quality, risk, compliance and audit. Significant incidents and themes reported will be discussed at the organisation's clinical governance meetings, staff meetings and at the MAC.

A system was also in place to ensure that urgent communications, safety alerts and notices will be reviewed and where appropriate, made available to key staff in a timely manner. A risk register was in place and arrangements in place for regular review.

Notifiable Events/Incidents

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

Cathedral Dermatology management team confirmed that any learning from incidents are discussed with staff. There was a process in place for analysing incidents and events to detect potential or actual 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 organisation's clinical governance meetings and medical advisory and health and safety committees.

Complaints Management

A copy of the complaints procedure was available in the hospital and was found to be in line with the relevant legislation and the Department of Health (DoH) guidance on complaints handling.

Cathedral Dermatology management team confirmed that a copy of the complaints procedure is made available for patients and their representatives on request and staff demonstrated a good awareness of complaints management.

A review of the complaints audit confirmed that all complaints received since the previous inspection had been investigated and responded to appropriately to include details of all communications with complainants; 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.

Observation of insurance documentation confirmed that current insurance policies were in place.

Overall, the governance structures within the hospital provide the required level of assurance to the senior management team and the MAC.

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

The inspectors reviewed the arrangements for the provision of day surgery services in the hospital outlined under their statement of purpose and categories of care. The review of these arrangements evidenced that the service operates in accordance with best practice and national standards to ensure care delivery is safe and effective. It was confirmed that the hospital provides a limited day dermatology surgical service under local anaesthesia as appropriate. No procedures are undertaken using intravenous sedation or using a general anaesthetic. It was confirmed that surgical services are provided to over 18 year olds only.

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

The patient will meet with the consultant dermatologist for assessment and to commence the consent process in advance of the day of surgery. The patient will receive information about the procedure and any preparation necessary in advance, together with the consent form.

The consent process is completed by the consultant carrying out the procedure as part of the admission process. Patients will be admitted to the treatment room and will receive local anaesthesia which is provided by a consultant dermatologist.

An identified member of nursing staff, with relevant experience, is in charge during all procedures. Staff complete a surgical safety checklist based on World Health Organisation (WHO) guidance and compliance is routinely audited through the hospital's auditing process.

It was confirmed that patients will be observed during and after the procedure by appropriately trained staff.

Patients are discharged in accordance to discharge criteria by the nursing staff directly from the treatment room. It was confirmed that if there were any concerns about the patient's condition, the consultant would be immediately informed for ongoing management. Patients are provided with clear, post procedure information on follow up and who to contact in the event of a post treatment emergency.

A Surgical register was in place and was found to be well recorded in accordance with regulation. It was confirmed that no surgical assistants were used in the hospital.

Supplies of sterile instrument packs and reprocessed instruments 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 clinic. Clinical equipment was evidenced to be clean and fit for purpose, and traceability labels were used to identify when equipment had been cleaned.

A wide range of comprehensive policies and procedures were in place to ensure that safe and effective care is provided to patients, which are in accordance with good practice guidelines and national standards. Advice was given to develop a written procedure in relation to the use of surgical diathermy (electro surgery) and consider providing a fire blanket in theatre as part of the safeguards in relation to the use of diathermy. Following the inspection, RQIA received evidence that this matter had been actioned.

Patient care pathway records were reviewed and found to provide a framework for the record of admission, medical history, infection status, medication, WHO surgical safety checklist and intra-procedure details. It was advised to further develop the patient record to include the nurse's role and provide evidence of an admission and discharge process. Following the inspection, RQIA received evidence that this matter had been actioned.

It was confirmed that due consideration would be given to individual patients on the use of a venous thromboembolism (VTE) risk assessment and this is recorded in the patient record.

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.

An emergency trolley is located in theatre and checked daily by nursing staff. Emergency medicines, oxygen and equipment were all in date and clear stock control is in place. Medical emergencies were discussed including the management of massive blood loss emergency. It was noted that there was a separate massive blood loss tray in place.

As a result of the actions taken following the inspection, it is determined that there are safe practices in place for the delivery of surgical services.

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

The arrangements for the recruitment and selection of staff were reviewed. A recruitment policy and procedure was in place that in the main, was in keeping with legislation and best practice guidance. This matter was discussed with Ms Shaw and following the inspection, RQIA received confirmation that this matter had been addressed.

A review of the staff register identified that further development was required. This matter was discussed with Ms Shaw and the staff register was updated during the inspection in keeping with legislation.

It was evidenced that, in the main, staff were recruited and employed in accordance with relevant employment legislation and best practice guidance. Ms Shaw informed us that four new staff members had been employed since the last inspection. The personnel files of the newly recruited staff were reviewed and it was identified some matters needed addressed. This was discussed with Ms Shaw and following the inspection, RQIA received confirmation that all of the information required by legislation was now retained in the files.

Staffing arrangements were reviewed and discussed with the Cathedral Dermatology management team.

It was confirmed that appropriately skilled and qualified staff will be involved in the delivery of services to include a team consisting of a consultant dermatologist, registered nurses and health care assistants who have evidence of specialist qualifications and skills in surgical services.

A review of the details of medical practitioner records evidenced the following:

- confirmation of identity
- current General Medical Council (GMC) registration
- professional indemnity insurance
- qualifications in line with services 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
- an appointed responsible officer
- arrangements for revalidation

A review of the appraisal documents for the PD's identified that some annual appraisals were overdue. This matter was discussed with Ms Shaw and following the inspection, RQIA received confirmation that dates had been agreed to complete these.

A detailed induction programme was in place which was reflective of the job role and responsibilities to be undertaken.

A review of training records evidenced that staff had completed basic life support, IPC, fire safety awareness and safeguarding adults and children at risk of harm training in keeping with the RQIA training guidance with the exception of one staff member who required to update safeguarding training. Following the inspection, RQIA received confirmation that the training had been updated.

Through discussion and review of relevant documentation, it was confirmed that there were rigorous systems in place for undertaking, recording, and monitoring all aspects of staff supervision, appraisal, and ongoing professional development.

Evidence was available that staff who have professional registration undertake continuing professional development (CPD) in accordance with their professional body's recommendations.

As a result of the actions taken following the inspection, it is determined that staffing levels are safe and staff are appropriately trained to meet the needs of patients.

5.2.4 How does the service ensure that it adheres to infection prevention and control and decontamination procedures?

The arrangements for IPC procedures throughout the hospital were reviewed to evidence that the risk of infection transmission to patients, visitors and staff was minimised. It was confirmed that a range of IPC policies and procedures were in place that were in keeping with best practice guidance and include outbreak management, notifiable diseases, transmission precautions, prevention, control and surveillance and cleaning, disinfection and sterilisation. IPC arrangements in Cathedral Dermatology included an IPC lead and developing IPC audit programme. A surgical site infection (SSI) log for Cathedral Dermatology was available for surveillance purposes.

A tour of the premises was undertaken and the hospital was found to be clean, tidy, uncluttered and finished to a high standard of décor. Cleaning records were noted to have been completed and were up to date. Staff described the arrangements to decontaminate the environment and equipment between patients in keeping with best practice.

A review of records confirmed that an IPC audit had been undertaken and all action required had been completed.

Personal protective equipment (PPE) was readily available in keeping with best practice guidance. Waste management arrangements were in place and clinical waste bins were pedal operated in keeping with best practice guidance. Sharps boxes were in place including a pharmaceutical waste sharps box. There was a collection of clinical waste contract in place.

The treatment room and consultation rooms provided dedicated hand washing facilities and hand sanitiser was available throughout the hospital. A surgical hand wash dispenser had been installed in the treatment room.

Staff have access to an external IPC nurse consultant and a microbiologist should advice be required, and the Public Health Agency (PHA) details are also available for staff.

There is planned monitoring and measuring of IPC practices to reduce the risk of health care associated infections (HCAI).

As previously discussed, staff training records confirmed that staff have completed IPC training including Aseptic Non Touch Technique (ANTT) training commensurate with their roles and responsibilities.

The Cathedral Dermatology management team demonstrated good knowledge and understanding of IPC procedures.

5.2.5 Does the service have suitable arrangements in place to record equality data?

The arrangements in place in relation to the equality of opportunity for patients and the importance of staff being aware of equality legislation and recognising and responding to the diverse needs of patients was discussed with the Cathedral Dermatology management team.

Discussion and review of information evidenced that the equality data collected will be managed in line with best practice.

6.0 Quality Improvement Plan/Areas for Improvement

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



The Regulation and Quality Improvement Authority
James House
2-4 Cromac Avenue
Gasworks
Belfast
BT7 2JA

Tel 028 9536 1111
Email info@rqia.org.uk
Web www.rqia.org.uk
 [@RQIANews](https://twitter.com/RQIANews)