The Wells Clinic at Robert Denholm House

Inspection report

Robert Denholm House
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Date of inspection visit: 05/08/2021 to 10/08/2021
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This report describes our judgement of the quality of care at this service. It is based on a combination of what we found when we inspected, information from our ongoing monitoring of data about services and information given to us from the provider, patients, the public and other organisations.

Ratings

Overall rating for this location	Good
Are services safe?	Good
Are services effective?	Good
Are services well-led?	Good

Overall summary

This service is rated as Good overall.

The key questions are rated as:

Are services safe? – Good

Are services effective? – Good

Are services well-led? – Good

We carried out a comprehensive inspection of The Wells Clinic at Robert Denholm House on 23 July 2019. We identified breaches of regulation 9 (Person-centred care), regulation 17 (Good governance) and regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 and issued requirement notices. The service was rated as inadequate for providing safe services, requires improvement for providing effective and well-led services and good for providing caring and responsive services. The service was rated as requires improvement overall.

We carried out this announced comprehensive inspection of The Wells Clinic at Robert Denholm House between 5 and 10 August 2021 under Section 60 of the Health and Social Care Act 2008. 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. At this inspection we checked that the service was providing safe, effective and well-led services.

Throughout the COVID-19 pandemic CQC has continued to regulate and respond to risk. However, taking into account the circumstances arising as a result of the pandemic, and in order to reduce risk, we have conducted our inspections differently.

This inspection was carried out in a way which enabled us to spend a minimum amount of time on site. This was with consent from the provider and in line with all data protection and information governance requirements.

This included:

- Speaking with staff in person and using video conferencing.
- Requesting documentary evidence from the provider.
- A site visit.

We carried out an announced site visit to the service on 9 August 2021. Prior to our visit we requested documentary evidence electronically from the provider. We spoke to staff by telephone and using video conferencing, prior to and following our site visit.

The Wells Clinic at Robert Denholm House is an independent provider of a range of GP services, including consultations, child and adult immunisations, travel health advice and vaccinations, well man and woman health checks and cervical screening. Botox (Botulinum toxin) injections are provided for the treatment of excessive sweating. A minor surgery service is provided which includes the excision of moles and other lesions. The service is registered with the National Travel Health Network and Centre (NaTHNac), as a Yellow Fever Vaccination Centre.

This service is registered with CQC under the Health and Social Care Act 2008 in respect of some, but not all, of the services it provides. There are some exemptions from regulation by CQC which relate to particular types of regulated

Overall summary

activities and services and these are set out in Schedule 1 and Schedule 2 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The Wells Clinic at Robert Denholm House also provides a wide range of non-surgical aesthetic interventions. This includes cosmetic Botox injections, dermal fillers and facial peels, which are not within CQC scope of registration. Therefore, we did not inspect or report on these services.

The Wells Clinic at Robert Denholm House is registered with the Care Quality Commission to provide the following regulated activities: Treatment of disease, disorder or injury and Surgical procedures. Prior to our inspection we identified that the provider was carrying out the excision of skin lesions and sending those tissue samples for histological review without being registered to provide the required regulated activity Diagnostic and screening procedures. The provider immediately submitted an application to provide Diagnostic and screening procedures as a regulated activity.

The service director 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.

Our key findings were:

- Staff had received training in key areas. There was a clear plan of training for staff. There was comprehensive monitoring of training undertaken by clinical staff employed on a sessional basis.
- There were processes in place for performance review, clinical supervision and monitoring/oversight of clinical staff employed on a sessional basis. Staff employed by the service had undergone appraisals.
- There were effective systems and processes to assess monitor and control the spread of infection.
- There were safeguarding systems and processes to keep people safe. Staff had received training in the safeguarding of adults and children.
- Arrangements for chaperoning were effectively managed. Staff had received chaperone training and had been subject to Disclosure and Barring Service (DBS) checks.
- There were appropriate arrangements to manage medical emergencies and suitable emergency medicines and equipment in place.
- Fire safety processes were in place. Staff had participated in fire drills and had received fire safety training.
- There were general health and safety and premises risk assessments in place. There were arrangements for regular review of leasing arrangements with premises managers.
- Clinical record keeping was clear, comprehensive and complete.
- There was some evidence of clinical audit and regular auditing of clinical record keeping processes.
- There were clear and improved governance and monitoring processes to provide assurance to leaders that systems were operating as intended. Risks were promptly identified and responded to.
- Best practice guidance was followed in providing treatment to patients. For example, excised lesions were routinely sent for histological review.
- There were comprehensive records to demonstrate that recruitment checks had been carried out in accordance with regulations, including for staff employed on a sessional basis.
- Staff found leaders highly approachable and supportive and felt they provided an individual service to patients.
- Policies and procedures were monitored, reviewed and kept up to date with relevant and sufficient information, to provide effective guidance to staff.
- There was frequent and open communication amongst the staff team which was well documented and monitored to ensure agreed actions were completed.
- Service users were routinely asked to provide feedback on the service they had received. Complaints were managed appropriately.

Overall summary

The areas where the provider **should** make improvements are:

- Establish arrangements for the retention of all records which relate to staff immunisation status.
- Develop clinical audit processes further, to include additional clinical conditions.

Dr Rosie Benneyworth BM BS BMedSci MRCGP

Chief Inspector of Primary Medical Services and Integrated Care

Our inspection team

Our inspection team was led by a CQC lead inspector and included a GP Specialist Advisor.

Background to The Wells Clinic at Robert Denholm House

The Wells Clinic at Robert Denholm House is an independent provider of a range of GP services, including consultations, child and adult immunisations, travel health advice and vaccinations, well man and woman health checks and cervical screening. Botox (Botulinum toxin) injections are provided for the treatment of excessive sweating. A minor surgery service is provided which includes the excision of moles and other lesions. The service is registered with the National Travel Health Network and Centre (NaTHNac), as a Yellow Fever Vaccination Centre. Services are provided to both children and adults.

The Registered Provider is The Wells Clinic Limited.

The Wells Clinic at Robert Denholm House is located at Robert Denholm House, Bletchingley Road, Nutfield, Redhill, Surrey, RH1 4HW.

The service is run from one ground floor consulting room within a shared building, which is leased by the provider. There is a shared reception and waiting area for patients. Patients are able to access toilet facilities on the ground floor. Access to the premises is at street level for patients with limited mobility.

The Wells Clinic team is comprised of a lead GP who is the service director (female) and one sessional GP (male). Administration support is provided by two part-time administrators. The service utilises an external call handling service to provide call answering from 8am to 6pm Monday to Friday.

The service is open for bookings and enquiries from 8am to 6pm Monday to Friday and 9am - 4pm on Saturdays.

Patient appointments are available from 8.30am to 4.30pm on Tuesdays and Wednesdays and 9:30am to 2pm on Fridays.

Good

Are services safe?

Safety systems and processes

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

- The service had systems and processes to safeguard children and vulnerable adults from abuse. We reviewed the provider's safeguarding policies which provided clear guidance for staff. Staff we spoke with had a clear understanding as to who was the safeguarding lead within the service and how to raise safeguarding concerns about a patient. At our previous inspection, we found that not all staff had undergone training in the safeguarding of adults. At this inspection our review of training records confirmed that all staff had received training in safeguarding adults and children at a level appropriate to their role.
- At our previous inspection, we found that recruitment checks had not been always undertaken prior to employment. At this inspection we reviewed personnel files and found that the provider had carried out all required checks at the time of recruitment and all required ongoing monitoring, such as professional registration status and medical indemnity confirmation. Disclosure and Barring Service (DBS) checks were undertaken for all staff. (DBS checks identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable).
- Staff we spoke with told us that patients were routinely offered a chaperone and we saw there was signage on display within the service which prompted patients to request a chaperone. All staff who acted as chaperones were trained for the role and had undergone a DBS check.
- At our previous inspection we found that the service did not have systems in place to assure themselves that an adult accompanying a child had parental authority. At this inspection we found the service had developed systems to monitor the personal identification of both children and adults attending the service. Evidence of personal identification was also required where remote consultations were provided for adults. Children were not treated via remote consultations.
- The service had developed improved systems to manage health and safety risks within the premises since our previous inspection. There were processes in place to ensure relevant premises safety information was obtained from premises managers. There were documented risk assessments in place to manage risks associated with the premises and general environment. Legionella risk assessments were carried out and resulting actions had been completed. (Legionella is a particular bacterium which can contaminate water systems in buildings). There was guidance and information, including risk assessments, available to staff to support the control of substances hazardous to health (COSHH).
- The provider had carried out regular fire safety risk assessments. Staff had last participated in a fire drill on 22 March 2021. There was appropriate fire-fighting equipment located within the premises which was regularly serviced and maintained. The service had designated staff who were trained as fire marshals and staff had undertaken fire safety training.
- The provider ensured that facilities and equipment were safe, and that equipment was maintained according to manufacturers' instructions. We reviewed records to confirm that electrical equipment had undergone portable appliance testing in May 2021.
- At our previous inspection we found there was a lack of effective systems to manage infection prevention and control within the service. At this inspection we found the provider had established a comprehensive infection prevention and control policy which provided clear guidance to staff. All staff had received training in infection prevention and control. Cleaning and monitoring schedules were in place for the consulting room which was also used to carry out treatments. There were appropriate processes in place to minimise risks associated with COVID-19 transmission. The provider had undertaken an audit of their infection prevention and control processes and all resulting actions had been completed. Regular audits of hand hygiene processes were undertaken.

Good

Are services safe?

- There were systems for safely managing healthcare waste, including sharp items. We saw that clinical waste disposal was available in the consulting room. Bins used to dispose of sharps items were signed, dated and not over-filled. External, lockable bins were used to store healthcare waste awaiting collection by a waste management company.
- The provider had processes in place to monitor staff immunisation status in line with Public Health England guidance (PHE) which outlines the recommended programme of vaccination for frontline healthcare staff (Hepatitis B, varicella, tetanus, polio, diphtheria and MMR (measles, mumps, rubella). Our review of records confirmed the provider had monitored and recorded the immunisation status of all staff but had not always retained the evidence to support that record. We noted that evidence had not been retained relating to one clinician. Immediately following our inspection, the provider sent us evidence to confirm the immunisation status of that staff member.

Risks to patients

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

- There were arrangements for planning and monitoring the number and mix of staff required to meet patient needs. The service had recently employed a second doctor to provide services on a sessional basis. The service director told us that this arrangement also provided some opportunity for cover for periods of annual leave and sickness.
- There were planned induction processes in place. Staff told us induction processes included shadowing other staff and comprehensive support from the service director. There was a clear plan of required training for staff to complete as part of the induction process.
- We reviewed arrangements within the service to respond to medical emergencies. We found there were suitable medicines and equipment to deal with medical emergencies which were stored appropriately and checked regularly. There were documented records of those checks. The service had a defibrillator available within the consulting room and oxygen with adult and children's masks. The defibrillator pads, battery and the oxygen were all in date and the oxygen cylinder was full. There was a second oxygen cylinder available if a further supply was required.
- Staff understood their responsibilities to manage emergencies and to recognise those in need of urgent medical attention. Our review of training records confirmed that staff had undertaken training in sepsis awareness since our previous inspection. Sepsis red flag guidance was now on display within the consulting room to provide further guidance and reminders to staff. All staff had received basic life support training. Staff who administered vaccines had received training in anaphylaxis (a severe, potentially life-threatening allergic reaction).
- The service had clear processes to assess the risks associated with COVID-19 transmission. Staff booking appointments for patients were required to ask key questions relating to possible symptoms of COVID-19 prior to patients attending for a face-to-face appointment.
- The service had a first aid kit in place which was appropriately stocked, and we saw evidence that the contents were regularly checked.
- There were appropriate professional indemnity arrangements in place for clinical staff.

Information to deliver safe care and treatment

Staff had the information they needed to deliver safe care and treatment to patients.

- Individual care records were written and managed in a way that kept patients safe. We reviewed clinical records relating to 10 patients. The clinical records we reviewed showed that information needed to deliver safe care and treatment was available to relevant staff in an accessible way. Clear, accurate and contemporaneous patient records were kept. Treatment planning and information were fully documented.
- The service had systems for sharing information with staff and other agencies to enable them to deliver safe care and treatment.

Good

Are services safe?

- Clinicians made appropriate and timely referrals in line with protocols and up to date evidence-based guidance. For example, for patients requiring onward referral to secondary care services.
- Patients' NHS GP details were routinely recorded unless a patient had declined to share that information. Staff told us it was rare for a patient to decline their consent for staff to share information with the NHS registered GP.
- The service had a system in place to retain medical records in line with Department of Health and Social Care (DHSC) guidance in the event that they cease trading.

Safe and appropriate use of medicines

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

- There were systems and arrangements for managing the safe handling of medicines and prescribing practices in a way which minimised risks to patients. The service kept prescription stationery securely and monitored its use.
- Our review of clinical records confirmed that staff prescribed and administered medicines to patients, and gave advice on medicines, in line with legal requirements and current national guidance.
- Appropriate processes were in place for the ordering, receipt and monitoring of stock medicines held and staff kept accurate records of those medicines.
- Emergency medicines were readily available and in date and supplies were regularly checked. There were documented records of those checks.
- Medicines were stored securely in a locked cupboard in the consulting room. Vaccines were stored in a vaccine refrigerator which was monitored to ensure it maintained the correct temperature range for safe storage. All temperatures recorded had been within the range for safe storage.
- The service had carried out medicines audits to ensure prescribing was in line with best practice guidelines for safe prescribing. For example, the service had completed a two-cycle audit of their antibiotic prescribing in the treatment of urinary tract infections to ensure they met best practice guidelines.

Track record on safety and incidents

The service had a good safety record.

- There were comprehensive risk assessments in relation to safety issues.
- The service had developed clear and improved monitoring processes to provide assurance to leaders that systems were operating as intended.
- The service maintained a risk register which was reviewed by the service director, in conjunction with the staff team, on a monthly basis. Risks were promptly identified and responded to which led to safety improvements. For example, the service had recently transferred their clinical records from one electronic system to another. In doing so the data relating to some NHS GP practices had not been transferred. Prompt action had been taken by the service to retain an element of the previous system whilst the situation was rectified.

Lessons learned and improvements made

The service had systems to ensure they learned when things went wrong.

- There was a system for recording and acting on significant events. Staff understood their duty to raise concerns and report incidents and near misses. The service director supported them when they did so. The service had recorded six incidents within the last 12 months.
- There were appropriate systems for reviewing and investigating when things went wrong. The service learned, and shared lessons, identified themes and took action to improve safety in the service. For example, in conducting regular

Good

Are services safe?

auditing of cervical screening processes and test results, the service identified that a small number of reviewed results had not been retained on their previous clinical records system. Prompt action had been taken to request the results were resent and a new clinical records system ensured improved integration with laboratories submitting results to the service.

- The provider was aware of and complied with the requirements of the Duty of Candour. The provider encouraged a culture of openness and honesty. For example, we saw that the service had provided an open and honest apology to one patient who had attended for a treatment which could not be fulfilled. The service had taken immediate steps to remedy the situation and to ensure processes were reviewed to avoid a recurrence of the incident.
- The service had systems in place for knowing about notifiable safety incidents. The service acted on and learned from external safety events as well as patient and medicine safety alerts. When there were unexpected or unintended safety incidents the service gave affected people reasonable support, truthful information and a verbal and written apology.

Good

Are services effective?

Effective needs assessment, care and treatment

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

- The provider had systems in place to keep clinicians up to date with current evidence- based practice. We saw evidence that clinicians assessed needs and delivered care and treatment in line with current legislation, standards and best practice guidance relevant to their service. For example, to support decisions around travel vaccination requirements for patients, doctors followed guidance issued by Public Health England (PHE) and the National Travel Health Network and Centre (NaTHNaC).
- We reviewed clinical records relating to 10 patients. We found that patients' immediate and ongoing needs were fully assessed. Where appropriate this included their clinical needs and their mental and physical wellbeing.
- Clinicians had enough information to make or confirm a diagnosis.
- We saw no evidence of discrimination when making care and treatment decisions.
- Staff assessed and managed patients' pain where appropriate. Minor surgical procedures were performed using local or topical anaesthetic.

Monitoring care and treatment

The service was able to demonstrate quality improvement activity.

- The service was able to demonstrate that it gathered and used information about care and treatment to make improvements.
- There was clear evidence of action taken to monitor and improve quality. The service monitored quality through the use of completed audits. Clinical audit was limited but had some positive impact on quality of care and outcomes for patients. For example, the service had completed a two-cycle audit of their antibiotic prescribing in the treatment of urinary tract infections to ensure they met best practice guidelines. We noted that audit outcomes were difficult to interpret due to the small number of patients attending the service for a particular clinical condition.
- Since our previous inspection the service had implemented a rigorous quality improvement programme which included quality monitoring and performance reporting of cervical screening processes, clinical record keeping, minor surgical procedures, medicines management and yellow fever vaccinations administered. Outcomes and findings were reviewed on a monthly basis and prompt action taken to address identified risks.
- Clinical staff employed on a sessional basis were subject to a structured review of their performance within the service and there was continuous review of their clinical decision making, prescribing and patient treatment outcomes.

Effective staffing

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

- At our previous inspection we found that staff had not always received the training they required and that not all training was up to date. At this inspection we found that all staff had the appropriate skills and training to carry out their roles. There were planned induction processes in place. There was a clear plan of required training for staff to complete as part of the induction process.
- The provider understood the learning needs of staff and provided protected time and training to meet them. Up to date records of skills, qualifications and training were maintained. The service had developed a comprehensive training matrix to monitor when training updates were required.
- Staff whose roles included for example, travel vaccination services, cervical screening or minor surgery, had all received specific training which was up to date and closely monitored by the service. Doctors administering yellow fever vaccinations were trained to the standard required by NaTHNaC.

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Are services effective?

- The service held records which confirmed medical professionals were registered with the General Medical Council (GMC) and were up to date with revalidation. The service had recently become a designated body in order to provide appraisal and revalidation support to medical professionals working there. The service director was the responsible officer for one doctor employed by the service. (A responsible officer evaluates the fitness to practice of doctors with whom the designated body has a prescribed connection and makes a recommendation to the GMC regarding revalidation). There were no nurses employed within the service.

Coordinating patient care and information sharing

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

- Patients received coordinated and person-centred care. Staff referred to, and communicated effectively with, other services when appropriate.
- Information needed to plan and deliver care and treatment was available to relevant staff in a timely and accessible way.
- Before providing treatment, GPs at the service ensured they had adequate knowledge of the patient's health, any relevant test results and their medicines history. Patients were signposted to more suitable sources of treatment where this information was not available to ensure safe care and treatment.
- All patients were asked for consent to share details of their consultation and any medicines prescribed with their NHS registered GP. Care provided to children was routinely shared with the NHS registered GP.
- Where patients agreed to share their information, we saw evidence of letters sent to their registered GP in line with GMC guidance. Doctors within the service were able to send electronic correspondence securely, directly from the service's clinical records system.
- Some patients attended the service for assessment and treatment of skin lesions such as moles, lipomas and cysts. All removed lesions were routinely sent for histological review. Staff told us if a lesion appeared suspicious, they would refer the patient onwards to independent secondary care dermatology services or back to their NHS registered GP for referral to NHS secondary care.
- Patient information was shared appropriately (this included when patients were referred to other professional services). There were clear and effective arrangements for following up on patients who had been referred to other services. For example, staff provided a recent example of communications with a local independent hospital when a child failed to attend their appointment following referral by the service.

Supporting patients to live healthier lives

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

- Where appropriate, staff gave people advice so they could self-care.
- Risk factors were identified, highlighted to patients and where appropriate highlighted to their normal care provider for additional support.
- Where patient needs could not be met by the service, staff redirected them to the appropriate service for their needs.
- The service implemented inclusive pricing for some minor surgical procedures which meant that patients were not charged for initial assessment of their lesions or follow up appointments. This encouraged patients to attend for initial review and follow up and ensured for example, effective wound care management following treatment.

Consent to care and treatment

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

Good

Are services effective?

- Staff understood the requirements of legislation and guidance when considering consent and decision making.
- Staff supported patients to make decisions and provided sufficient information to support that decision making.
- Where appropriate, they assessed and recorded a patient's mental capacity to make a decision.
- There was a documented consent policy which provided appropriate guidance for staff. At our previous inspection we found that consent processes had not always been fully documented. At this inspection we found that consent processes were consistently applied. Our review of patient clinical records found completed consent forms for all patients who required one. For example, for patients undergoing vaccination or minor surgery. Where travel vaccinations had been administered a travel vaccination risk assessment form was completed which included confirmation of the consent process.
- The service continually monitored the process for seeking consent. Quality monitoring processes included monthly auditing of clinical records relating to ten percent of all patients seen within the month. Auditing included review of consent processes and monitoring of completed consent records.

Good

Are services well-led?

Leadership capacity and capability:

Leaders had the capacity and skills to deliver high-quality, sustainable care.

- Leaders were knowledgeable about issues and priorities relating to the quality and future of services. They understood the challenges and were addressing them. For example, the provider had recently employed a second GP and intended to lease additional space within the premises, in order to expand upon the breadth and availability of services.
- Leaders were visible and approachable. They worked closely with the small team of staff and others to make sure they prioritised compassionate and inclusive leadership.
- There was a staffing structure in place across the service and staff were aware of their individual roles and responsibilities.
- There were clear, open lines of communication between all staff. Staff we spoke with felt well supported and described leaders within the service as highly approachable and responsive. Staff told us they had regular one-to-one interaction with the service director due to the small nature of the service.

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 had a vision and desire to provide a high-quality service that put caring at its heart, and which promoted good outcomes for patients.
- There was a clear vision and set of values. The service had a realistic strategy and supporting business plans to achieve priorities.
- The service director told us they intended to expand the service, to increase the number of consulting rooms, the availability of appointments and the number of clinicians providing services.
- The service developed its vision, values and strategy jointly with staff and external partners.
- Staff were aware of and understood the vision, values and strategy and their role in achieving them. We saw that all staff were fully engaged in ensuring the promotion of optimum outcomes for patients.

Culture

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

- Staff felt respected, supported and valued. They were proud to work for the service and told us they enjoyed being part of a close team.
- The service was focused upon the needs of patients.
- Leaders and managers encouraged behaviour and performance consistent with the vision and values.
- Openness, honesty and transparency were demonstrated when responding to incidents and complaints. The provider was aware of and had systems to ensure compliance with the requirements of the duty of candour.
- Staff told us they could raise concerns and were encouraged to do so. They had confidence that these would be addressed.
- There were processes for providing all staff with the development they needed. Staff had received regular annual appraisals in the last year. Staff were supported to meet the requirements of professional revalidation where necessary and were subject to supervision and evaluation of their clinical work.

Good

Are services well-led?

- There was a strong emphasis on the safety and well-being of all staff. All staff had undergone individual COVID-19 risk assessments to support their well-being during the pandemic. Those staff who worked from home had been required to demonstrate the safety and security of their working environment and were supported in making improvements where required.
- The service actively promoted equality and diversity. It identified and addressed the causes of any workforce inequality. Staff had received equality and diversity training. Staff felt they were treated equally.
- The service was comprised of a small team of four staff members. There were positive relationships between staff and prompt and effective communications across the staff team.

Governance arrangements

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

- Improved structures, processes and systems to support good governance and management had been clearly set out and established since our previous inspection. The provider had sought external support in establishing those governance processes and had continued to implement them effectively.
- Staff understood their individual roles and responsibilities and were well supported by the service director in fulfilling those roles.
- The provider had established appropriate policies, procedures and systems to ensure services were delivered safely and assured themselves that they were operating as intended. Prior to our inspection the provider sent us a range of key policies, at our request. We found the policies contained sufficient and up to date information to provide clear guidance to staff. Policies we saw had been recently reviewed and reflected current good practice guidance from sources such as the National Institute for Health and Care Excellence (NICE) and the Health and Safety Executive (HSE).
- The governance and management of partnerships, joint working arrangements and shared services promoted interactive and co-ordinated person-centred care. We saw examples of timely and effective sharing of information with other agencies and patients' NHS GPs, in order to ensure the safe care and treatment of patients.
- Staff spoke of regular team meetings they had attended, and we saw records and documented actions resulting from those meetings where for example, updates, incidents and complaints had been discussed. There were clear and well-planned arrangements for the review and clinical supervision of clinical staff employed on a sessional basis.

Managing risks, issues and performance

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

- There were effective governance processes to ensure leaders were able to identify, understand, monitor and address current and future risks including risks to patient safety.
- There was clear evidence of a commitment to change services to improve quality where necessary. The service had demonstrated clear improvements to quality monitoring and governance processes since our previous inspection.
- Leaders had oversight of safety alerts, incidents, and complaints. There was a system for recording and acting upon significant events. Staff understood their duty to raise concerns and report incidents and near misses. Leaders and managers supported them when they did so.
- The service had processes to manage current and future performance. Performance of clinical staff could be demonstrated through clinical supervision, audit of their consultations, prescribing and referral decisions.
- Clinical audit had an impact on quality of care and outcomes for patients. The service had implemented a programme of audit which included auditing of antibiotic prescribing, cervical screening processes and clinical records.

Good

Are services well-led?

- The provider had a comprehensive business continuity plan in place which was located in a prominent position within the consulting room and was also accessible electronically, for ease of access in the event of a serious incident or interruption to services.

Appropriate and accurate information

The service acted on appropriate and accurate information.

- Since our previous inspection, the provider had established improved systems to gather quality, governance and operational information to monitor performance and drive improvement. Plans were promptly put in place to address any identified weaknesses.
- The provider had developed a monthly quality monitoring tool which facilitated the reporting and review of a range of quality indicators. These included for example, a register of risks; complaints information; patient feedback; incident reporting; a log of all yellow fever vaccinations administered; cervical screening monitoring; a lesion excision log; a staff training summary.
- The provider had established appropriate policies, procedures and systems to ensure appropriate guidance for staff and to ensure services were delivered safely.
- Meetings were held regularly where quality and risks were discussed. We reviewed minutes of weekly meetings held within 2021. We saw that actions, outcomes and learning from the meetings were documented and cascaded to staff.
- The service submitted data or notifications to external organisations as required.
- There were arrangements in line with data security standards for the availability, integrity and confidentiality of patient identifiable data, records and data management systems. Processes ensured that all confidential electronic information was stored securely on computers. Staff demonstrated a good understanding of information governance processes. The service had recently changed to a new electronic clinical records system which required a two-step user authentication system for enhanced security.

Engagement with patients, the public, staff and external partners

The service involved patients, the public, staff and external partners to support high-quality sustainable services.

- The service encouraged and valued feedback from patients, the public and staff. Feedback was closely monitored and acted upon to shape services.
- Staff could describe to us the systems in place for them to give feedback.
- The service used 'Doctify', an online healthcare review platform, to gather and review feedback from patients. Feedback gathered via the platform featured directly on the service's website. The service provided patients with an electronic device to access the platform whilst attending for an appointment if they wished. The service also monitored feedback provided via Facebook and Google reviews. All feedback was collated and reviewed as part of the service's monthly quality monitoring and reporting tool and appropriate actions taken.
- The service was transparent and open with stakeholders about the feedback received. We reviewed one recent example whereby the service had responded promptly and appropriately to negative feedback provided as a Google review. The provider had made direct contact with the patient and had identified learning as a result of the comments made.
- Information about how to make a complaint or raise concerns was available within the service. Staff treated patients who made complaints compassionately. The service had complaint policy and procedures in place. The service process indicated how they would learn lessons from individual concerns and complaints and also from analysis of trends. The service had received two complaints in 2021. Our review of those complaints confirmed that appropriate and timely actions had been taken in response to the complaint.

Good

Are services well-led?

Continuous improvement and innovation

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

- There was a focus on continuous learning and improvement within the service.
- The service team had made clear improvements in response to the findings of our previous inspection.
- The service made use of internal and external reviews of processes to make improvements.
- The service director actively encouraged staff to participate in the review of objectives, processes and performance in order to drive improvement.