Brighton Skin Surgery

Inspection report

Mile Oak Medical Centre
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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?	Requires Improvement
Are services effective?	Good
Are services caring?	Good
Are services responsive to people's needs?	Good
Are services well-led?	Good

Overall summary

This service is rated as Good overall.

The key questions are rated as:

Are services safe? – Requires improvement

Are services effective? – Good

Are services caring? – Good

Are services responsive? – Good

Are services well-led? – Good

We carried out an announced comprehensive inspection of Brighton Skin Surgery on 17 June 2022 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. This was the first rated inspection of the service. The service was previously inspected in December 2017, when it was found that the service did not always provide well-led services and a breach of regulation was identified. We carried out a follow up inspection in March 2018 and the service was found to be meeting all regulations.

Throughout the COVID-19 pandemic the Care Quality Commission (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 17 June 2022. Prior to our visit we requested documentary evidence electronically from the provider. We spoke to staff using video conferencing prior to our site visit.

Brighton Skin Surgery provides an independent, doctor-led dermatology minor surgery service.

Procedures offered include skin tag, cyst, mole, wart and cherry or blood spot removal. The service is based within a local NHS GP practice, Mile Oak Medical Centre, on the outskirts of the city of Brighton and Hove.

This service is registered with CQC under the Health and Social Care Act 2008 in respect of all of the services it provides.

Overall summary

Brighton Skin Surgery is registered with the Care Quality Commission to provide the following regulated activities: Treatment of disease, disorder or injury, Diagnostic and screening procedures and Surgical procedures.

The medical 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:

- There were safeguarding systems and processes to keep people safe.
- Arrangements for chaperoning were effectively managed. Staff had received chaperone training and had been subject to Disclosure and Barring Service checks.
- There were effective systems and processes to assess the risk of, and prevent, detect and control the spread of infection. There were processes for auditing of infection prevention control arrangements.
- The monitoring of staff immunisations did not always reflect current guidance.
- There were appropriate arrangements to manage medical emergencies and suitable emergency medicines and equipment in place.
- There had been insufficient action taken to identify and address some legionella, fire safety and health and safety risks which were managed by the host GP practice.
- Clinical record keeping was clear, comprehensive and complete.
- There was evidence of clinical audit, monitoring of patient treatment outcomes and regular auditing of clinical record keeping processes.
- Best practice guidance was followed in providing treatment to patients. For example, excised lesions were routinely sent for histological review.
- There were clear and effective clinical governance and monitoring processes. However, the provider had not sought sufficient assurances that the premises they were leasing were safe and appropriately managed.

The areas where the provider must make improvements as they are in breach of regulations are:

- Ensure care and treatment is provided in a safe way to patients.

(Please see the specific details on action required at the end of this report).

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

- Provide information for patients on the service's website about how to make a complaint.
- Monitor policies to ensure their timely review.

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.

Background to Brighton Skin Surgery

Brighton Skin Surgery provides an independent, doctor-led dermatology minor surgery service. Procedures offered include skin tag, cyst, mole, wart and cherry or blood spot removal. The service is based within a local NHS GP practice, Mile Oak Medical Centre, located on the outskirts of the city of Brighton and Hove.

The Registered Provider is Dr Avni Patel.

Brighton Skin Surgery is located at Mile Oak Medical Centre, Chalky Road, Brighton BN41 2WF

The service's opening times are:

Monday to Friday: 9am to 5pm – enquiries only.

Fridays and occasional Tuesdays: minor surgery services by appointment.

Services are provided by the medical director, Dr Avni Patel, an experienced GP with a special interest in dermatology, who holds a Diploma in Dermatology. There are no other staff employed by the service.

Brighton Skin Surgery is supported by the host GP practice which provides some practice policies, protocols, premises management and non-clinical governance processes to the service.

The service is run from a minor surgical suite which is leased by the provider. The service utilises a reception and waiting area which is staffed and managed by the host GP practice. Access to the premises and the minor surgical suite are at street level to support patients with limited mobility.

How we inspected this service

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

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

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

Requires Improvement

Are services safe?

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

- The service had systems and processes to safeguard children and vulnerable adults from abuse. Staff had received training in safeguarding vulnerable adults and children at a level appropriate to their role. The provider had an agreement in place to follow safeguarding policies implemented by the host GP practice. The medical director was the safeguarding lead within the service.
- As the sole employee of the service, the medical director held all required evidence to support their suitability for the role and evidence of professional registration status and medical indemnity cover. The provider had an agreement with the host GP practice for them to supply reception staff support and staff to act as chaperones when required. The host GP practice carried out all required checks of those staff at the time of recruitment. 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). All staff who acted as chaperones were trained for the role and had undergone a DBS check.
- There were mainly effective systems to manage infection prevention and control within the service. The premises were well maintained. Cleaning and monitoring schedules were in place. Auditing of all infection prevention processes was undertaken annually and had last been completed in June 2022. We reviewed processes for the monitoring of staff immunisations. The provider held records of their immunisation status in line with current guidance. However, records held by the host GP practice in relation to the immunisation status of reception staff were incomplete. We found that an immunisation monitoring template was in use, but this was not supported by evidence of immunisation or blood antibody testing.
- The service performed minor surgical procedures for which they used single-use, disposable items. There were sufficient stocks of personal protective equipment, including masks, aprons and gloves.
- There were systems for safely managing healthcare waste, including sharp items. We saw that clinical waste disposal was available in the surgical suite. Bins used to dispose of sharps items were signed, dated and not over-filled. An external, lockable bin was used to store healthcare waste awaiting collection by a waste management company.
- Health and safety risks within the premises were managed by the host GP practice on behalf of the provider. We found that risks associated with fire safety and legionella were not adequately monitored or managed. There was a lack of Legionella risk assessment for the premises and no record of actions taken to mitigate any potential risks, such as regular temperature testing of water samples. (Legionella is a particular bacterium which can contaminate water systems in buildings). Following our inspection, the host GP practice commissioned an external supplier to undertake initial temperature testing of water samples which indicated that hot water temperatures were falling below the required minimum. They told us they intended to schedule a Legionella risk assessment for the premises.
- Fire safety arrangements were not sufficiently well managed. The host GP practice had implemented a fire drill immediately prior to our site visit but there were no records that fire drills had been carried out in the 12 months prior to that. Managers told us that the recent evacuation drill had been slow as some staff had failed to respond to the alarm. The provider, as the sole employee of Brighton Skin Surgery, had not participated in a fire drill or any simulated evacuation.
- Actions resulting from a fire risk assessment undertaken in July 2019 were in the process of being reviewed at the time of our site visit. The host GP practice was able to demonstrate following our site visit that some of the required remedial actions had been completed. However, there had been no updated fire risk assessment undertaken since 2019. Managers told us they had recently identified that there were no trained fire marshals within the practice. As a result, they had requested that all staff undertook online fire marshal training as an interim measure. At the time of our site visit 10 staff members had completed the training.
- Emergency lighting systems had been serviced in May 2022, with multiple failures identified and corrected. However, there were no records of routine, regular testing of emergency lighting systems. There was appropriate fire-fighting

equipment located within the premises which was regularly serviced and maintained. Fire alarm and fire extinguisher servicing had been undertaken in May 2022. The electrical safety certificate for the premises had expired in November 2021. Following our inspection, the host GP practice commissioned an external supplier to provide an updated electrical safety certificate.

- There was guidance and information, including risk assessments, available to staff to support the control of substances hazardous to health (COSHH). There were some documented risk assessments in place to manage risks associated with the premises and general environment. The host GP practice completed monthly health and safety checklists related to the general environment.
- Liquid nitrogen was stored within the service and used to provide cryotherapy to treat some skin lesions. The host GP practice had adequately assessed the risks associated with the storage and use of liquid nitrogen and provided detailed guidance for staff in its use.
- The host GP practice ensured that equipment was maintained according to manufacturers' instructions. We reviewed records to confirm that electrical equipment had undergone portable appliance testing in May 2022.

Risks to patients

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

- The provider ensured they scheduled sufficient consultation and treatment sessions required to meet patient demand. One weekly session was usually scheduled. An alternative weekly session was made available where required, in order to provide more flexibility for patients.
- There was an established process for sending samples for histology and receiving results for review. Samples sent for histology were recorded in a minor operations log, and all samples were tracked when dispatched to ensure their timely review. The medical director contacted patients directly to discuss results and sent patients copies of their results. Where there was cause for concern, onward referrals were made when necessary.
- The medical director was available to offer advice and support to patients following their treatment if required. They told us they routinely called patients on the evening following their treatment to confirm their well-being. Patients were contacted the next working day if they requested advice out of hours via email or telephone.
- The service implemented inclusive pricing which meant that patients who were required to attend for follow up appointments for removal of sutures or review of a wound, were not charged for follow up appointments. This encouraged patients to attend for review and ensured effective wound care management following treatment.
- The provider understood their responsibilities to manage emergencies and to recognise those in need of urgent medical attention. Staff had received basic life support training which was annually updated.
- We reviewed arrangements within the service to respond to medical emergencies. We found the provider had an agreement in place with the host GP practice to utilise emergency medicines and equipment and to access support from practice staff in the event of an emergency. Emergency medicines and equipment were stored behind the main reception desk which was easily accessible to all and staff knew of their location. There were appropriate supplies of emergency medicines available to staff and a defibrillator and oxygen available on the premises which were subject to regular checks.
- The service had a first aid kit in place which was appropriately stocked, and its' contents were regularly checked.
- The provider had appropriate professional indemnity arrangements in place.

Information to deliver safe care and treatment

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

- We reviewed clinical records relating to six patients who had received treatment within the service.

Requires Improvement

Are services safe?

- Individual care records were written and managed in a way that kept patients safe. The care records we saw showed that information needed to deliver safe care and treatment was available to relevant staff in an accessible way. The provider used a clinical notes template to ensure consistency of clinical record keeping. Clear, accurate and contemporaneous patient records were kept. Treatment planning and information were fully documented.
- Clinical records were stored on a secure, password-protected, electronic system. Hand-written records were stored securely in locked cabinets within a locked room.
- Consent processes were comprehensive and consistently applied. There was a documented consent policy. Patient records clearly documented the consent process and discussions between the medical director and patient.
- Patients attended the clinic for assessment and treatment of skin lesions such as moles, lipomas and cysts. The medical director had received specialist dermatology training and followed best practice guidance, such as that provided by the British Association of Dermatologists (BAD). For example, screening of moles and other lesions included the use of a dermatoscope and removed lesions were routinely sent for histological examination. (A dermatoscope is a hand-held visual aid device used to examine and diagnose skin lesions and diseases).
- The service had systems for sharing information with staff and other agencies, for example, the patient's NHS GP, to enable them to deliver safe care and treatment.
- 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 for skin cancer treatment. The medical director told us that if a lesion appeared suspicious, they would immediately refer the patient back to their registered GP or directly onto a secondary care pathway.
- 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 some systems for the appropriate and safe handling of medicines.

- The service kept prescription stationery securely and monitored its use. 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 monitored prescribing to ensure it was in line with best practice guidelines for safe prescribing.
- Our review of clinical records confirmed that the medical director 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. Medicines requiring refrigeration were stored in a 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.

Track record on safety and incidents

- Management of health and safety within the premises was undertaken by the host GP practice. However, some maintenance and monitoring processes, for example with regard to fire safety and legionella, were not up to date. The provider had not fully assured themselves that health and safety requirements were met and carried out in a timely manner.
- There were monitoring and auditing processes in place to provide assurance to the provider that clinical systems were operating as intended. The medical director undertook regular auditing of their patient treatment outcomes, including for example, complications, abnormal histology and onward referrals required.

Requires Improvement

Are services safe?

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. The provider had not recorded any serious incidents within the past 12 months.
- There were appropriate systems for reviewing and investigating when things went wrong. Lessons from significant events were discussed and shared appropriately with peers with similar interests, in order to ensure action was taken to improve safety.
- The provider was aware of and complied with the requirements of the Duty of Candour. The provider encouraged a culture of openness and honesty.
- There was a system for receiving, reviewing and taking action on safety alerts from external organisations such as the Medicines and Healthcare products Regulatory Agency (MHRA). Histology results were reviewed by the medical director with appropriate follow-up action taken.

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 medical director was the sole clinician for the service and had high levels of skills, knowledge and experience to deliver the care and treatment offered by the service.
- Patients were referred to the service by their GP or self-referred.
- The medical director kept up to date with current evidence-based practice. They assessed needs and delivered care and treatment in line with relevant current legislation, standards and guidance. These included the National Institute for Health and Care Excellence (NICE) and British Association of Dermatologists (BAD) best practice guidelines.
- We reviewed clinical records relating to six patients who had received treatment within the service. We found there was a consistent approach to clinical record keeping and risks to the patient were comprehensively assessed, discussed and documented. Treatment planning and information were fully documented. Clear, accurate and contemporaneous clinical records were kept.
- The service ensured they provided information to support patients' understanding of their treatment, including pre- and post-treatment advice and support. The medical director provided a telephone call to the patient following their treatment to confirm their well-being. Patients were able to access post treatment support via follow up appointments and also on the telephone.
- Patients' pain was assessed and managed where appropriate. Patients were prescribed local anaesthetic medicines prior to their surgical procedures, where appropriate.
- We saw no evidence of discrimination when making care and treatment decisions.

Monitoring care and treatment

The service was able to demonstrate quality improvement activity.

- The service used information about care and treatment to assess the need to make improvements.
- The provider reviewed the effectiveness and appropriateness of the care provided and was actively engaged in monitoring and improving quality and promoting optimum patient treatment outcomes.
- Audits were carried out annually to demonstrate quality improvement and implement benchmarking against comparable services. For example, the provider had conducted an annual audit of histology outcomes and found that 100% of removed lesions were benign. They had concluded this was due to services being provided to a selective population with stable, long-standing lesions.
- The host GP practice had undertaken regular auditing of their infection prevention and control processes and action points arising from the audits were identified and closely monitored until completion.

Effective staffing

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

- Staff had the appropriate skills and training to carry out their roles. There were planned induction processes in place for reception staff employed by the host GP practice. There was a plan of required training for staff to complete as part of the induction process.
- All training set out as mandatory by the provider was monitored. Up to date records of skills, qualifications and training were maintained.
- Learning needs were identified and supported through a system of meetings, appraisals, peer review and support for revalidation. For example, the GP attended a regular learning set meeting with colleagues from the local area to facilitate learning.

Good

Are services effective?

- The service held records which confirmed that the medical director was registered with the General Medical Council (GMC), was up to date with revalidation and had undergone appraisal within the last 12 months.

Coordinating patient care and information sharing

- Patients who used the service received coordinated and person-centred care. Before providing treatment, the medical director ensured they had adequate knowledge of the patient's health and previous medical history.
- Staff referred to, and communicated effectively with, other services where appropriate. For example, when referring patients to secondary care services or informing the patient's own GP of any concerns.
- We noted that the provider had, within the last 12 months, identified two patients who presented with lesions which appeared suspicious. They had declined to treat those patients and prompt communication with the patients' GP had highlighted the need for urgent referral to secondary care.
- There were effective arrangements for following up on patients where their care involved other services, for example there were processes for tracking histology results following lesion excision. The provider told us that where patients were referred to secondary care pathways, they diarised a date to follow up on that patient, to confirm the treatment outcome and to monitor the patient journey.

Supporting patients to live healthier lives

- Patients were provided with information about procedures, including the benefits and risks of treatments provided. The service provided pre- and post-treatment advice and support to patients, for example about wound care. All patients received a support telephone call from the medical director immediately following their treatment.
- In the event that patients presented with concerns or complications post treatment, patients were able to access advice and support from the medical director in a timely manner.
- Where lesions were removed or treated within the service, samples were routinely sent for histology. Rigorous processes were in place to ensure the recording and tracking of samples sent for histological review. The medical director reviewed all results prior to patients being notified of the outcome.

Consent to care and treatment

The service had processes to ensure consent to care and treatment was obtained in line with legislation and guidance.

- Staff understood the requirements of legislation and guidance when considering consent and decision making. Staff had completed training in the Mental Capacity Act 2005. Staff described processes for the assessment of patients' suitability for treatment which included their psychological well-being, mental capacity and vulnerability. Staff told us they would not agree to treat patients about whom they had any concerns.
- There was a documented consent policy. Consent processes were comprehensive and consistently applied. Patient records we reviewed clearly documented the consent process and discussions between the practitioner and patient.

Good

Are services caring?

Kindness, respect and compassion

Staff treated patients with kindness, respect and compassion.

- Staff understood patients' personal, cultural, social and religious needs. They displayed a welcoming, understanding and non-judgmental attitude to all patients.
- The service gave patients timely support and information in relation to their care and treatment.
- The service actively invited feedback on the quality of care patients received. The provider conducted annual patient surveys to seek to improve the service. The most recent survey was conducted in 2021/2022 and 34 patients had responded. We noted that 98% of patients who responded said the provider was good at making them feel at ease and 98% of patients said they found the provider to be good at providing or arranging treatment.
- The provider had sought additional feedback from patients in the form of written comment cards, in September 2021. Patients were wholly positive in their feedback, describing the service as, for example, excellent, reassuring and professional.

Involvement in decisions about care and treatment

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

- The service ensured that patients were provided with all the information they required to make decisions about their treatment prior to treatment commencing. Information about pricing was available to patients on the service's website and within the service. Patients were provided with individual quotations for their treatment following their first consultation.
- Patients were provided with information about their histology results by return appointment, phone and letter.
- Interpretation services were available for patients who did not have English as a first language. The service had a hearing loop installed.

Privacy and Dignity

The service respected patients' privacy and dignity.

- Staff recognised the importance of people's dignity and respect. Patients were collected from the waiting area by the medical director and escorted into the consultation room.
- Consultations and treatments took place behind closed doors and conversations could not be overheard. Staff knocked and waited before entering a room, to maintain patients' privacy and dignity.
- There was a curtain in the surgical suite to maintain patients' privacy and dignity during assessment and treatment.
- Chaperones were available should a patient choose to have one. All staff who provided chaperoning services had undergone required employment checks and received training to carry out the role.
- Staff complied with the service's information governance arrangements. Processes ensured that all confidential electronic information was stored securely on computers. All patient records and information kept as hard copies was stored in a locked cabinet within a locked room.

Good

Are services responsive to people's needs?

Responding to and meeting people's needs

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

- The provider understood the needs of their patients and arranged services in response to those needs. Doctor-led dermatology services were provided according to patient need.
- The facilities and premises were generally well maintained and were appropriate for the services and treatments delivered.
- Reasonable adjustments had been made so that people in vulnerable circumstances could access and use services on an equal basis to others. For example, there was a hearing loop and translation support services were available.

Timely access to the service

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

- Patients had timely access to initial assessment, test results, diagnosis and treatment. Appointments could be booked by email request via the provider's website or by telephone.
- The provider monitored email and telephone enquires daily to ensure a timely response for patients outside the service's normal opening times.
- Waiting times, delays and cancellations were minimal and managed appropriately.
- Referrals to other services were undertaken in a timely way and were managed appropriately. For example, for patients requiring onward referral to secondary care services for skin cancer treatment.

Listening and learning from concerns and complaints

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

- The service had a complaints policy in place and information about how to make a complaint or raise concerns was available for patients to read within the service. We noted that there was no information available about how to make a complaint on the provider's website. The provider had identified this at the time of our inspection and told us they had plans to update their website to include information about their complaints procedure.
- Staff treated patients who made complaints compassionately. The service had received no complaints within the previous 12 months, but complaints processes demonstrated how appropriate and timely actions were taken in response to a complaint.
- The service clearly informed patients of further action that may be available to them should they not be satisfied with the response to their complaint. The service's written complaints policy included up to date information to support patients should their complaint remained unresolved.
- The provider told us that if complaints were received, they would seek support and input from peers within a learning set, an appraiser or if required, their medical indemnity provider.

Good

Are services well-led?

Leadership capacity and capability:

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

- The provider operated as a single practitioner with support from staff employed by the host GP practice on the same site. Non-clinical governance and premises management systems, as well as reception services, were provided by the host GP practice.
- The provider demonstrated the capacity to implement systems and processes to support the delivery of high-quality clinical care.
- Leaders within the host GP practice were visible and approachable. The GP practice management team were newly appointed and working to address shortfalls in premises risk management and governance identified since their recent appointment. They were keen to work closely with the provider and had developed open lines of communication with the provider within a short period of time.
- There was a service level agreement in place which clearly set out the responsibilities of the provider and the host GP practice in the delivery of services.
- Although there was open dialogue between the two parties, the provider had not fully assured themselves that aspects of premises management and health and safety, implemented by the host GP practice, were fulfilled.

Vision and strategy

- The provider had a clear vision to provide a high-quality service that put caring and patient safety at its heart.
- The provider had a realistic strategy and supporting business plans to achieve priorities.

Culture

There were systems and processes to support a culture of high-quality sustainable care.

- The provider promoted behaviour and performance consistent with the vision and values. The service was focused upon the needs of patients.
- Openness, honesty and transparency were demonstrated when responding to incidents and complaints. There were systems in place for recognising and reporting notifiable safety incidents. There had been no serious incidents in the past 12 months.
- The provider was aware of and had systems to ensure compliance with the requirements of the duty of candour.
- There were processes in place to ensure the medical director received the development they needed. This included regular appraisal, review of their performance and professional revalidation.
- The service actively promoted equality and diversity. Staff had received equality and diversity training.

Governance arrangements

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

- Structures, processes and systems to support good governance and management were set out within a service level agreement between the provider and the host GP practice. However, we noted that the provider had not fully assured themselves that aspects of premises management and health and safety, implemented by the host GP practice, were fulfilled. For example, to ensure that risks associated with legionella, electrical and fire safety arrangements were adequately assessed, addressed and monitored.
- The provider had established their own policies, procedures and activities to ensure clinical aspects of patient safety. The provider had an agreement in place to adopt some policies implemented by the host GP practice.

Good

Are services well-led?

- The provider and the host GP practice met regularly to share information between the two parties.
- Staff understood their individual roles and responsibilities.
- The provider used performance information, which was reported and monitored.
- The provider 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.

Managing risks, issues and performance

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

- There were mainly effective governance processes to ensure leaders were able to identify, understand, monitor and address current and future risks. Managers within the host GP practice were working to address shortfalls in premises risk management and governance identified since their recent appointment.
- The service had processes to manage current and future performance. The provider carried out comprehensive auditing of their clinical record keeping and patient treatment outcomes.
- Clinical audit had a positive impact on the quality of care and treatment outcomes for patients. There was clear evidence of action taken to review services to improve quality.
- The provider had oversight of safety alerts, incidents, and complaints. There was a system for recording and acting upon significant events. The provider understood their duty to raise concerns and report incidents and near misses.

Appropriate and accurate information

The service acted upon appropriate and accurate information.

- Quality and operational information was used to monitor performance and drive improvement.
- The service used feedback from patients combined with performance information, to drive improvement.
- Individual care records were written and managed in a way that kept patients safe. The care records we saw demonstrated that clear, accurate and contemporaneous patient records were kept. Treatment planning and treatment records were fully documented.
- Processes ensured that confidential electronic information was stored securely on computers. All patient information kept as hard copies was stored in locked cabinets within a locked room. Staff demonstrated a good understanding of information governance processes.
- The provider had an agreement in place to adopt some policies implemented by the host GP practice. For example, with regard to health and safety, infection prevention and control and safeguarding. We noted that some policies such as the infection prevention and control policy, were overdue a review. The health and safety policy was not dated and included no date for review.

Engagement with patients, the public, staff and external partners

The service involved patients, staff and external partners to support sustainable services.

- The service encouraged and heard views and concerns from the public, patients and external partners and acted on them to shape services.
- The service was transparent, collaborative and open with stakeholders about performance.
- The service encouraged and valued feedback from patients and conducted an annual patient survey to assess the service. The provider had also collated verbal and written feedback from patients.

Continuous improvement and innovation

Good

Are services well-led?

There was evidence of systems and processes for learning, continuous improvement and innovation.

- There were systems and processes for learning, continuous improvement and innovation.
- The provider made use of internal reviews, clinical audits, incidents and complaints and consistently sought ways to improve the service.
- The provider sought input from peers and colleagues and participated in a learning set, in order to promote continuous learning and improvement.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Diagnostic and screening procedures Surgical procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment The registered person had not ensured that they were doing all that is reasonably practicable to mitigate risks to the health and safety of service users of receiving care or treatment. In particular: To ensure that risks associated with legionella, electrical and fire safety arrangements within the premises are adequately assessed, addressed and monitored. To ensure appropriate records are held relating to staff immunisations, in line with current guidance.