# Meyerhealth Ltd

## Inspection report

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Date of inspection visit: 21 June 2022
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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 | Requires Improvement |
| Are services safe? | Inadequate |
| Are services effective? | Requires Improvement |
| Are services caring? | Good |
| Are services responsive to people's needs? | Good |
| Are services well-led? | Requires Improvement |

# Overall summary

**This service is rated as Requires improvement overall.**

The key questions are rated as:

Are services safe? – Inadequate

Are services effective? – Requires improvement

Are services caring? – Good

Are services responsive? – Good

Are services well-led? – Requires improvement

We carried out an announced comprehensive inspection of Meyerhealth Ltd on 21 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 provider's first inspection of the service since it registered with the Care Quality Commission (CQC).

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, on the telephone and using video conferencing.
- Requesting documentary evidence from the provider.
- A site visit.

We carried out an announced site visit to the service on 21 June 2022. Prior to our visit we requested documentary evidence electronically from the provider. We spoke to staff on the telephone and using video conferencing prior to our site visit.

Meyerhealth Ltd is a small independent service, led by a single GP who specialises in dermatology, minor surgery and women's health. Services include GP consultations, phlebotomy and minor surgical procedures, including the excision of moles and other skin lesions.

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 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. Meyerhealth Ltd provides a wide range of non-surgical aesthetic interventions and anti-ageing treatments, for example, anti-wrinkle injections, dermal fillers and thread vein treatments, which are not within CQC scope of registration. Therefore, we did not inspect or report on these services.

# Overall summary

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

**Our key findings were:**

- Medical staff had the relevant skills, knowledge and experience to deliver the care and treatment offered by the service.
- There were processes in place for the training, performance review and monitoring of staff. However, non-clinical staff had not received training or guidance in the identification of 'red flag' signs or symptoms of sepsis in patients.
- Staff dealt with patients with kindness and respect and involved them in decisions about their care.
- Staff worked well together as a team and all felt supported to carry out their roles. There was a strong team ethos and culture of working together.
- The service encouraged and valued feedback from patients and staff. Feedback from patients was positive.
- Emergency medicines held on site were insufficient given the patient population to which services were provided. There was a lack of some emergency equipment available.
- There had been insufficient action taken to address some legionella, fire safety and health and safety risks which were managed by the host dental practice.
- Best practice guidance was not always followed in providing treatment to patients. For example, excised lesions were not routinely sent for histological review. There was a lack of clear process for tracking histology results.
- There were some processes to assess the risk of, and prevent, detect and control the spread of infection. However, staff immunisations were not monitored in line with current guidance.
- Medicines were stored securely, however fridge temperature monitoring processes did not ensure the correct temperature range for their safe storage.
- Policies provided up to date, relevant and sufficient information, to provide effective guidance to staff. However, policy content was not always reflected in processes undertaken within the clinic.
- There was a lack of evidence of clinical audit and regular auditing of clinical record keeping processes.
- There was a lack of effective governance and risk assessment processes in some areas. For example, with regard to prescribing of controlled drugs, the provision of phlebotomy services and processes for managing incoming test results.

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.
- Establish effective systems and processes to ensure good governance in accordance with the fundamental standards of care

We took enforcement action and issued a warning notice against the provider in relation to Regulation 12(1)(2) Safe care and treatment.

We issued a requirement notice against the provider in relation to Regulation 17(1)(2) Good governance.

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

# Overall summary

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

- Only supply unlicensed medicines against valid special clinical needs of an individual patient where there is no suitable licensed medicine available.
- Consider processes to confirm the identity of patients where appropriate.
- Review arrangements to access electrocardiogram (ECG) monitoring.

**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 adviser.

## Background to Meyerhealth Ltd

Meyerhealth Ltd is a small independent service led by a single GP who specialises in dermatology, minor surgery and women's health. Services include GP consultations, phlebotomy and minor surgical procedures, including the excision of moles and other skin lesions.

The service also provides non-regulated aesthetic treatments, for example, anti-wrinkle injections, dermal fillers and thread vein treatments, as well as nutritional advice and therapies, which are not within CQC scope of registration.

The Registered Provider is Meyerhealth Ltd.

Meyerhealth Ltd is located at Main Road, Fishbourne, Chichester, West Sussex, PO18 8AN.

The clinic opening times are:

Monday, Tuesday, Thursday, Friday: 08:00 to 16:00

Wednesday 08:00 to 18:00

The staff team which supports the medical director includes a clinic manager, a clinical assistant and a receptionist.

The service is run from shared, ground floor premises which are leased by the provider and located within a dental service, The Bosham Clinic. The provider leases a suite of consultation and treatment rooms, with a separate reception and waiting area. Access to the premises is at street level to support patients with limited mobility. Toilet facilities are located on the ground floor.

The service is currently undergoing construction adjacent to the existing premises on the same site, to develop their own self-contained unit.

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.

Inadequate

# Are services safe?

**Safety systems and processes**

**The service had a lack of systems in some areas, to keep people safe and safeguarded from abuse.**

- The service had systems and processes to safeguard children and vulnerable adults from abuse. All staff had received training in safeguarding vulnerable adults and children at a level appropriate to their role. We reviewed the provider's safeguarding policies which provided appropriate 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.
- Treatment was offered to patients of all ages, including those under the age of 18 years. However, there was a lack of processes to formally confirm a patient's identification prior to treatment or to ensure that an adult accompanying a child had parental authority.
- The provider carried out staff checks at the time of recruitment and on an ongoing basis where appropriate. Disclosure and Barring Service (DBS) checks were undertaken where required. (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.
- The service had some systems to manage health and safety risks within the premises. There were service level agreements in place which defined some areas of responsibility between the provider and the host dental practice. For example, the dental practice managed the premises with regard to legionella, fire safety and health and safety. (Legionella is a particular bacterium which can contaminate water systems in buildings).
- Multiple remedial actions had been identified in legionella, fire safety and health and safety risk assessments undertaken on 25 May 2022. Previous risk assessments were undertaken in August 2020 and some remedial actions identified in 2020 had not been addressed at the time of our inspection. For example, with regard to legionella management, hot water storage vessels were required to be drained and cleaned annually and air conditioning units required annual inspection and maintenance. Dental practice staff monitored water temperatures on a monthly basis to mitigate the risks associated with legionella. However, some hot water temperatures had been recorded as significantly below the required minimum for a period of 18 months prior to our inspection. This had not been reported to or identified by leaders and no action had been taken to respond to the low temperatures.
- A fire risk assessment, undertaken in August 2020, had identified remedial actions which had not been addressed at the time of our inspection. These included required upgrades to the fire alarm and fire detection systems, which were identified as high-risk actions requiring immediate attention. Staff told us that these requirements would be addressed as part of the development of the new premises which were planned to be completed before the end of 2022. There was appropriate fire-fighting equipment located within the premises which was regularly serviced and maintained. Weekly fire alarm testing records were held. Fire extinguishers had been serviced in October 2021. The service had designated staff who were trained as fire marshals and staff had undertaken fire safety training. Staff had participated in a fire drill at annual intervals.
- The provider ensured that equipment was safe and maintained according to manufacturers' instructions. We reviewed records to confirm that electrical equipment had undergone portable appliance testing in October 2021. There was an electrical safety certificate for the premises dated April 2022 which indicated that remedial works were required to the fire alarm panel. The provider told us this work was planned in conjunction with commissioning a new fire alarm as part of the current building works.
- There were mainly effective systems to manage infection prevention and control within the service. Cleaning and monitoring schedules were in place for clinical areas. All staff had received training in infection prevention and control. An audit of infection prevention processes had been undertaken. There were sufficient stocks of personal protective equipment, including masks, aprons and gloves. However, the provider was unable to demonstrate that they held appropriate records relating to staff immunisations.

Inadequate

# Are services safe?

- We reviewed the service's staff immunisation policy dated June 2022. The policy reflected current guidance in relation to staff immunisation requirements. Our review of immunisation records confirmed a record of Hepatitis B status was held for all four staff members. However, there were no other vaccination records available for one staff member who provided clinical care to patients. There were variable immunisation records available relating to varicella, tetanus, polio, diphtheria and MMR (measles, mumps, rubella) in line with current guidance, for other staff members. Personnel records we reviewed did not therefore reflect the provider's policy in monitoring the immunisation status of staff and monitoring was not in line with national guidance.
- There were systems for safely managing healthcare waste, including sharp items. We saw that clinical waste disposal was available in clinical rooms. 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.
- The provider used reusable instruments for minor surgical procedures which underwent decontamination processes employed by the host dental practice. There was a service level agreement in place between the two parties which reflected this arrangement. The dental practice followed national guidance for cleaning, sterilising, packaging and storing instruments. There were systems in place to ensure that all equipment used to sterilise instruments was maintained and validated in line with current guidance. Staff had received appropriate training in cleaning and decontamination processes.
- 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.
- Liquid nitrogen was stored within the service and used to provide cryotherapy to treat some skin lesions. The service had adequately assessed the risks associated with the storage and use of liquid nitrogen and provided detailed guidance for staff in its use.

**Risks to patients**

**There was a lack of some systems in some areas, to assess, monitor and manage risks to patient safety.**

- There were planned induction processes in place and a plan of required training for staff to complete as part of the induction process.
- There were arrangements for planning and monitoring the number and mix of staff required to meet patient needs. Appointments with the medical director, who was the sole clinician, were scheduled according to patient demand.
- Staff 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. However, the service had not provided specific guidance to non-clinical staff to support their understanding of managing patients with 'red flag' symptoms, severe infection and sepsis.
- We reviewed arrangements within the service to respond to medical emergencies. We noted that there was a service level agreement in place to enable the service to access emergency medicines and equipment provided by and shared with, the host dental practice.
- However, we found that emergency medicines and equipment held on site were insufficient given the patient population to which services were provided. We found there was no antihistamine, no penicillin for injection, no steroid solution for the treatment of children with croup, no nonsteroidal anti-inflammatory medicine to treat pain and inflammatory disease and no anti- sickness medicine. There was no documented risk assessment to support the decision not to hold those emergency medicines. There was one oxygen cylinder, with face masks for both adults and children and an auto external defibrillator on site. We found that a second oxygen cylinder was free-standing and not stored securely and was significantly out of date. There was no risk assessment to support the decision to have only one working oxygen cylinder shared between two different services. There was no paediatric pulse oximeter available, despite services being open to children and no risk assessment to support this decision.
- There were appropriate professional indemnity arrangements in place for clinical staff.

Inadequate

# Are services safe?

- The provider had in place public and employer's liability insurance policies effective from April 2022.

**Information to deliver safe care and treatment**

**Staff did not always have the information they needed to deliver safe care and treatment to patients.**

- We reviewed a sample of clinical care records relating to patients who had received treatment within the service.
- 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 utilised a secure electronic clinical notes system which provided templates specific to the type of consultation and promoted consistency of clinical record keeping. Patient clinical records kept, including treatment planning information, were adequately documented.
- The service had some systems for sharing information with staff and other agencies to enable them to deliver safe care and treatment. We saw some examples of sharing of information with other agencies and patients' NHS GPs, where a patient's consent was obtained, in order to ensure the safe care and treatment of patients.
- The service used an independent pathology service to analyse blood and other specimens. Results were received by the service in encrypted format. Administration staff filed results determined to be normal. However, there was a lack of protocol to define what was normal, for example in cancer markers, and a lack of clarity around what level of results the clinician would review. There was no clear alert process in place if a patient with concerning results did not return for review.
- The provider had a phlebotomy service which enabled patients to book directly for a blood test of their choice without referral by a clinician and without being seen by a clinician within the service. Results were sent directly to the patient with no review or analysis by a clinician. The service provided no documented disclaimer to patients in this regard and no advice to patients to seek clinical review of their results by their registered GP or other healthcare professional. The provider had not undertaken an assessment of the risks associated with this service.
- Our review of patient clinical records identified that the provider did not always follow best practice guidance in relation to its dermatology service. Staff told us that excised lesions were not routinely sent for histology. There was a lack of clear processes for tracking, monitoring or auditing of histology results. Staff told us they might put a reminder in a diary to highlight when a histology result should have been received. However, there was a lack of clear processes to ensure this happened. Our review of clinical records identified that the use of a dermatoscope was not consistently documented in the assessment of a skin lesion.
- We noted that the service did not have an electrocardiogram (ECG) machine on site (an ECG is used to monitor a patient's heart rhythm and electrical activity). There were no arrangements in place to enable a clinician to refer a patient for such monitoring outside of the service, if this was required, prior to the prescription of some medicines. For example, medicines to treat psychosis or depression. The provider had not assessed the risks associated with this lack of arrangements. However, we did not identify any patients who had been affected.

**Safe and appropriate use of medicines**

**The service did not always have reliable systems for appropriate and safe handling of medicines.**

- The systems and arrangements for managing medicines, emergency medicines and equipment did not always minimise risks.
- The service kept prescription stationery securely and monitored its use.
- Staff mainly prescribed and administered medicines to patients and gave advice on medicines in line with legal requirements and current national guidance. However, our review of patient records identified instances where prescribing of pain-relieving medicines which were controlled drugs, did not always follow best practice guidance to ensure the safe care and treatment of patients. (Controlled drugs are medicines that have the highest level of control due to their risk of misuse and dependence). There was a lack of processes to formally confirm a patient's

identification prior to treatment. Communication with a patient's NHS GP did not routinely occur, to ensure information sharing prior to treatment and once an episode of treatment was completed. There was a lack of processes and guidance to support clinicians in their decision making and assessment of risk in the prescribing of controlled drugs. These factors increased the risks associated with patients potentially attending the service with the intention of seeking prescriptions for controlled drugs.

- Some medicines prescribed within the service, such as Bioidentical Hormone Replacement Therapy, were unlicensed. Treating patients with unlicensed medicines is higher risk than treating patients with licensed medicines, because unlicensed medicines may not have been assessed for safety, quality and efficacy. These medicines were not recommended by the National Institute for Health and Care Excellence (NICE) or the British Menopause Society. NICE Guidance NG23 states that clinicians must explain to patients that the efficacy and safety of unregulated compounded bioidentical hormones are unknown. Where the service prescribed unlicensed medicines, the risks, benefits and possible side effects were explained to patients and we saw that patient information leaflets were provided to help patients understand the treatment.
- Medicines were stored securely in a clinical room. Medicines requiring refrigeration were stored in a lockable fridge which was suitable for use. Temperature monitoring records confirmed only once daily checks of the fridge temperature. Although the fridge enabled the upper and lower temperature ranges to be recorded for a given period, staff had recorded only the actual temperature of the fridge at the time of monitoring, rather than the highest and lowest temperatures during a given period. Therefore, the provider could not be assured that the temperature range had not fallen outside of what was recommended for safe storage. All actual temperatures recorded had been within the required range.
- The service had not carried out medicines audits to ensure prescribing was in line with best practice guidelines for safe prescribing.

**Track record on safety and incidents**

- Management of health and safety within the premises was shared between the host dental practice and the provider. The provider had undertaken some general health and safety risk assessments of their designated areas and in relation to for example, lone working, display screen equipment usage and moving and handling. The provider had not fully assured themselves that all premises health and safety requirements were met and carried out in a timely manner.
- The service undertook some monitoring and review activities which helped it to understand some risks. For example, immediately prior to our inspection, the service had undertaken auditing of their consenting process and monitoring of their wound infection rates following minor surgery. The provider had not undertaken any other previous clinical audit.

**Lessons learned and improvements made**

**The service learned made improvements 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. Leaders and managers supported them when they did so.
- There were adequate systems for reviewing and investigating when things went wrong. The service had recorded two incidents within the 12 months preceding our inspection. These were associated with non-regulated activities and the provider had taken timely and appropriate action to make changes as a result.
- The provider was aware of and complied with the requirements of the Duty of Candour. The provider encouraged a culture of openness and honesty. 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. The service had an effective mechanism in place to disseminate alerts to all members of the team.

Requires Improvement

# Are services effective?

**Effective needs assessment, care and treatment**

**The provider had some 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 noted that the medical director had a special interest in women's health and followed guidance for example, from the British Menopause Society. However, some unlicensed medicines prescribed by the service, such as Bioidentical Hormone Replacement Therapy, were not recommended by the British Menopause Society.
- Patients' immediate and ongoing needs were fully assessed. Where appropriate this included their clinical needs and their mental and physical wellbeing.
- We saw evidence that clinicians assessed needs and delivered care and treatment generally in line with current legislation, standards and guidance relevant to their service. However, our review of patient clinical records identified that the provider did not always follow best practice guidance in relation to some services provided. Excised lesions were not routinely sent for histology and the use of a dermatoscope was not consistently documented in the assessment of a lesion. The prescribing of controlled drugs did not always follow best practice guidance to ensure the safe care and treatment of patients.
- The service ensured they provided information to support patients' understanding of their treatment, including pre- and post-treatment advice and support. Patients were able to access post treatment support via follow up appointments and also on the telephone.
- We saw no evidence of discrimination when making care and treatment decisions.
- Staff assessed and managed patients' pain where appropriate. Patients were prescribed local anaesthetic medicines prior to some procedures, where appropriate.

**Monitoring care and treatment**

**The service had undertaken some quality improvement activity**.

- The service gathered some information about care and treatment to make some improvements.
- The service had undertaken some risk assessment and monitoring activities. For example, in relation to infection prevention and control and general health and safety. Following announcement of our inspection the provider had undertaken an initial review of their consent process and infection rates following minor surgery. There was otherwise a lack of clinical audit to demonstrate a positive impact on quality of care and treatment outcomes for patients. The service had not carried out regular medicines audits to ensure prescribing was in line with best practice guidelines for safe prescribing.

**Effective staffing**

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

- Staff mainly had the appropriate skills and training to carry out their roles. However, non-clinical staff had not received training or guidance in the identification of 'red flag' signs or symptoms of sepsis in patients.
- There were planned induction processes in place. There was a 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 provider had identified that an update in phlebotomy training was required for one staff member and was in the process of arranging this.

Requires Improvement

# Are services effective?

- There was regular review of individual performance. Staff underwent regular one-to-one review meetings with the service manager and annual appraisal.
- The service held records which confirmed medical professionals were registered with the General Medical Council (GMC) and were up to date with revalidation.

**Coordinating patient care and information sharing**

**Staff did not always share information with other organisations to deliver effective care and treatment.**

- Patients who used the service received coordinated and person-centred care. Before providing treatment, doctors at the service generally ensured they had adequate knowledge of the patient's health, previous medical and medicines history.
- However, prescribing of pain-relieving medicines which were controlled drugs, did not always follow best practice guidance. There was a lack of processes to formally confirm a patient's identification prior to treatment and communication with a patient's NHS GP did not routinely occur, to ensure information sharing prior to treatment and once an episode of treatment was completed.

**Supporting patients to live healthier lives**

- Where appropriate, staff gave people advice so they could self-care.
- 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.
- Where patients' needs could not be met by the service, staff told us they redirected them to the most appropriate service for their needs. For example, staff told us that if they were concerned about a suspicious lesion, they would decline to treat the patient and would refer the patient back to their GP or directly onto a secondary care pathway.

**Consent to care and treatment**

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

- Staff we spoke with 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.**

- The service gave patients timely support and information in relation to their care and treatment.
- The service invited feedback on the quality of care patients received. Following the announcement of our inspection, the provider sought written feedback from a selection of 24 patients who attended the service between 7 and 13 June 2022. Patients who responded indicated that they were happy with the care and treatment they had received. Patients said for example, that they were treated in a professional, friendly and understanding way.
- Staff understood patients' personal, cultural, social and religious needs. They displayed an understanding and non-judgmental attitude to all patients.

**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, including costs, they required to make decisions about their treatment prior to treatment commencing. Information about pricing was available to patients within the service and on the service's website. 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.
- Staff communicated with people in a way that they could understand, for example, communication aids such as a hearing loop were available.

**Privacy and Dignity**

**The service respected patients' privacy and dignity.**

- Staff recognised the importance of people's dignity and respect. Consultations took place behind closed doors and staff knocked when they needed to enter.
- Patients were collected from the waiting area by the GP and escorted into the consultation room.
- Reception staff were aware that if patients wanted to discuss sensitive issues or appeared distressed, they could offer them a private room to discuss their needs.
- Chaperones were available on request and the practice was able to provide consultations and treatment with either a male or female GP.
- Staff complied with the practice's information governance arrangements. Practice processes ensured that all confidential electronic information was stored securely on computers. All confidential information kept as hard copies was stored in locked cupboards.

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.
- The facilities and premises were sufficiently 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.
- Patients were directed to local NHS services if they required assistance when the service was closed.

**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. Staff told us that if required, appointments were usually available either on the same day or the day following a request.
- Waiting times, delays and cancellations were minimal and managed appropriately.
- Appointments could be booked in person, by telephone or via the service's website.
- Patients with the most urgent needs had their care and treatment prioritised.
- Referrals to other services were undertaken in a timely way and were managed appropriately.

**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 and on the provider's website.
- Staff treated patients who made complaints compassionately. The service had received eight complaints within the previous 12 months and was able to demonstrate 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.
- There was evidence that complaints had been discussed and the learning shared amongst the team. We reviewed documented evidence of staff meetings where complaints had been discussed.

Requires Improvement

# Are services well-led?

**Leadership capacity and capability:**

**Leaders had some skills to deliver high-quality, sustainable care.**

- Leaders had not always demonstrated the capacity to implement systems and processes to support the delivery of high-quality care. There was a lack of organisational strategy in some key areas, such as clinical governance and risk management.
- Leaders had some awareness and understanding of the issues and priorities relating to the quality and future of the service.
- Leaders expressed a clear desire to address issues raised on inspection and to make improvements to deliver high quality care.
- Leaders within the service were visible and approachable. They worked closely with the small team of staff and others and told us 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. The medical director and clinic manager were keen to further develop quality and governance processes.
- There were formal and informal open lines of communication between staff working within the service. Staff we spoke with felt well supported and described leaders within the service as approachable. Staff told us they had regular one-to-one interaction with managers due to the small nature of the service and we saw evidence of documented one-to-one meetings. Staff spoke of team meetings they attended, and we saw records of those meetings.

**Vision and strategy**

**The service had a clear vision and 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.
- The service had a strategy and business plan to develop new, self-contained premises and to expand upon services offered to patients and to increase the staff team. However, there was a lack of established governance and risk management processes in some areas to support this expansion.
- 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 developing processes further to ensure the promotion of optimum outcomes for patients.

**Culture**

**The service had a culture to promote some aspects 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.

Requires Improvement

# Are services well-led?

- There were processes for providing all staff with the development they needed. This included appraisal and career development conversations. All staff had received regular annual appraisals in the last year. Staff were supported to meet the requirements of professional revalidation where necessary.
- 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 practice was comprised of a small team of four staff members. There were positive relationships between staff and prompt and effective communications.

**Governance arrangements**

**There was a lack of systems of accountability to support good governance and management.**

- Some processes and systems to support good governance and management were not clearly set out or established in some areas.
- Staff understood their individual roles and responsibilities. The provider had identified individual members of staff to assume lead roles in key areas. For example, safeguarding and infection prevention and control.
- The provider utilised the services of an external supplier to provide support with human resource processes and policy development.
- Some premises and equipment management systems, such as the supply of emergency equipment, decontamination services, fire safety and legionella management were implemented by the host dental practice. Service level agreements between the two parties defined their areas of responsibility. There were open lines of communication between the managers of both services and they met regularly to review operational arrangements.
- Although there was open dialogue between the two parties, the provider had not fully assured themselves that aspects of service delivery implemented by the host dental practice, were fulfilled or appropriate for the nature of services they provided. For example, some aspects of fire safety and legionella management had not been actioned in a timely manner; emergency medicines and equipment shared between the two parties, were insufficient given the patient population to which services were offered.
- Written policies provided clear guidance for staff and reflected current good practice guidance from sources such as the National Institute for Health and Care Excellence (NICE). However, staff lacked knowledge and understanding of best practice and legislative requirements in some areas and processes implemented within the service did not always reflect policy content provided by the external supplier. For example, personnel records we reviewed did not reflect the provider's policy or national guidance for monitoring the immunisation status of staff; governance and risk management processes, including proposed audit cycles outlined within the service's governance and risk policy, were not implemented within the service.

**Managing risks, issues and performance**

**There was a lack of clear and effective processes for managing risks, issues and performance in some areas.**

- There was a lack of effective processes in some areas, to identify, understand, monitor and address current and future risks, including some risks to patient safety. For example, there was a lack of processes and guidance to support clinicians in their decision making and assessment of risk in the prescribing of controlled drugs; there was a lack of clear processes for tracking, monitoring or auditing histology results; there was a lack of clarity around which pathology results a clinician would review; the service had not provided specific guidance to non-clinical staff to support their understanding of managing patients with 'red flag' symptoms; some health and safety premises risk had not been appropriately monitored or actioned.

Requires Improvement

# Are services well-led?

- The provider was unable to demonstrate that clinical audit had had a positive impact on the quality of care and outcomes for patients. There was a lack of evidence of a quality improvement programme or continuous clinical audit to monitor quality and to drive improvement. The service had not implemented a programme of clinical audit prior to the announcement of our inspection. Immediately prior to our inspection the provider undertook an audit of their consenting process and monitoring of their infection rates following minor surgery.
- Leaders had oversight of safety alerts, incidents, and complaints should they arise. There was a system for recording and acting on 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 provider did not have a business continuity plan in place to ensure continuity of services should the premises or key personnel, become unexpectedly unavailable.

**Appropriate and accurate information**

**The service acted on appropriate and accurate information.**

- Quality and operational information which was gathered was used to ensure and improve performance. There were plans to address some identified weaknesses. Immediately following our inspection, and in response to initial feedback of our findings, the provider took prompt action to begin to address the findings.
- Practice meetings were held regularly where quality and risks were discussed. We reviewed minutes of monthly meetings held within 2021/2022. 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. Practice processes ensured that all confidential electronic information was stored securely on computers. All patient information kept as hard copies was stored in locked cupboards. Staff demonstrated a good understanding of information governance processes.

**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 the services and culture of the practice. For example, clinical and aesthetic services were provided solely by the medical director in response to patient feedback.
- Staff could describe to us the systems in place for them to give feedback. The small team of staff worked closely together and had both formal and informal opportunities to provide feedback through staff meetings, appraisals and discussion.
- The service was transparent, collaborative and open with stakeholders about performance.

**Continuous improvement and innovation**

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

- There was some evidence of learning and improvement.
- The staff team demonstrated their commitment to continuous improvement and acted immediately to respond to the initial findings of our inspection.
- The service made use of internal and external reviews of incidents and complaints. Learning was shared and used to make improvements.

Requires Improvement

# Are services well-led?

- Leaders and managers encouraged staff to take time out to review individual and team objectives, processes and performance.

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<br><br>Surgical procedures<br><br>Treatment of disease, disorder or injury | Regulation 17 HSCA (RA) Regulations 2014 Good governance<br><br>The provider was unable to demonstrate that systems and processes were implemented effectively to assess, monitor and improve the quality and safety of the services provided in the carrying on of the regulated activities.<br><br>In particular:<br><br>• To ensure effective governance and risk assessment processes with regard to: Prescribing of controlled drugs; the provision of phlebotomy services; processes for managing and tracking incoming test results;<br>• To ensure processes for clinical audit and regular auditing of clinical record keeping processes in order to monitor quality and drive improvement.<br>• To ensure policy content is reflected in processes undertaken within the service.<br>• To ensure governance and monitoring processes to provide assurance to leaders that leased premises are safe and suitable for use. To adequately assess and monitor the risks associated with legionella, electrical and fire safety.<br>• To ensure non-clinical staff receive training and guidance to support their understanding of managing patients with 'red flag' symptoms, severe infection and sepsis.<br>• To ensure there is a business continuity plan in place.<br><br>This was in breach of regulation 17(1)(2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. |

This section is primarily information for the provider

# Enforcement actions

## Action we have told the provider to take

The table below shows the legal requirements that were not being met.

| Regulated activity | Regulation |
|---|---|
| Diagnostic and screening procedures<br>Surgical procedures<br>Treatment of disease, disorder or injury | Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment<br>The provider had not done all that was reasonably practicable to ensure care and treatment was provided in a safe way for service users.<br>In particular:<br>• To ensure emergency medicines and equipment held on site are sufficient to respond to medical emergencies within the service.<br>• To ensure processes to ensure the safe prescribing of controlled drugs to patients.<br>• To ensure appropriate records are held relating to staff immunisations, in line with current guidance.<br>• To implement fridge temperature monitoring processes which ensure the correct temperature range for the safe storage of medicines.<br>• To implement protocols for sending excised lesions for histology and processes for tracking, monitoring or auditing histology results.<br>This was in breach of regulation 12 (1)(2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.<br>Warning Notice issued. |