Meyerhealth Ltd

Inspection report

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This report describes our judgement of the quality of care at this service. It is based on a combination of what we found when we inspected, information from our ongoing monitoring of data about services and information given to us from the provider, patients, the public and other organisations.

Ratings

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

Overall summary

This service is rated as Good overall.

The key questions are rated as:

Are services safe? – Good

Are services effective? – Good

Are services caring? – Good (carried over from previous inspection)

Are services responsive? – Good (carried over from previous inspection)

Are services well-led? – Good

We previously carried out a comprehensive inspection of Meyerhealth Ltd on 21 June 2022. We identified breaches of regulation 12 (Safe care and treatment) and regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We issued a regulation 12 warning notice and regulation 17 requirement notice. The service was rated as inadequate for providing safe services, requires improvement for providing effective and well-led services, and good for providing caring and responsive services. The service was rated as requires improvement overall.

We carried out a further focused inspection on 22 September 2022 to confirm the provider had taken sufficient action to comply with the regulation 12 warning notice issued.

We carried out this announced comprehensive inspection of Meyerhealth Ltd on 5 June 2023 under Section 60 of the Health and Social Care Act 2008. This inspection was planned to check whether the service was meeting the legal requirements and regulations associated with the Health and Social Care Act 2008. At this inspection we checked that the service was providing safe, effective and well-led services. Our ratings of good for caring and responsive services are carried over from the previous inspection.

How we carried out the inspection:

This inspection was carried out in a way which enabled us to spend a minimum amount of time on site.

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 5 June 2023. 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 the medical director, a 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.

Overall summary

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.

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.

There was no registered manager for the service at the time of our inspection, further to recent changes in personnel. 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. The medical director told us they were in the process of submitting their application to register as the registered manager.

Our key findings were:

- Clinical 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 induction, training and monitoring of staff.
- There were safeguarding systems and processes to keep people safe.
- There were records to demonstrate that staff recruitment checks had been carried out in accordance with regulations for all staff.
- Arrangements for chaperoning were effectively managed.
- There were processes to assess the risk of, and prevent, detect and control the spread of infection.
- There were governance, risk assessment and monitoring processes to ensure the safety of the newly developed premises.
- Some actions to address findings from a disability access risk assessment remained outstanding.
- There were systems in place to ensure the proper and safe storage of medicines and vaccines requiring refrigeration.
- There was evidence of clinical audit, and clinical decision making was in line with current, best practice guidance.
- Clinical record keeping was clear, comprehensive and complete.
- There was evidence of communication and information sharing amongst the small staff team.
- Staff were subject to regular review of their performance and felt well supported by managers.
- Written policies provided appropriate guidance to staff.
- Service users were asked to provide feedback on the service they had received and there were high levels of patient satisfaction across the service.

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

- Complete outstanding actions to support access to the premises by patients with restricted mobility, in line with risk assessment findings.
- Complete works to ensure the safe external storage of clinical waste awaiting collection.
- Display current CQC inspection ratings clearly and conspicuously within the service.

Dr Sean O'Kelly BSc MB ChB MSc DCH FRCA

Chief Inspector of Health 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 the medical director, 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 practice manager, a registered nurse, a clinical assistant and a receptionist.

Services are provided from newly constructed, self-contained, two storey premises which are owned by the provider. The premises had been developed since our previous inspection, within the grounds of the shared premises from which services were previously provided. Construction of the premises had been completed in March 2023.

The premises provide a high standard of accommodation which includes a suite of spacious consulting and treatment rooms, administration and staff breakout areas.

Patients access to the premises is via a ramp at street level, to support patients with limited mobility. Patients enter the premises via a large open reception and waiting area. Toilet facilities are located on the ground floor. A patient lift is installed within the premises to support access to the first floor. The lift was not in use at the time of our inspection but patients with limited mobility could be provided with care within one of the ground floor consulting rooms. The provider told us that these arrangements were temporary whilst they awaited installation of an evacuation device, to ensure such patients could be safely evacuated from the first floor of the premises, in the event of an emergency.

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.

Good

Are services safe?

Safety systems and processes

The service had systems in place 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. Patients were asked to provide personal identification on registration with the service. There were systems in place to assure that an adult accompanying a child had parental authority.
- There were records to demonstrate that recruitment checks had been carried out in accordance with regulations for all staff. 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 systems in place to manage health and safety risks within the premises. The provider had sought specialist external advice and review to ensure the safety of the newly developed premises. Comprehensive risk assessments had been undertaken with regard to legionella, fire safety and general health and safety of the premises. Required actions had mostly been completed and where necessary, appropriate mitigations implemented.
- There was a fire safety risk assessment in place and all required actions had been completed. There was appropriate fire-fighting equipment located within the premises, emergency lighting and a fire alarm. The fire alarm and emergency lighting were tested weekly. The service had designated staff who were trained as fire marshals and staff had undertaken fire safety training. Staff had participated in fire drills in March and June 2023.
- A Legionella risk assessment had been undertaken and resulting actions, which included regular water temperature monitoring and flushing of infrequently used outlets, were carried out (Legionella is a particular bacterium which can contaminate water systems in buildings).
- We noted that some required actions resulting from a disability access risk assessment, undertaken in March 2023, had not yet been completed. For example, the provider had not yet provided designated parking bays nor installed the recommended external signage for patients with restricted mobility. However, parking immediately near the main entrance to the service was plentiful and the entrance clearly visible. There was a lift to the first floor installed within the premises which was not in use at the time of our inspection. The provider told us they were awaiting installation of an evacuation device, to ensure patients with restricted mobility could be safely evacuated from the first floor of the premises in the event of an emergency. The provider had taken appropriate action to address this risk in the meantime and told us that where required, patients could be treated within one of the ground floor consulting rooms. Staff told us that all new patients contacting the service would be screened to identify any additional access requirements ahead of their first visit and would be supported on an individual basis to meet their needs.
- 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 May 2023. There was an electrical safety certificate for the premises dated October 2022. Medical equipment had undergone calibration and testing in August 2022.
- There were 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 in May 2023 and auditing of staff hand hygiene techniques in April 2023. There were sufficient stocks of personal protective equipment, including masks, aprons and gloves. The service used single use instruments only to undertake minor surgical procedures.

Good

Are services safe?

- We reviewed the service's staff immunisation policy which reflected current guidance in relation to staff immunisation requirements. The provider was able to demonstrate that they held appropriate records relating to staff immunisations, in line with UK Health Security Agency (UKHSA) 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. The provider held appropriate records related to the collection and transfer of their healthcare waste by a waste management company.
- An external, lockable bin was used to store healthcare waste awaiting collection. We noted that whilst the bin was locked, it required further securing to minimise the risk of public access. The provider told us they intended to build a secure bin store to further limit public access. Meanwhile, the provider had taken steps to reduce potential risks when the service was closed, by locking a gate to the entrance to the grounds. However, the bin was out of sight of staff during opening hours and therefore inappropriate access, or removal, could not be easily monitored.
- There was guidance and information, including risk assessments, available to staff, including cleaning staff, to support the control of substances hazardous to health (COSHH).
- Liquid nitrogen was stored within the service and used to provide cryotherapy to treat some skin lesions. (Cryotherapy is the removal of surface skin lesions by freezing them.) 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. For example, guidance from the British Compressed Gases Association was available.
- The provider had introduced measures to ensure staff were able to alert others to an emergency situation within the service. All staff wore personal alarms which could be heard throughout the premises.
- The service held an emergency 'grab' box, which contained a range of items which might be needed in an emergency situation requiring evacuation of the premises. For example, items such as a torch, bottled water and a high visibility jacket were included.

Risks to patients

There were systems in place 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.
- Patients had timely access to initial assessment, test results, diagnosis and treatment.
- Appointments with the medical director, who was the sole clinician, were scheduled according to patient demand. Waiting times, delays and cancellations were minimal and managed appropriately.
- Patients with the most urgent needs had their care and treatment prioritised.
- 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. The service had 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 found there were appropriate supplies of emergency medicines available to staff in the event of a medical emergency. There was an oxygen supply and a defibrillator available to support the management of medical emergencies, which were subject to regular checks. Staff had completed training in basic life support.
- There was a first aid kit available within the service which was subject to regular checks.
- The provider had in place a public and employer's liability insurance policy.
- There were appropriate professional indemnity arrangements in place for clinical staff.

Information to deliver safe care and treatment

Good

Are services safe?

Staff had 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 comprehensively documented.
- The service had systems for sharing information with staff and other agencies to enable them to deliver safe care and treatment. We saw examples of sharing of information with 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. The clinician reviewed all results received and communicated those results to the patient and, where appropriate, the patient's NHS GP. There was a clear tracking process in place to monitor and record samples taken, receipt of results, their processing, and onward communications with the patient and other services.
- The service provided an outpatient phlebotomy service which enabled patients to book directly for a blood test requested by an external clinician, without being seen by a clinician within the service. Patients were required to attend with the appropriate test kit and results were sent directly to the patient, for review and analysis by the referring clinician. The provider implemented a clear protocol to support this process. Patients requesting blood tests without referral were required to be seen by the GP within the service prior to testing, in order to ensure appropriate clinical review and advice.
- Our review of patient clinical records confirmed that the provider followed best practice guidance in the care and treatment of patients. We saw that the assessment of skin lesions, including use of a dermatoscope, were fully documented. (A dermatoscope is a hand-held visual aid device used to examine and diagnose skin lesions and diseases.) We saw that the GP wrote to the patient and their NHS GP to confirm histology results received. Staff told us that where a lesion appeared suspicious, they would immediately refer the patient back to their NHS GP or directly onto a secondary care pathway.

Safe and appropriate use of medicines

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

- There were systems and arrangements for managing the safe handling of medicines and prescribing practices in a way which minimised risks to patients.
- Appropriate processes were in place for the ordering, receipt and monitoring of stock medicines held and staff kept accurate records of those medicines.
- The service kept prescription stationery securely and monitored its use.
- Staff prescribed and administered medicines to patients, and gave advice on medicines, in line with legal requirements and current national guidance. The service had carried out medicines audits to ensure prescribing was in line with best practice guidelines for safe prescribing.
- The provider had developed clearly defined processes to support the safe prescribing of controlled drugs, in line with national guidance. There was a clear protocol to ensure the identification of each patient was confirmed at the point of registration with the service and prior to an episode of treatment. The provider had developed guidance to support clinicians in the prescribing of controlled drugs and their assessment of associated risks. This included a requirement for routine communication with a patient's NHS GP when controlled drugs were prescribed.
- Some medicines prescribed within the service, such as some 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 occasionally prescribed unlicensed medicines, the risks, benefits and possible side effects were fully explained to patients, and we saw that patient information leaflets were provided to help patients understand their treatment.

- The provider had established processes to ensure the safe storage of medicines. Medicines were stored securely in a clinical room. Medicines requiring refrigeration were stored in a lockable fridge which was suitable for use. Staff recorded the highest and lowest temperatures during a given period, as well as the actual temperature of the fridge at the time of recording. Staff had received guidance and training to ensure their understanding of the process and the importance of reporting any temperatures which fell outside of the recommended range.

Track record on safety and incidents

- There were monitoring and auditing processes in place to provide assurance to leaders that systems were operating as intended. There were risk assessments in place in relation to safety issues, to support the management of health and safety within the newly built premises. The provider had utilised a specialist external supplier to undertake those risk assessments and had completed required actions in a timely manner or implemented appropriate mitigations where actions were outstanding.
- There was monitoring and review of clinical activities to support the provider in identifying potential risks within the service. Managers responded promptly when safety concerns or risks were identified. The provider had further developed their programme of clinical audit since our previous inspection. For example, the service had undertaken auditing of their consenting process and monitoring of wound infection rates following minor surgery.

Lessons learned and improvements made

The service learned and 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 appropriately recorded and reviewed incidents which had occurred and had taken timely and appropriate action to make changes as a result. We saw that incidents were discussed and reviewed within team meetings.
- 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 monitor and disseminate alerts to all members of the team.

Good

Are services effective?

Effective needs assessment, care and treatment

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

- The provider had systems in place to keep clinicians up to date with current evidence-based practice. We noted that the medical director had a special interest in women's health and followed guidance for example, from 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 in line with current legislation, standards and guidance relevant to their service. Our review of patient clinical records confirmed the provider followed best practice guidance in relation to services provided. Excised lesions were routinely sent for histology and the use of a dermatoscope was consistently documented in the assessment of a lesion. The prescribing of controlled drugs followed best practice guidance to ensure the safe care and treatment of patients.
- 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. For example, prior to excision of a skin lesion.

Monitoring care and treatment

The service was able to demonstrate an improved programme of quality improvement activity.

- The provider gathered information about care and treatment in order to make improvements to services.
- The service had undertaken appropriate risk assessment and monitoring activities. For example, in relation to infection prevention and control and health and safety of the premises.
- Since our previous inspection the provider had developed a more comprehensive programme of clinical audit in order to promote a positive impact on the quality of care and treatment outcomes for patients. For example, the provider had carried out regular medicines audits, to ensure prescribing was in line with best practice guidelines for safe prescribing and auditing of their management of patients with an underactive thyroid gland.

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. There was a plan of required training for staff to complete as part of the induction process.
- The provider had clearly set out the training all staff were required to complete in key areas, via an online platform. For example, vulnerable adult and child safeguarding, infection control, information governance and health and safety. Some training, such as basic life support was delivered face-to-face.
- 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.
- Individual objectives and competencies were established to support staff to carry out their roles. The provider ensured additional support and supervision was provided where this was required. One staff member told us of supervision and guidance provided by the medical director to support development of their phlebotomy skills, further to external training.
- We noted that reception staff had access to a support file containing protocols and guidance relevant to their role. For example, emergency contact information, patient information literature and safety checklists.

Good

Are services effective?

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

Coordinating patient care and information sharing

Staff shared 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 ensured they had adequate knowledge of the patient's health, previous medical and medicines history.
- Since our previous inspection, the provider had implemented protocols to ensure the prescribing of pain-relieving medicines which were controlled drugs, followed best practice guidance. There were processes to formally confirm a patient's identification prior to treatment and communication with a patient's NHS GP routinely occurred, 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 patients 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.
- Patients received a support telephone call from the service on the day following their treatment and 7-10 days later, to confirm their satisfaction and to identify any areas of concern, such as signs of infection. Support calls were structured and comprehensively documented by the service.
- We noted that the service operated an electronic patient portal in order to share information directly with patients about their care and treatment.
- 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. This included consent to pre- and post-treatment photographs being taken and the limitations of their subsequent use. Patient records we reviewed clearly documented the consent process and discussions between the practitioner and patient.

Good

Are services well-led?

Leadership capacity and capability:

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

- Leaders demonstrated the capacity to implement systems and processes to support the delivery of high-quality care. There were improved processes in key areas, such as clinical governance and risk management.
- Leaders had improved awareness and understanding of the issues and priorities relating to the quality and future of the service. Issues identified at our previous inspection had been appropriately addressed and improvements implemented to promote the delivery of high- quality care.
- Leaders within the service included the medical director and the recently appointed practice manager, who were visible and approachable. They worked closely with the small team of staff 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 practice manager were keen to further develop and embed 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 offer new services and expand their staff team, further to the development of their move to newly built, self-contained premises. Since our previous inspection, the provider had begun to establish appropriate governance and risk management processes 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

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

- The service was focused upon the needs of patients.
- Staff felt respected, supported and valued. They told us they enjoyed being part of a close team.
- Leaders and managers encouraged behaviour and performance consistent with the vision and values.
- Openness, honesty and transparency were demonstrated when responding to incidents and complaints. The provider was aware of and had systems to ensure compliance with the requirements of the duty of candour.
- Staff told us they could raise concerns and were encouraged to do so. They had confidence that these would be addressed.
- There were processes for providing all staff with the development they needed. 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.

Good

Are services well-led?

- The service actively promoted equality and diversity. Staff had received equality and diversity training. Staff felt they were treated equally.
- The practice was comprised of a small team of five staff members. There were positive relationships between staff and prompt and effective communications. Staff team meetings were held regularly. For example, staff participated in monthly practice meetings which were fully documented.

Governance arrangements

There were systems of accountability to support good governance and management.

- Processes and systems to support good governance and management had been more clearly set out and established since our previous inspection. For example, health and safety premises risk assessment processes and clinical auditing programmes were more effectively managed.
- 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. Managers told us they valued this additional resource to help ensure their compliance with regulatory and best practice guidance.
- At our previous inspection we found that where services were provided from shared premises, the provider had not assured themselves that premises and equipment management systems were operating as intended. At this inspection we saw that the provider had full control over processes which applied to their self-contained premises. The provider had ensured that aspects of health and safety, such as fire safety, legionella management, and supplies of emergency medicines and equipment, were appropriately set out and managed to ensure the safety of staff and patients.
- 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). Processes followed within the service had been reviewed since our previous inspection to ensure they reflected the best practice and legislative requirements outlined within policy content. For example, personnel records we reviewed now reflected the provider's policy and national guidance for monitoring the immunisation status of staff.

Managing risks, issues and performance

There were processes for managing risks, issues and performance.

- There were improved processes to identify, understand, monitor and address current and future risks, including risks to patient safety. There were improved processes and guidance to support clinicians in their decision making and assessment of risk in the prescribing of controlled drugs; there were processes for tracking, monitoring and auditing histology results; the service had provided specific guidance to non-clinical staff to support their understanding of managing patients with 'red flag' symptoms; there were improved processes to monitor and manage health and safety risks within the premises.
- There was evidence of a developing programme of quality improvement activities which had begun to be established since our previous inspection. The provider had completed a series of clinical audits to monitor the quality of care provided and to drive improvement.
- Leaders had oversight of safety alerts, incidents, and complaints. 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.

Appropriate and accurate information

Good

Are services well-led?

The service acted on appropriate and accurate information.

- Quality and operational information was used to ensure and improve performance. The provider had responded to the findings of our previous inspection and had taken appropriate action to address the findings.
- Practice meetings were held regularly where quality monitoring processes and risks were discussed. We reviewed minutes of monthly meetings. 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 services. The service used feedback from patients, combined with performance information, to drive improvement.
- Patients were invited to complete a feedback form, available in the waiting room and also electronically, by scanning a barcode on display within the practice, using a mobile device.
- 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.
- We noted that the provider had not displayed their current CQC inspection ratings clearly and conspicuously within the service. However, ratings information was available on the provider's website.

Continuous improvement and innovation

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

- There was evidence of learning and improvement.
- The provider had developed self-contained premises of a high standard to enhance their patients' experience.
- The staff team demonstrated their commitment to continuous improvement and had acted to respond to the findings of our previous inspection.
- The service made use of internal and external reviews of incidents and complaints. Learning was shared and used to make improvements.
- Leaders and managers encouraged staff to take time out to review individual and team objectives, processes and performance.