Med-Pol Ltd

Inspection report

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Date of inspection visit: 2 Aug 2019
Date of publication: 04/09/2019

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?	Requires improvement
Are services effective?	Good
Are services caring?	Good
Are services responsive?	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? – Requires improvement

Are services effective? – Good

Are services caring? – Good

Are services responsive? – Good

Are services well-led? – Requires improvement

We carried out an announced comprehensive inspection of Med-Pol Ltd on 2 August 2019 as part of our inspection programme.

We had previously carried out an announced comprehensive inspection of the service on 14 December 2017 and found that it was not compliant with regulation 17 'good governance', due to a lack of quality improvement activity. We subsequently carried out an announced focused inspection on 12 October 2018 to check whether the service had taken action to meet the requirements of the Health and Social Care Act 2008, and found at that inspection that the service was compliant with the relevant regulations.

Med-Pol Ltd is an independent health service based in East London.

Our key findings were:

- The service had some systems in place to keep people safe and safeguarded from abuse, however some were not in place or were ineffective.
- There were reliable systems for the appropriate and safe handling of medicines.
- The service had systems to record and review significant events and complaints, although none had occurred in the past 12 months.
- The service reviewed the effectiveness and appropriateness of the care and treatment provided through quality improvement activity.
- The service treated patients with kindness, respect and dignity, and patient feedback was positive about the service.
- The service had a clear vision and staff stated they felt respected, supported and valued.
- There were gaps in policies and processes to support good governance and management, and a lack of clarity around processes for managing risks, issues and performance.

We identified regulations that were not being met and the provider **must**:

- 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.

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

There were areas where the provider could make improvements and **should**:

- Ensure all staff are clear on who is the safeguarding lead for the service, as set out in the safeguarding policy.
- Review the security arrangements for paper handwritten records and assess the issues that paper records present in terms of carrying out clinical audits and searches.
- Carry out peer reviews and record keeping checks to improve and maintain effective clinical oversight.

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Chief Inspector of Primary Medical Services and Integrated Care

Our inspection team

Our inspection team was led by a CQC lead inspector, who was supported by a GP specialist advisor and a practice nurse specialist advisor. A Polish interpreter also attended the inspection to assist the team.

Background to Med-Pol Ltd

Med-Pol Ltd is an independent health service based in East London. The service provides consultations and treatment for adults who primarily come from Poland; the service does not see any patients under 18 years old.

The staff team at Med-Pol Ltd consists of two male and two female doctors (a gynaecologist, a general surgeon, a urologist and a dermatologist) who are supported by an administrative staff member; there is also a clinical translator who works for service as and when needed.

The provider undertakes regulated activities from one location and is registered with the CQC to provide the following regulated activities: diagnostic and screening procedures; family planning; surgical procedures; and treatment of disease, disorder or injury.

The service is open on Fridays from 11am to 1pm and from 5pm to 9pm and on Saturdays from 9:30am to 3pm, although earlier and later appointments are available upon request.

One of the doctors at the service is also the registered manager. A registered manager is a person who is registered with the CQC 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 inspection was carried out on 2 August 2019. During the visit we:

- Spoke with staff, including the two doctors who own the provider organisation (the gynaecologist and the general surgeon), the administrative staff member and the clinical translator.
- Reviewed a sample of patient care and treatment records.
- Reviewed comment cards in which patients shared their views and experiences of the service.

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

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

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

Requires improvement

Are services safe?

We rated safe as Requires improvement because:

- One staff member's adult and child safeguarding training had expired.
- Regular fire alarm tests were not documented.
- The service had not completed an infection control audit.
- The service did not have a risk assessment in place for the storage of hazardous substances (COSHH risk assessment).
- There was no decontamination policy in place and no record of decontamination of reusable equipment.
- There were some gaps in the records of staff vaccinations.
- Medical equipment had been calibrated, except for one pair of weighing scales.
- The service did not have a system in place to log receipt of safety alerts and record what action was taken.

Safety systems and processes

The service had some systems in place to keep people safe and safeguarded from abuse, however some were not in place or were ineffective.

- The service had clear systems to keep patients safe and safeguarded from abuse. There were adult and child safeguarding policies in place which set out the process for reporting a safeguarding concern and contained contact details for Tower Hamlets safeguarding teams.
- We saw staff had received safeguarding training appropriate to their role, except for the administrative staff member whose safeguarding training was overdue (as it had expired in December 2018). Following the inspection, the service provided evidence the staff member had completed level 2 child and adult safeguarding training on 5 August 2019.
- Staff we spoke to knew how to recognise and report safeguarding concerns, although one of the doctors we spoke to identified the wrong member of staff as being the service's safeguarding lead.
- The service carried out staff checks, including checks of professional registration where relevant, on recruitment and on an ongoing basis.
- The service had undertaken Disclosure and Barring Service (DBS) checks for staff (DBS checks identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable).
- The service had a chaperone policy in place and we saw a sign in reception advising patients of the availability of chaperones. Staff who acted as chaperones had received training and were DBS checked.
- We saw risk assessments had been completed to ensure the premises were safe, for example a health and safety risk assessment in May 2019, a fire risk assessment in December 2018 and fire extinguisher checks in July 2019. We saw evidence of regular fire drills, which detailed which staff members were present, how long the evacuation took, and whether there were any obstructions or issues. Staff told us fire alarms were tested by the landlord every week, however these were not documented. Following the inspection, the provider sent a fire alarm testing log in which to record fire alarm tests going forward, which included the most recent test on 2 August 2019. Legionella testing had been carried out in May 2019 (legionella is a bacterium which can contaminate water systems in buildings).
- The service ensured that facilities and equipment were safe, and equipment was maintained according to manufacturers' instructions. We saw evidence of portable appliance testing of electrical items and calibration of medical equipment, except for one pair of weighing scales. Following the inspection, the service provided evidence they had purchased a new pair of weighing scales.
- The service had an infection control policy in place, all staff had completed up to date infection control training and the premises were visibly clean. However, the service had not completed any infection control audits to ensure compliance with policies and training and identify and address any infection control risks. The service did not have a risk assessment in place for the storage of hazardous substances (COSHH risk assessment), such as cleaning products. There was no decontamination policy in place and no record of decontamination of reusable equipment such as the proctoscope, cryotherapy machine and electrotherapy equipment; the doctor who carried out minor surgery told us they decontaminated the reusable equipment but did not document this. Following the inspection, the service provided evidence that an infection control audit had been completed by one of the doctors on 5 August 2019, which included premises and cleaning checks as well as governance issues and policy compliance. We received a service-specific decontamination policy, which detailed the process for

cleaning and decontaminating the reusable equipment. The service also sent a COSHH policy and a blank COSHH risk assessment template, although the COSHH risk assessment had not been completed.
- There were gaps in the service's records of staff vaccinations, as there was no record of immunisation for one of the doctors other than their Hepatitis B status, and no record of any immunisations for the administrative staff member. Following the inspection, the service sent a signed self-declaration from the doctor confirming they had had all the required vaccinations.
- We saw evidence of cleaning schedules and there were systems for safely managing healthcare waste.

Risks to patients

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

- There were arrangements for planning and monitoring the number and mix of staff needed.
- There was an induction system for staff tailored to their role which was outlined in the staffing and recruitment policy, however no new members of staff had joined the service since this policy came into place in 2017.
- Staff understood their responsibilities to manage emergencies on the premises and to recognise those in need of urgent medical attention, and we saw evidence that emergency medicines and equipment were checked regularly.
- Staff knew how to identify and manage patients with severe infections, for example, sepsis. Sepsis had been discussed in a specific clinical meeting.
- All staff had completed up to date basic life support training.

Information to deliver safe care and treatment

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

- Patient records were handwritten and kept in paper form in locked cupboards, which meant that it presented some challenges for the service to carry out clinical audits and searches of patient records. However, individual patient records were written and managed in a way that kept patients safe.
- There was a documented approach to effectively managing test results and contact with patients' NHS GPs.
- The service had a system in place to retain medical records in line with guidance in the event that they cease trading.
- Clinicians made appropriate and timely referrals.

Safe and appropriate use of medicines

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

- There were no medicines held on the premises, except for medicines for use in a medical emergency and liquid nitrogen for use in cryotherapy.
- The systems for managing medicines, including medical gases and emergency medicines and equipment, minimised risks.
- Blank prescriptions were kept securely.
- The service had prescribing protocols in place which followed national prescribing guidelines, and we saw the service held a clinical meeting in June 2019 to discuss antimicrobial prescribing guidance.
- Patients' health was monitored to ensure medicines were being used safely.

Lessons learned and improvements made

The service had systems to learn and make improvements when things went wrong, however there was no system in place act upon safety alerts.

- There was a system in place for reporting and recording significant events and a significant event policy and notification form in place for staff to refer to and complete.
- There had been no significant events recorded during the previous 12 months.
- Staff understood their duty to raise concerns and report incidents and near misses. Staff told us that where patients had been impacted, they would receive an explanation and an apology where appropriate.
- The service was aware of the requirements of the duty of candour.
- The service did not have a system in place to log receipt of safety alerts and record whether any patients were affected and what action was taken by the service. The gynaecologist told us safety alerts are received by email by the surgeon and then printed out and discussed if relevant to the service. However, there was no evidence of this and when we asked the surgeon they were not aware of this. We asked the gynaecologist whether they were aware of any safety alerts being issued about

Requires improvement

Are services safe?

sodium valproate and whether this had impacted upon any of the patients, however they were not aware of this alert (although we were told none of the doctors at the service prescribe this medicine). Following the inspection, the service advised that all staff members were now registered to receive safety alerts by email, and that any safety alerts applicable to the service would be logged.

Good

Are services effective?

We rated effective as Good .

Effective needs assessment, care and treatment

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

- We checked patient records and found the service delivered care in line with relevant and current evidence-based guidance and standards.
- Doctors were encouraged to access guidelines relevant to their specific areas of practice online, and we saw that clinical guidelines were also discussed in meetings.
- We saw minutes of a clinical meeting in June 2019 in which the doctors discussed antimicrobial prescribing, with reference to National Institute for Health and Care Excellence (NICE) antimicrobial prescribing guidance.
- We saw no evidence of discrimination when making care and treatment decisions.
- Staff advised patients what to do if their condition got worse and where to seek further help and support.

Monitoring care and treatment

The service was involved in quality improvement activity.

- The service completed quality improvement activities such as clinical audits and we saw the results and learning from audits were discussed in clinical meetings.
- The service had completed one cycle of an antibiotic prescribing audit, which reviewed the appropriateness of antibiotic prescribing for the common conditions seen by the service. The audit identified that further training should be completed to increase the doctors' awareness of antibiotic prescribing and the service intends to complete a second cycle of this audit.
- The service had completed one cycle of a cryotherapy audit, reviewing the healing time for skin lesions removed through cryotherapy. The audit confirmed that healing times were as expected, and appropriate treatment was being given.
- The service was in the process of carrying out a cytology audit, to identify whether appropriate follow ups were being arranged for abnormal results. The results of this audit were not available as the audit was still in progress at the time of the inspection.

Effective staffing

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

- Staff had sufficient time to carry out their roles effectively.
- We saw up to date records of skills, qualifications and training for staff, and we were told staff were encouraged and given opportunities to develop.
- The doctors were registered with the General Medical Council (GMC) and were up to date with revalidation.
- The service had an induction programme for newly appointed staff, although no new members of staff had joined the service since the induction process came into place in 2017. The induction programme covered such topics as safeguarding, infection control, fire safety, health and safety and confidentiality.
- Doctors completed training and updates relevant to their specific roles and specialisms.
- The service provided staff with support through mandatory training and staff meetings.
- Annual appraisals were completed by the GMC for the doctors and evidence of completed appraisals was retained in staff personnel files.
- The service did not have specific policies in place for supporting and managing staff when their performance was poor or variable. Staff explained that, because it was such a small staff team, any issues would be dealt with informally and staff would be supported to improve, and then advice from external organisations would be sought if necessary.

Coordinating patient care and information sharing

Staff worked together to deliver effective care and treatment.

- Patients received coordinated and person-centred care.
- Doctors would refer patients back to their NHS GP where appropriate and we saw letters contained all the required information. The service did not make any referrals to other specialists.
- Information was shared with patients' NHS GP if the patient consented. The doctors were aware of circumstances where they would override patient consent and confidentiality.
- Where patients' needs could not be met by the service, staff redirected them to the appropriate service for their needs, which was usually patients' NHS GP.

Consent to care and treatment

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

Good

Are services effective?

- The service had a consent policy in place and a consent checklist for clinicians to refer to.
- The service's consent form was available in both English and Polish. There was information available in English and Polish with regards to the services provided and the cost of these.
- Doctors understood the requirements of legislation and guidance when considering consent and decision making. We checked a sample of staff files and saw doctors had completed up to date Mental Capacity Act 2005 training.
- Staff supported patients to make decisions about their care and treatment.
- We saw evidence of consent having been recorded appropriately, for example for patients having minor surgical procedures at the service.

Good

Are services caring?

We rated caring as Good .

Kindness, respect and compassion

Staff treated patients with kindness, respect and compassion.

- Staff understood patients' personal, cultural and social needs.
- The service gave patients timely support and information.
- All of the 16 patient CQC comment cards we received were positive about the service experienced. Patients described staff as professional, caring and friendly.
- The comment cards were in line with patient feedback obtained by the doctors for the purposes of their revalidation and appraisals with the GMC (copies of this feedback were retained in staff personnel files). Feedback from patients rated all four doctors at the service as 'very good' for being polite and making them feel at ease. Patients commented that they would recommend all four doctors.

Involvement in decisions about care and treatment

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

- The service primarily saw patients who come from Poland and all staff spoke Polish.
- The service's website also available in Polish.
- Patients in the CQC comment cards stated they are given time and attention and that doctors explain things clearly.

Privacy and Dignity

The service respected patients' privacy and dignity.

- The service was registered with the Information Commissioner's Office (ICO) and complied with the General Data Protection Regulation (GDPR).
- Patient information and records were held securely and were not visible to other patients in the reception area.
- Staff told us that if patients wanted to discuss sensitive issues or appeared distressed they would take them to a private room to discuss their needs.
- The service's patient records were handwritten and kept in paper form in locked cupboards, although the cupboards were not fire- or water-proof. Images and scans taken by the service were printed off and kept with the patient's paper record, and the images were backed up onto a USB stick every week.
- Conversations taking place in treatment rooms could not be overheard.
- There were curtains available in the treatment rooms for patients to use if needed to maintain dignity.

Good

Are services responsive to people's needs?

We rated responsive as Good .

Responding to and meeting people's needs

The service organised and delivered services to meet patients' needs.

- The facilities and premises were appropriate for the services delivered.
- The service made reasonable adjustments when patients found it hard to access services and there was a lift available for patients to use if needed.
- The service's website provided details of the clinicians, services and procedures available, and the associated fees.
- Where patients' needs could not be met by the service, staff redirected them to the appropriate service for their needs, which was usually patients' NHS GP.

Timely access to the service

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

- The service is open on Fridays from 11am to 1pm and from 5pm to 9pm and on Saturdays from 9:30am to 3pm, although earlier and later appointments are available upon request.
- The appointment system was easy to use. Patients could make appointments by telephone or via the service's website and could ask to see a specific clinician.
- Referrals and communication with patients' NHS GP were managed and completed in a timely way.
- Some patients in the CQC comment cards stated that the service was quick.

Listening and learning from concerns and complaints

The service took complaints and concerns seriously.

- The service had a complaints policy in place. Information about how to make a complaint was available to patients and this advised patients they could refer their complaint to the Medical Support Union, the GMC or the CQC if they were not happy with how their complaint had been managed or with the outcome of their complaint.
- The service had not received any complaints in the last 12 months.

Requires improvement

Are services well-led?

We rated well-led as Requires improvement because:

- There were missing policies and processes to support good governance and management.
- There was a lack of clarity around processes for managing risks, issues and performance, for example in relation to training, premises and equipment checks and decontamination, infection control, and safety alerts.

Leadership capacity and capability

Leaders were visible, however they had not identified and effectively managed some risks.

- Two of the doctors owned and managed the provider organisation. The two doctors were responsible for the organisational direction and development of the service and the day to day running of it. However, the provider had not identified and managed certain risks to patients which we identified during the inspection.
- We saw clinical meetings were held every other month in which the doctors discussed clinical governance issues and best practice guidance. For example, we saw meetings over the past 12 months had included discussion of and training on: antimicrobial prescribing, management of test results, adult safeguarding, uses and risks of liquid nitrogen, GDPR, recognising symptoms and screening for depression, and sepsis.
- Staff told us that, as the service had a small staff team of five people, informal discussions were held whenever the service was open.

Vision, strategy and culture

The service had a clear vision and staff stated they felt respected, supported and valued.

- The provider's business strategy was to continue the service in its present state and there were no plans to increase the scope or staff members.
- Staff were aware of and understood the vision and values of the service and their role in achieving them.
- Staff told us they felt able to raise concerns and were confident these would be addressed.
- Staff described the culture of the service as friendly and open and felt supported by management. There were positive relationships between staff.
- The service was aware of the requirements of the duty of candour and had a specific duty of candour policy in place.

Governance arrangements

The service was missing some policies and processes to support good governance and management.

- There was a clear staffing structure in place. Staff understood their roles and responsibilities, although one of the doctors identified the wrong member of staff as being the service's safeguarding lead.
- Leaders had established some policies, procedures and activities to ensure safety and assured themselves that they were operating as intended, however we found gaps in these arrangements. For example, no infection control audits were being completed, there was no system to act upon safety alerts, and one staff member's safeguarding training had expired.
- Service specific policies and processes had been developed and implemented and were accessible to staff on the computer and in hard copy. These included policies in relation to safeguarding, consent, complaints, chaperones, and infection control. Policies we looked at contained review dates.

Managing risks, issues and performance

There was a lack of clarity around processes for managing risks, issues and performance.

- The two doctors who owned the provider organisation had oversight of significant events and incidents, however there appeared to be some confusion as to who had responsibility for medicines and safety alerts and there was no system to effectively act upon safety alerts. This has not been identified as a risk by the service.
- We saw evidence that staff completed various checks to monitor the safe and effective running of the service, for example checks of emergency medicine and equipment, cleaning schedules and fire drills. However, during the inspection we found some risks were not being managed effectively, for example in relation to infection control, safety alerts, equipment calibration and decontamination of reusable equipment.
- The service had a business continuity plan in place and had advised staff of the processes in the event of major incidents.
- Clinical audits were being completed which demonstrated quality improvement for patients.
- The service did not have any formal processes to manage current and future performance of staff, due to

the small size of the team. Staff explained that any issues would be dealt with informally and staff would be supported to improve, and then advice from external organisations would be sought if necessary.

- Performance and oversight of the doctors was being monitored through clinical audits, although the service was not carrying out any regular peer reviews or record keeping checks to improve and maintain effective clinical oversight. Following the inspection, the service provided a copy of a patient record check and peer review system, which set out that approximately five to ten records for each of the four doctors would be peer reviewed every three months and the findings documented.

Appropriate and accurate information and continuous improvement

The service had appropriate and accurate information and there was evidence of learning being discussed to encourage improvement.

- The service adhered to data security standards to ensure the availability, integrity and confidentiality of patient identifiable data and records, although the paper records were stored in locked cupboards which were not fire or water proof. As patient records were handwritten this meant that it presented some challenges for the service to carry out clinical audits and searches of patient records.
- The service was aware of how to submit data and notifications to external bodies as required.
- Learning and actions to improve the service were discussed in clinical meetings, for example clinical audit results.

Engagement with patients and staff

The service sought feedback from patients and staff.

- Feedback from patients was encouraged and there was a comments box in the waiting area for patients to comment on the service experienced.
- The service retained copies of patient feedback obtained by the doctors for the purposes of their revalidation and appraisals with the GMC.
- Staff told us they felt able to raise concerns and provide feedback to the provider about the service.

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 the service provider was not meeting. The provider must send CQC a report that says what action it is going to take to meet these requirements.

Regulated activity	Regulation
Diagnostic and screening procedures Family planning services Surgical procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment **The registered persons had not done all that was reasonably practicable to mitigate risks to the health and safety of patients receiving care and treatment. In particular:** • Gaps in safeguarding training. • Regular fire alarm tests not documented. • Infection control audits not completed. • No COSHH risk assessment. • No decontamination policy and no record of decontamination of reusable equipment. • Gaps in the records of staff vaccinations. • Weighing scales not calibrated. • No system to receive and act upon safety alerts. **These matters are in breach of regulation 12(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014**

Regulated activity	Regulation
Diagnostic and screening procedures Family planning services Surgical procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance **There were ineffective systems in place to assess, monitor and mitigate risks to patients and staff. In particular:** • Risks had not been identified and were not being managed effectively, for example in relation to training, premises and equipment checks and decontamination, infection control, and safety alerts. **These matters are in breach of regulation 17(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014**