Pacific House

Inspection report

Pacific House
1 Easter Island Place
Eastbourne
BN23 6FA
Tel: 01323470370

Date of inspection visit: 13 May 2021
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This report describes our judgement of the quality of care at this service. It is based on a combination of what we found when we inspected, information from our ongoing monitoring of data about services and information given to us from the provider, patients, the public and other organisations.

Ratings

Overall rating for this location	Inspected but not rated
Are services safe?	Inspected but not rated
Are services effective?	Inspected but not rated
Are services well-led?	Inspected but not rated

Overall summary

We carried out a focused inspection of Pacific House (East Sussex Outpatient Services Ltd) on 12 February 2021 in response to concerns about the safe care and treatment of patients and governance arrangements within the service. We found breaches of regulations and took enforcement action. We issued warning notices against Regulation 12 (Safe care and treatment) Regulation 17 (Good governance) and Regulation 18 (Staffing), of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We carried out this inspection of Pacific House to confirm that the service now met the legal requirements in relation to those breaches of regulations and to ensure sufficient improvement had been made. This report only covers findings in relation to those requirements. The service was not rated as a consequence of this inspection.

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

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

This included:

- Conducting remote and face-to-face interviews with staff.
- Reviewing patient records and patient tracking processes to identify issues and clarify actions taken by the provider.
- Requesting evidence from the provider.
- A short site visit.

We conducted a remote review of patient records on 11 May 2021 and carried out an announced site visit on 13 May 2021. Prior to our site visit on 13 May 2021 we requested supporting evidence and documents from the provider which we reviewed remotely.

Pacific House is the administrative and management base for services provided by East Sussex Outpatient Services Ltd. East Sussex Outpatient Services (ESOPS) is an independent provider of consultant-led NHS commissioned outpatient services. Clinical outpatient services are provided from a neighbouring host location at Harbour Medical Centre, 1 Pacific Drive, Eastbourne BN23 6DW. This location is not a registered location under ESOPS's registration with the Care Quality Commission (CQC).

The service is registered with CQC to provide the following regulated activities: Treatment of disease, disorder or injury; Diagnostic and screening services.

The medical director is the registered manager. A registered manager is a person who is registered with 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.

Our key findings were:

- There were processes for reviewing patients who may be subject to delays in treatment. However, these required further embedding, review and audit to ensure their efficacy.
- Systems for the reporting, review and recording of significant events had been improved.

Overall summary

- Staff had received updated guidance to ensure their awareness of the safeguarding lead and procedures they would follow if they had a safeguarding concern.
- Infection prevention and control auditing processes had been introduced. However, an action plan/log of findings was still required. Cleaning logs had been established in clinical rooms.
- There were clear processes in place to minimise risks associated with Covid-19 with regard to screening patients attending for appointments. However individual staff risk assessments and support arrangements associated with Covid-19 had not been documented.
- Processes for cleaning and decontamination of devices were more clearly defined. There were improved systems to ensure decontamination of devices was adequately documented. These processes required further embedding, review and auditing.
- There were improvements in the management of training for administrative staff. Staff had received training in key areas. Processes introduced to monitor training undertaken by clinical staff employed on a sessional basis were incomplete.
- Systems had been introduced to establish monitoring and oversight of clinical staff employed on a sessional basis. Consultants had been given access to organisational policies.
- There were improved processes for responding to verbal complaints which ensured these were recorded to assist with review, audit and learning.
- A structure of formal team meetings and improved processes for sharing information, guidance and learning with staff had been introduced.
- Staff found leaders approachable and supportive and were keen to contribute to individual and organisational improvements.
- Review of organisational policies was still underway and some required further revision. Staff had access to multiple versions of the same policy in some instances.
- Monitoring processes, to provide assurance to leaders that premises they were leasing were safe and suitable for use, were not clearly defined.

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

- 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).

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

- Continue to review and develop organisational policies to ensure staff have access to up-to-date guidance.
- Develop an action plan and log to monitor outcomes of infection prevention and control audit findings.
- Establish review of training and development needs of staff as part of annual review processes.
- Review and update staff COVID-19 risk assessments as individual needs and guidance change.
- Establish data sharing agreements with referring GP practices.
- Establish arrangements to share and review actions and learning from complaints and significant events as a whole staff team.

Dr Rosie Benneyworth BM BS BMedSci MRCGP

Chief Inspector of Primary Medical Services and Integrated Care

Our inspection team

Our inspection team comprised a CQC lead inspector, a second CQC inspector and a GP specialist advisor.

Background to Pacific House

Pacific House is the administrative and management base for services provided by East Sussex Outpatient Services. East Sussex Outpatient Services (ESOPS) is an independent provider of consultant-led NHS commissioned outpatient services. The Registered Provider is East Sussex Outpatient Services Ltd.

Services are provided from:

Pacific House, 1 Easter Island Place, Eastbourne, East Sussex, BN23 6FA.

Clinical outpatient services are provided from a neighbouring host location at:

Harbour Medical Centre, 1 Pacific Drive, Eastbourne BN23 6DW.

Opening times are Monday to Friday 9am to 5pm.

Services are provided by specialist consultants who are employed on a sessional basis to provide outpatient consultation and diagnostic services in a range of specialties which include, gynaecology, Ear, Nose and Throat (ENT), musculoskeletal (MSK), urology, colorectal, ophthalmology, gastroenterology and general surgery. Two nurses and a healthcare assistant provide support to those outpatient services. Services are managed by a team of five directors and an office manager, who are supported by administration and reception staff. Administration staff are located at both Pacific House and Harbour Medical Centre and some staff work across both sites.

The service works closely with local referring GP services who refer patients for outpatient consultation, diagnostic and treatment services. Patients requiring treatment are referred onwards to local secondary care providers.

Inspected but not rated

Are services safe?

Risks to patients

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

- We reviewed patient referral and tracking processes. Patient referrals were received electronically from referring GPs. Referrals were screened and triaged by the relevant ESOPS consultant and each patient priority level was determined. Patient progress through initial consultation, diagnostic investigations and referral to treatment, was monitored via the provider's electronic patient tracking list.
- As part of this inspection, we reviewed the clinical records of 26 patients via the provider's electronic patient tracking list and their patient clinical records system, EMIS. Our selection of records included patients from a range of service specialties.
- At our previous inspection we found the provider had recently been given notice of withdrawal of services by their main provider of endoscopy services. At this inspection we noted that receipt of new patient referrals for gastroenterology or colorectal services, who may require endoscopy, had been suspended. The provider had identified an alternative endoscopy service provider to enable management of the existing endoscopy waiting list.
- We found that the service had some processes and guidance for staff to follow for reviewing patients who may be subject to delays in treatment. We found there was some improvement in the oversight, governance and leadership of risk assessment and patient review processes by ESOPS directors. Revised risk assessment processes had been introduced in order to assess and review risks associated with delays to treatment for individual patients. ESOPS directors had formally agreed the revised processes since our last inspection and these were still being embedded at the time of our inspection. We reviewed minutes of weekly meetings held to discuss harm review and patient tracking processes which confirmed their ongoing evaluation by key members of the team. However, there were further amendments, review and auditing of those processes required to ensure their efficacy and a consistent approach to ensuring patient safety.
- Staff told us that the revised processes ensured that all patients experiencing delays in treatment were subject to regular clinical harm reviews by their designated consultant. Reviews were planned to be undertaken at 12-weekly intervals. For example, at the time of our inspection, these were being carried out at 40, 52, 64 and 76 weeks, following referral to treatment. Weekly monitoring reports were produced to identify patients reaching those markers. Parts of this process were manual, paper-based processes, and we found that completeness of those processes could not always be ensured. For example, when a clinical harm review was raised and submitted to the consultant for completion, this was not entered onto the patient tracking list. Harm reviews were given to consultants in a hard copy file and requested to be completed and returned on the same day. It was unclear how staff would identify immediately if a harm review was not returned. Staff told us that the medical director would countersign harm reviews generated in the absence of the designated consultant.
- We reviewed the provider's documented 'patient tracking list monthly analysis procedure'. We saw that a monthly analysis report was run to ensure a review of each patient had been completed at the appropriate time intervals. As part of the harm review process, patients were graded by their consultant to confirm the urgency of their need for treatment. However, we found that the grading and the date of any re-grading was not recorded within the patient tracking list. We saw that letters outlining delays were sent to patients following completion of a harm review.
- At our previous inspection we found that staff had received no training in health and safety or fire safety. Records confirmed that staff working at Pacific House had not participated in a fire drill since April 2019. There were no records to show that staff working at Harbour Medical Centre had participated in a fire drill. Some staff we spoke with had a poor understanding of fire evacuation procedures at Harbour Medical Centre, where services were provided from first floor rooms.

Inspected but not rated

Are services safe?

- At our inspection on 13 May 2021 we reviewed training records and found that staff had completed fire safety and health and safety training. Administrative staff working at Pacific House had participated in a simulated fire drill, as a full evacuation of the shared premises was restricted due to the pandemic. We reviewed documents which confirmed the provider had oversight of fire safety management within Pacific House.
- Fire safety arrangements within Harbour Medical Centre had been reviewed since our last inspection. A fire safety officer was appointed to liaise with staff from Harbour Medical Centre. Remedial works were being carried out within Harbour Medical Centre to meet the requirements of a fire risk assessment undertaken on 29 April 2021. Arrangements had been established to ensure that ESOPS patients who were unable to evacuate via the stairs in the event of a fire, were isolated at a first-floor refuge point for a limited period of time. We found that one fire drill had been carried out at Harbour Medical Centre since our last inspection. However, this did not capture all part-time and sessional staff. Records confirmed that simulated fire drills and verbal and written fire instructions had been provided to administrative staff. Clinical staff who worked on a sessional basis were in the process of receiving the same information and instruction. We noted that whilst the provider had obtained some limited assurance documentation from Harbour Medical Centre with regard to fire safety, they had not had sight of the fire risk assessment at the time of our inspection. The provider was therefore not aware of all findings of the risk assessment nor the remedial actions required. Following the inspection and at our request, the provider obtained a copy of the risk assessment which they sent to us.
- The provider had a chaperone policy in place which had been reviewed in April 2021. The policy confirmed that all staff who undertook a chaperone role must be trained in the role. Staff told us that nurses and healthcare assistants undertook chaperoning for intimate examinations. At our previous inspection we found that administration staff who were required to act as chaperones for non-intimate examinations had not received training to support the role. At this inspection we found that all staff had completed chaperone training.
- The provider had developed an infection control and decontamination policy which we saw had been reviewed in May 2021. A ‘face to face consultation standard operating procedure' gave guidance to staff on personal protective equipment (PPE) requirements, including those for staff involved in carrying out aerosol generating procedures. The provider had determined that some Ear, Nose and Throat (ENT) diagnostic procedures, such as nasolaryngoscopies, were aerosol generating. (A nasolaryngoscopy involves a thin flexible tube with a light and a camera at the end being passed through the nose to the back of the throat.) Two rooms were available for each ENT clinic, to allow for cleaning and fallow time in between procedures, in line with the provider’s policy. At our previous inspection, staff told us that ENT consultants were not supported by a nurse during their outpatient clinics and cleaning of the rooms in between patients was undertaken by administration staff. Those staff had received no training in infection prevention and control. We found there were no cleaning logs or checklists in the consulting rooms to confirm what items staff should clean or if they had cleaned them. At our inspection on 13 May 2021 we found that all staff involved in the cleaning of those rooms had received infection prevention and control training appropriate to their role. We saw that cleaning logs had been completed for each room. There was guidance on display for staff to follow on what items were to be cleaned, cleaning methods and the PPE to be used.
- At our previous inspection we found that the lead staff member for infection prevention and control had not completed training at an appropriate level to support the role. At this inspection the provider confirmed that the lead staff members for infection prevention and control within the service were a nurse and the medical director. Since our previous inspection both of those staff members had begun completion of infection prevention training modules to support their roles. We saw they were due to attend regional infection prevention forums and learning events.
- Since our previous inspection the provider had made improvements to the management and implementation of their infection prevention and control monitoring processes. The provider had sought support and guidance from specialist advisors within the local clinical commissioning group in this regard. They had also established a buddying arrangement with another local service which provided them with additional support. A programme of audits had been commenced which included monitoring of, for example, hand hygiene, aseptic technique, decontamination of equipment and environmental cleanliness. However, actions identified had not been used to develop an action plan in order that completion of those tasks could be logged and monitored.

Inspected but not rated

Are services safe?

- There were processes for the weekly cleaning of ESOPS's equipment located within Harbour Medical Centre and we saw evidence of those cleaning records. The service used ultrasound probes, including some intracavity probes which required high levels of disinfection. Staff told us that appropriate cleaning and disinfection of ultrasound probes was implemented in between patients. However, at our previous inspection we found that processes for cleaning and decontamination of those devices were not adequately documented and there was no system of assurance to ensure that all staff were consistent in their approach to decontamination processes.
- At our inspection on 13 May 2021 we found the provider had introduced processes to ensure recording of their use of devices specific to individual patients. This included probe identifiers and decontamination activities, in line with current guidance, to enable incident tracking to be undertaken if required. For example, we reviewed completed records relating to the use and decontamination of the nasolaryngoscope. The provider had developed written procedures for the decontamination of each device and staff had received updated guidance and training on those decontamination processes. The medical director told us they planned to continuously monitor and audit device tracking and decontamination processes, to ensure their clinical oversight and consistency of implementation across service specialties. There was no evidence of initial auditing in order to evaluate embedding of these processes and ensure patient safety, at the time of our inspection.
- The provider had developed clear processes for the triaging of patients in order to minimise risks associated with COVID-19. At our previous inspection we found the provider had developed an overarching COVID-19 risk assessment dated July 2020 which identified some limited risks and mitigations in place in each area of service delivery. However, individual risk assessments which reflected the support needs of staff had not been documented. For example, we identified one clinician who had experienced some difficulties with the fitting of their FFP3 mask. They had used their own respirator closed helmet system for a period of time for some procedures. The provider confirmed that this had not been documented or subject to formal review. At this inspection we noted the overarching risk assessment had been subject to a review in March 2021 but we found no changes had been made to the document. We found that the provider continued to fail to record risks associated with COVID-19 which reflected the support needs of individual staff members. Following our inspection and at our request, the provider retrospectively documented the identified risks and support needs of vulnerable staff and sent that information to us.

Inspected but not rated

Are services effective?

Effective staffing

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

- At our previous inspection on 12 February 2021, we reviewed training records available within the service and found that there was no clear plan of required training for staff. Administration staff had not received training in key areas including but not limited to: infection control, fire safety, basic life support, health and safety, equality and diversity, mental capacity, confidentiality. Staff who were required to act as chaperones for non-intimate examinations had not received training to support the role. At this inspection we found that the provider had developed a clear plan of required training for administrative staff. This was reflected within the provider's training policy which had been reviewed and revised in April 2021. We reviewed training records and confirmed that all required training had been completed by those staff since our previous inspection. The lead staff members for infection prevention and control within the service were a nurse and the medical director. Since our previous inspection both of those staff had begun completion of infection prevention training modules to support their roles and were to attend regional infection prevention forums and learning events.
- At our previous inspection we reviewed appraisal records for five out of ten administrators employed by the service. We found that all of those staff had undergone appraisal in December 2020. However, the appraisals did not refer to required training or include a training needs analysis or objective setting. At this inspection the provider told us that a review of training needs and objective setting were planned as part of future appraisals scheduled for December 2021.
- At our previous inspection we found that training completed by clinical consultant staff, who provided services to ESOPS on a sessional basis was not monitored or recorded. The medical director told us they confirmed verbally with each clinician on an annual basis, that all mandatory training had been completed externally. However, there was no verifiable monitoring of their training and no evidence gathered to confirm completion. At our inspection on 13 May 2021 the provider told us they had introduced processes to monitor completion of all required training by those consultants. The provider had written to each consultant requesting evidence of training and appraisal to be submitted. We reviewed minutes of meetings held with individual consultants in which those requests were confirmed and discussed. We reviewed training and appraisal records available at the time of our inspection and found that records had been obtained from six out of 13 consultants currently providing sessional services. The provider told us that they had imposed a deadline for submission of requested records. Consultants who failed to provide confirmation of training and appraisal would be required to cease providing services on behalf of the provider until all required documentation had been submitted.
- At our previous inspection, nursing staff employed on a sessional basis told us they were not subject to monitoring of their completed training and did not undergo appraisal or any form of clinical supervision within their ESOPS role. At this inspection we found the provider had requested documentary evidence to monitor training completed externally by nursing staff. However, at the time of our inspection, training records were not available for one nurse employed by the service. A programme of performance review and supervision had been introduced. For example, we reviewed the appraisal and supervision records of one nurse completed with the medical director. We noted that the appraisal supported review and reflection on all areas of clinical practice and identified areas for development. We reviewed minutes of meetings where the nurse and the medical director, who both held infection prevention and control lead roles, had worked closely together to review and evaluate practices and implement improvements.

Inspected but not rated

Are services well-led?

Governance arrangements

There were improving systems to support good governance and management.

- At our previous inspection on 12 February 2021, we found the provider had recently commissioned an external provider to ensure that their policies and procedures were fit for purpose. A web-based suite of new policies had been developed. Staff had access to those policies despite many not having been checked by directors for relevance and accuracy. Staff told us that clinical consultants did not have access to ESOPS policies. At this inspection staff told us that clinical consultants had been provided with access to all policies. One consultant we spoke with told us they were in the process of reading through all required policies.
- We reviewed a wide range of the provider's policies and found they were comprehensive and formed a good basis for future organisational improvement. However, at the time of our previous inspection, their sharing with staff was premature due to inaccuracies and required revisions. We noted that the policies did not always support protocols which staff were required to follow and some policies provided incorrect information. At this inspection we found that the provider was continuing to review and revise their policies. Many of the inaccuracies and required revisions identified at our previous inspection had been rectified. For example, the safeguarding of vulnerable adults' policy now included an algorithm which provided guidance and local authority contact details for staff needing to raise a safeguarding concern; staff members named as the infection prevention and control leads within the infection control policy had been corrected; references to home visits which the provider did not undertake, had been removed. However, we found that in some instances there were multiple versions of the same policy accessible to staff, as revisions were made, which may have led to confusion for staff. Directors told us they were still in the process of checking all policies for accuracy and required revisions.

Managing risks, issues and performance

There were improving processes for managing risks, issues and performance.

- At our previous inspection on 12 February 2021, the provider told us they had recorded no complaints, significant events or safeguarding concerns within the last 12 months. We reviewed the provider's complaints log and found there were no complaints recorded between July 2019 and January 2021, when one complaint had been recorded. Staff told us that patients were informed that formal complaints must be put in writing to the medical director. They told us that if patients raised lower level complaints they were managed and resolved verbally without being entered onto the complaints log. We found there was a lack of clear processes for responding to those verbal complaints.
- At our inspection on 13 May 2021 we found there were improved processes for responding to verbal complaints which ensured these were recorded to assist with review, audit and learning. We noted that five complaints had been recorded since our previous inspection. These included low level or verbal complaints which had been captured and recorded fully. The provider had developed a complaint recording form which staff were encouraged to use to note verbal complaints or concerns raised. Complaints had been reviewed by managers and appropriate and timely responses provided to patients. Actions and learning from complaints were discussed within the team and recorded. The provider told us they planned to have regular complaints review meetings. We saw that in the interim, complaints processes had been discussed within staff team meetings. The provider's complaints policy had been reviewed in April 2021 and clearly reflected their approach to managing complaints. We noted that a revised patient information guide was available to patients which included guidance on how to make a complaint to the service.
- At our previous inspection we found that staff were unclear on how to report an incident and on what constituted a reportable incident. The provider had two significant event policies and three different forms for reporting significant events. We were unable to establish which form staff were expected to use to report an incident. Staff told us they had never been made aware of the outcome of any incidents and had not been part of any discussions or meetings to promote shared learning when incidents had occurred. We reviewed the provider's incident log and found that there

had been one incident recorded since July 2019. At this inspection the medical director told us that incident reporting processes had been formalised. Staff were able to follow guidance within one policy which had been reviewed in April 2021. There was one incident form in use. We found that 7 incidents had been reported and recorded between March and May 2021. Incident recording included actions taken to respond to the incident and lessons learned which had been discussed within the team. The medical director told us they intended to hold monthly meetings to review significant events and complaints as a team.

- We found the provider had made improvements to safeguarding processes since our previous inspection. The provider told us they had sought support and guidance from advisors within the local clinical commissioning group in this regard and were in the process of completing a regional safeguarding standards toolkit. Staff had received updated guidance to ensure their awareness of the safeguarding lead and procedures they would follow if they had a safeguarding concern. All administrative staff had received safeguarding training since our last inspection. We reviewed the provider's safeguarding of vulnerable adults' policy which provided comprehensive safeguarding information. The safeguarding policy now included an algorithm which provided guidance and local authority contact details for staff needing to raise a safeguarding concern. Clinical consultants confirmed they now had access to the provider's policies. Patient clinical records were held within EMIS. However, as data sharing agreements with referring GP practices had not been initiated, staff were unable to access shared records and were unable to identify patients flagged as vulnerable within a GP practice record. Staff were able to flag a patient as vulnerable within their own records but no staff member we spoke with was able to give an example of when this had occurred.
- At our previous inspection on 12 February 2021, the provider confirmed there had been no formal meetings or documented minutes of meetings within the last 12 months. There were no arrangements in place to review incidents, complaints or safeguarding concerns as a team nor to disseminate learning or actions taken. Staff told us that communications from ESOPS leaders were generally verbal or via email. At our inspection on 13 May 2021 we reviewed records which confirmed that the provider had introduced a structure of formal team meetings and improved processes for sharing information, guidance and learning with staff. We reviewed documented minutes of regular administrative staff meetings, senior management team meetings, operational management team meetings, infection prevention and control review meetings and patient pathway tracking meetings. We found that these provided opportunities for sharing of information and guidance amongst team members and opportunities for key discussions around quality assurance processes.
- At our previous inspection we found that there was no verifiable monitoring of training undertaken by clinical staff employed on a sessional basis. The medical director told us they confirmed verbally with each clinician on an annual basis, that all mandatory training had been completed externally. There was no formal appraisal or documented review of each clinician undertaken by the provider.
- At our inspection on 13 May 2021 the provider told us they had introduced processes to monitor completion of all required training by those consultants. The provider had written to each consultant requesting evidence of training and appraisal to be submitted. We reviewed minutes of meetings held with individual consultants in which those requests were confirmed and discussed. We reviewed training and appraisal records available at the time of our inspection and found that records had been obtained from six out of 13 consultants currently providing sessional services. The provider told us that they had imposed a deadline for submission of requested records. Consultants who failed to provide confirmation of training and appraisal would be required to cease providing services on behalf of the provider until all required documentation had been submitted.
- At our previous inspection we found that nursing staff employed on a sessional basis were not subject to monitoring of their completed training and did not undergo appraisal or any form of clinical supervision within their ESOPS role. At this inspection we found the provider had requested documentary evidence to monitor training completed externally by nursing staff. However, at the time of our inspection, training records were not available for one nurse employed by the service. A programme of performance review and supervision had been introduced.

Inspected but not rated

Are services well-led?

- The provider leased a suite of rooms within Harbour Medical Centre for the purposes of providing services to patients. At our previous inspection they told us that they sought verbal assurances from the practice manager of Harbour Medical Centre with regard to safety, maintenance and premises checks of those areas. However, we were unable to see evidence of clear governance processes which would enable ESOPS managers to assure themselves that the premises they were leasing were safe and suitable for use.
- At our inspection on 13 May 2021 we reviewed records held by the provider in relation to premises management of Harbour Medical Centre. We found that some additional safety and assurance documents had been obtained since our last inspection. For example, evidence of air conditioning servicing and remedial works undertaken to address findings of a legionella risk assessment undertaken in 2019. However, there remained no clear approach to confirm what evidence the provider required from Harbour Medical Centre and how they intended to assure themselves of the safety and suitability of premises they were leasing. We reviewed the service level agreement between ESOPS and Harbour Medical Centre for the leasing of the premises. The agreement did not define the nature or frequency of the assurance evidence required by ESOPS. We were unable to confirm that assurance evidence which had been obtained by ESOPS leaders had been adequately reviewed and assessed. For example, Harbour Medical Centre had provided ESOPS with a copy of a certificate of 'fire safety conformity' dated 2 May 2021 which confirmed that a fire risk assessment had been undertaken on 29 April 2021. ESOPS leaders had not sought to obtain a copy of the fire risk assessment and were therefore unaware of the outstanding actions required and how these might present risks to staff using the premises. Following our inspection and at our request, the provider obtained a copy of the risk assessment for their records which they sent to us.

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 Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance The registered person had failed to established systems or processes that were operating effectively to enable them to assess, monitor and improve the quality and safety of services provided. In particular: To ensure patient tracking and clinical harm review processes are clearly defined, effectively managed and regularly audited to ensure their efficacy. To ensure the monitoring of training, supervision and appraisal of clinical staff employed on a sessional basis. To establish governance processes to provide assurance that leased premises are safe and suitable for use. To establish clear auditing processes to monitor decontamination and tracking of reusable probes and intracavity devices to ensure patient safety. This was in breach of regulation 17(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014