Total Health Ethos Limited

The Medical @ Temple Quay

Inspection report

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Ratings

Overall rating for this service	**Requires improvement**
Are services safe?	**Requires improvement**
Are services effective?	**Requires improvement**
Are services caring?	**Good**
Are services responsive to people's needs?	**Good**
Are services well-led?	**Inadequate**

Overall summary

This service is rated as Requires Improvement overall. (Previous inspection December 2017)

The key questions are rated as:

Are services safe? – Requires Improvement

Are services effective? – Requires Improvement

Are services caring? – Good

Are services responsive? – Good

Are services well-led? – Inadequate

We carried out an announced comprehensive inspection at The Medical @ Temple as part of our inspection programme

The Medical @ Temple Quay is a private doctor's consultation and treatment service.

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 service and these are set out in Schedule 2 of The Health and Social Care Act 2008 (Regulated Activities)

Summary of findings

Regulations 2014. Services at The Medical @ Temple Quay (The Medical) are provided to patients under arrangements made by their employer/ a government department. These types of arrangements are exempt by law from CQC regulation. Therefore we were only able to inspect the services which are within the regulatory parameters for which the provider is regulated.

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

As part of our inspection we asked for Care Quality Commission comment cards to be completed by patients prior to our inspection. We received feedback about the service from 38 patients. All the respondents commented positively about their experiences, stating they received a high level of service and were treated with care and consideration.

Our key findings were:

- Policies and processes were not always embedded in practice.
- Oversight of staff training was not properly maintained.
- Quality improvement activity was not comprehensive.
- Risks to patients safety was not always appropriately monitored.
- Patients were treated with dignity and respect.
- Services met patients' needs.

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.

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

- Conduct patient surveys to assess patient needs.
- Should update their website relating to patient eligibility as soon as possible.
- Ensure there is a system in place to retain medical records in line with Department of Health and Social Care guidance.

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

Dr Rosie Benneyworth BM BS BMedSci MRCGP

Chief Inspector of Primary Medical Services and Integrated Care

The Medical @ Temple Quay

Detailed findings

Background to this inspection

Total Health Ethos Limited is the provider and the location is The Medical @ Temple Quay which is a private doctor's consultation service and doctor's treatment service.

There is a branch at:

The Medical,

Unit 7b,

Aztec Centre,

Park Avenue,

Bristol,BS32 4TD

This branch was not visited as part of this inspection.

The statement of purpose of The Medical @ Temple Quay identifies the provision of GP services including immunisation to the general public. There are four GPs working at the service supported by a managerial and administrative team. The provider also offers services which are not regulated by CQC such as occupational health reviews. The GP service is available five days a week at Temple Quay and at the Aztec West branch. All GP appointments must be pre-booked. All patients are required to complete a comprehensive health questionnaire/declaration prior to their appointment.

How we inspected this service

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

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

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

Requires improvement

Are services safe?

Our findings

We rated safe as Requires Improvement because:

- Systems in place to mitigate risks relating to Legionella were not effective.
- The provider's significant event policy was not comprehensive or embedded in practice.
- Staff trained as chaperones could not demonstrate that the learning was embedded.
- Not all staff had received appropriate safeguarding training.

Safety systems and processes

The service did not always have clear systems to keep people safe and safeguarded from abuse.

- The provider could not evidence that all staff had received appropriate safeguarding training. We reviewed staff training logs and saw safeguarding training for two reception staff and one GP was not evidenced. We discussed this with the provider who advised that the staff members had received the training through a previous employer but the provider did not have the certificates to confirm this. Following inspection, the provider sent us evidence that this training had since been completed.
- Staff who acted as chaperones had received training, however this was not always embedded. For example, we spoke with one member of staff who could not demonstrate the appropriate procedure when acting as a chaperone.
- The provider had systems in place to ensure that an adult accompanying a child had parental authority.
- The provider worked with other agencies to support patients and protect them from neglect and abuse. Staff took steps to protect patients from abuse, neglect, harassment, discrimination and breaches of their dignity and respect.
- The provider carried out staff checks at the time of recruitment and on an ongoing basis where appropriate. Disclosure and Barring Service (DBS) checks were undertaken where required. (DBS checks identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable).
- The provider had appropriate safety policies, which were regularly reviewed and communicated to staff. They outlined clearly who to go to for further guidance. Staff received safety information from the service as part of their induction and refresher training.

Risks to patients

Systems to assess, monitor and manage risks to patient safety were not always effective.

- There were arrangements for planning and monitoring the number and mix of staff needed.
- Staff understood their responsibilities to manage emergencies and to recognise those in need of urgent medical attention. They knew how to identify and manage patients with severe infections, for example sepsis.
- There were appropriate indemnity arrangements in place to cover all potential liabilities.

The provider had an infection prevention and control (IPC) risk assessment which had been conducted in May 2019. Actions identified included that audits should be conducted for needle stick and sharps injuries. It was also identified, that training was required to improve reception staff awareness of what to do in the event of a spillage. At the time of inspection, these actions had not been completed. However, a review date of the IPC risk assessment was set for May 2020.

Systems and processes to monitor and mitigate risk relating to Legionella were not effective. We saw evidence that a risk assessment had been conducted in July 2017. However, the provider was unable to evidence that actions had been taken to mitigate the risks identified. For example, the risk assessment showed that water temperatures were out of range but no actions had been taken to mitigate this. The provider was also unable to evidence that they conducted ongoing monitoring of water temperatures.

Information to deliver safe care and treatment

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

- Individual care records were written and managed in a way that kept patients safe. The care records we saw showed that information needed to deliver safe care and treatment was available to relevant staff in an accessible way.

Requires improvement

Are services safe?

- The provider had systems for sharing information with staff and other agencies to enable them to deliver safe care and treatment.
- Clinicians made appropriate and timely referrals in line with protocols and up to date evidence-based guidance.
- The provider was unclear if they had a system in place to retain medical records in line with Department of Health and Social Care (DHSC) guidance in the event that they cease trading. We discussed this with them on inspection and they advised that all medical records were scanned onto their systems and the hard copies were shredded. If a patient had not used the service in eight years, they would be removed from the system. However, the provider was unable to give assurances of what would happen to medical records should they cease trading.

Safe and appropriate use of medicines

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

- The provider had not carried out medicines audits to ensure prescribing was in line with best practice guidelines for safe prescribing. They told us on inspection that they planned to conduct an audit on antibiotic prescribing but it was unclear when this would take place.
- The provider told us that they did not prescribe any controlled drugs.
- The systems and arrangements for managing medicines, including vaccines, emergency medicines and equipment minimised risks. On inspection we were told that prescriptions were not pre-printed. They were all done on blank paper and many of the medicines prescribed were dispensed in the practice.
- Processes were in place for checking medicines and staff kept accurate records of medicines. Where there was a different approach taken from national guidance there was a clear rationale for this that protected patient safety.
- There were effective protocols for verifying the identity of patients including children.

Lessons learned and improvements made

The service learned and made improvements when things went wrong but processes were not embedded.

- The provider had a significant event policy, however we found that it was not fully comprehensive as it did not identify what would constitute as a significant event. The policy also did not show who the nominated individual was. However, following inspection the provider sent us a document which was available to all staff which identified lead roles in the practice.
- A member of staff we spoke to who had started work at the practice in March 2019, was unaware of a significant event policy and was unable identify what kind of event would need to be reported using the provider's formal processes.
- The provider told us that all significant events were discussed at one of the practice's weekly team meetings which was attended by all clinicians and the lead receptionist. We were also told that all significant events were discussed at the provider's senior management meeting. No significant events had been raised in the 12 months prior to inspection. However, further discussion on inspection identified that learning events had occurred but had not been raised using the provider's formal processes as they were not included in the provider's definition of what a significant event was. The provider advised that they would update their policy to include such events to ensure that learning was identified.
- On inspection, we reviewed significant events records and found that they had all been discussed at practice level meetings with recorded minutes and actions.
- 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 provider had systems in place for knowing about notifiable safety incidents

When there were unexpected or unintended safety incidents:

- The provider was unable to evidence what action had been taken as a result of external safety events or patient and medicine safety alerts. We saw evidence that when an alert was received, it was cascaded to clinicians. However, no record was kept of what alerts had been received and what action had been taken as a result.
- The provider gave affected people reasonable support, truthful information and a verbal and written apology.

Requires improvement

Are services effective?

(for example, treatment is effective)

Our findings

We rated effective as Requires improvement because:

- The provider did not have a programme for quality improvement activity.
- Systems to ensure patient care was coordinated effectively with other services were not comprehensive.

Effective needs assessment, care and treatment

The provider had systems to keep clinicians up to date with current evidence based practice. We saw evidence that clinicians assessed needs and delivered care and treatment in line with current legislation, standards and guidance (relevant to their service).

- Patients' immediate and ongoing needs were fully assessed. Where appropriate this included their clinical needs and their mental and physical wellbeing.
- We saw no evidence of discrimination when making care and treatment decisions.
- Arrangements were in place to deal with repeat patients.

Monitoring care and treatment

The provider was not actively involved in quality improvement activity.

- The provider did not conduct audits on their prescribing practices to ensure prescribing was in line with best practice guidelines.
- Quality improvement activity was limited. We reviewed an audit conducted in March 2019 which looked at Hepatitis B immunity vaccines. The audit identified that out of the 20 patients who attended the service for this vaccine, 14 had received the completed course and 13 had their immunity tested and recorded in their notes. The provider identified that there had been poor follow up of patients who had not completed the full course of vaccines. The provider concluded that they would review how they follow up with patients on an administrative level. The audit we reviewed did not document how this would be done and at the time of inspection, no re-audit had been scheduled to identify improvements. The provider advised that as the audit was done in March 2019, there had not been enough time to conduct a second-cycle to review improvements made. Following inspection, the provider sent us evidence to show how they monitored patient outcomes following Hepatitis B immunity vaccinations. This included how many vaccines each patient had received and if they had a recorded immunity status.

Effective staffing

Staff did not always have the skills, knowledge and experience to carry out their roles.

- During our inspection, staff we spoke to were able to demonstrate the necessary skills and knowledge to carry out their roles. For example, they were able to demonstrate how they kept patient information secure and maintained confidentiality. However, we saw that not all staff had received training appropriate to their role. Following inspection, the provider sent us evidence to show that all training had since been completed.
- Relevant professionals (medical and nursing) were registered with the General Medical Council (GMC) and were up to date with revalidation.
- 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. Staff were encouraged and given opportunities to develop.
- Staff whose role included immunisation and reviews of patients with long term conditions had received specific training and could demonstrate how they stayed up to date.

Coordinating patient care and information sharing

Staff did not always work effectively with other organisations, to deliver effective care and treatment.

- The provider had a process to ask new patients for consent to share details of their care and treatment with their registered NHS GP.
- The provider had not risk assessed the treatments they offered. If the patient did not give their consent to share information with their GP, the provider did not have a formal process to ensure that certain medicines would not be prescribed. We were told that when a patient gave consent for their information to be shared with their NHS GP the provider would send a letter with the necessary information. However, the provider could not be assured this was done consistently as they did not have systems to monitor this.
- Following inspection, the provider sent us evidence that they had introduced a protocol for the communication

Requires improvement

Are services effective?

(for example, treatment is effective)

with GPs. However, we found that this protocol was not comprehensive and did not give structured guidance for clinicians. For example, it identified that when there were concerns about a patient, contact with their NHS GP was "recommended". No information was given regarding which medicines would be inappropriate to prescribe without the necessary information from the patient's GP. It was also not outlined what monitoring processes would be implemented to ensure the effectiveness of the protocol.

- Following this, the practice later sent us a revised protocol which had been introduced. It identified systems for the appropriate prescribing of certain medicines. For example, it identified that a maximum of 14 tablets should be prescribed for patients requiring the controlled drug, Diazepam (a sedative used to reduce anxiety). It also identified that patients requiring other controlled drugs should be referred back to their NHS GP.
- Patients who had attended the service received person-centred care.

Supporting patients to live healthier lives

Staff were consistent and proactive in empowering patients, and supporting them to manage their own health and maximise their independence.

- Where appropriate, staff gave people advice so they could self-care.
- Where patients needs could not be met by the service, staff redirected them to the appropriate service for their needs.

Consent to care and treatment

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

- Staff understood the requirements of legislation and guidance when considering consent and decision making.
- Staff supported patients to make decisions. Where appropriate, they assessed and recorded a patient's mental capacity to make a decision.
- We saw evidence that consent forms were used when patients attended the practice for immunisations.
- There was partial monitoring of the process for seeking consent appropriately. We were told that verbal consent was obtained and recorded for all aspects of care but systems to ensure this was obtained and recorded consistently, were not embedded. We reviewed the first cycle of an audit conducted in March 2019 which looked at the administration of vaccines and information recorded and given to patients. This included reviewing if consent was recorded in the patient's notes. The audit showed that out of 40 patients, 16 had recorded consent for administration of the vaccine. The audit was due to be repeated in July 2019.

Good

Are services caring?

Our findings

We rated caring as Good because:

- Patients were treated with kindness, respect and compassion.
- Patients were involved in decisions about care and treatment.
- Patients' privacy and dignity was respected.

Kindness, respect and compassion

Staff treated patients with kindness, respect and compassion.

- We received feedback from patients on CQC comment cards which was positive about the way staff treated people.
- Staff understood patients' personal, cultural, social and religious needs. They displayed an understanding and non-judgmental
- The provider gave patients timely support and information.

Involvement in decisions about care and treatment

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

- Interpretation services were available for patients who did not have English as a first language. Information leaflets were available in easy read formats, to help patients be involved in decisions about their care.
- Patients told us through comment cards, that they felt listened to and supported by staff and had sufficient time during consultations to make an informed decision about the choice of treatment available to them.
- Staff communicated with people in a way that they could understand, for example, communication aids and easy read materials were available.

Privacy and Dignity

The provider respected patients' privacy and dignity.

- Staff recognised the importance of people's dignity and respect.
- Staff knew that if patients wanted to discuss sensitive issues or appeared distressed they could offer them a private room to discuss their needs.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

We rated responsive as Good because:

- Patients who had attended the service had their individual needs met
- Patients were able to access care and treatment in a timely way.

Responding to and meeting people's needs

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

- The provider had plans to improve services to meet patient needs. For example, they had plans to recruit a nurse and a male GP which would increase appointment availability.
- No patient surveys had been conducted by the provider.
- The facilities and premises were appropriate for the services delivered.
- At the time of inspection, the provider's website was out of date. It advised that certain patient groups were excluded from care. We raised this with the provider as this appeared discriminatory. The provider confirmed that no patient groups were excluded and that the website would be updated in the near future.

Timely access to the service

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

- Patients had timely access to initial assessment, test results, diagnosis and treatment.
- Waiting times, delays and cancellations were minimal and managed appropriately.
- Patients with the most urgent needs had their care and treatment prioritised.
- Referrals and transfers to other services were undertaken in a timely way.

Listening and learning from concerns and complaints

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

- Information about how to make a complaint or raise concerns was available. Staff treated patients who made complaints compassionately.
- The provider informed patients of any further action that may be available to them should they not be satisfied with the response to their complaint.
- The provider had complaint policy and procedures in place. The provider learned lessons from individual concerns, complaints and from analysis of trends. It acted as a result to improve the quality of care. For example, two complaints had been received which related to information about the fees for vaccines not being clear. This had meant that patients had been charged more than they had expected. The provider investigated the complaints and apologies were issued. This was discussed at a team meeting. Action included updating the website. In addition each clinician was reminded to make the patients aware of the price of vaccines before they were administered and where necessary, to make it clear how many vaccines were required.

Are services well-led?

Inadequate

(for example, are they well-managed and do senior leaders listen, learn and take appropriate action?)

Our findings

We rated well-led as Inadequate because:

- Processes to support good governance were not always embedded.
- Processes to manage risk and performance were not always effective.

Leadership capacity and capability;

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

- Leaders were not always knowledgeable about issues and priorities relating to the quality and future of services. For example, they did not conduct patient surveys and quality improvement activity was minimal. However, the provider told us that they were in the process of introducing this.
- Leaders at all levels were visible and approachable. They worked closely with staff and others to make sure they prioritised compassionate and inclusive leadership.
- The provider had effective processes to develop leadership capacity and skills, including planning for the future leadership of the service.

Vision and strategy

The service had a vision and strategy to deliver quality care and promote good outcomes for patients.

- There was a clear vision and set of values. The provider had a realistic strategy and supporting business plans to achieve priorities.
- The provider developed its vision, values and strategy jointly with staff and external partners (where relevant).
- Staff were aware of and understood the vision, values and strategy and their role in achieving them.
- The provider monitored progress against delivery of the strategy.

Culture

The service had a culture of high-quality sustainable care.

- Staff felt respected, supported and valued. They were proud to work for the service.
- The provider focused on the needs of patients.
- Leaders and managers acted on behaviour and performance which was inconsistent 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.
- All staff received regular annual appraisals in the last year. Staff were supported to meet the requirements of professional revalidation where necessary. Clinical staff were considered valued members of the team.
- There was a strong emphasis on the safety and well-being of all staff. Staff were able to access all services provided by The Medical at no cost.
- The provider actively promoted equality and diversity. It identified and addressed the causes of any workforce inequality. Staff felt they were treated equally.
- There were positive relationships between staff and teams.
- Processes for providing all staff with the development they needed were not always effective as not all staff had received appropriate training for their role.

Governance arrangements

There were responsibilities, roles and systems of accountability to support good governance and management but these were not always embedded or consistently applied.

- The provider did not have comprehensive oversight of staff training and could not provide evidence that all staff had received training appropriate to their role and in line with national guidance. Following inspection, the provider sent us evidence to show that all staff had since completed the necessary training.
- Systems to ensure that learning was embedded was not always effective. For example, a member of staff who had received training was unaware of the correct procedure for chaperoning.

Are services well-led?

Inadequate

(for example, are they well-managed and do senior leaders listen, learn and take appropriate action?)

- Policies and procedures were not always comprehensive.
- Systems for obtaining and recording of consent for care and treatment was not embedded.
- The provider did not have proper oversight of external safety alerts. Processes did not ensure that alerts were read and understood by the necessary staff and no record was kept of actions taken.

Managing risks, issues and performance

Processes for managing risks, issues and performance were not always effective.

- The provider did not have proper oversight of risk assessments to ensure that actions identified were completed or that appropriate monitoring had been implemented to mitigate risk to staff and patients. For example, no action had been identified to mitigate risk relating to Legionella.
- Processes to share information with other services including a patient's NHS GP, were not comprehensive and did not give clear guidance to clinicians.
- The provider did not have processes to manage current and future performance. Audits were not conducted for consultations, prescribing or referral decisions.
- The provider had plans in place and had trained staff for major incidents.

Appropriate and accurate information

The service acted on appropriate and accurate information.

- There were arrangements in line with data security standards for the availability, integrity and confidentiality of patient identifiable data, records and data management systems.

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 provider encouraged and heard views and concerns from the public, patients, staff and external partners and acted on them to shape services and culture.
- Staff could describe to us the systems in place to give feedback. For example, patients were able to give feedback using their website.
- The provider was transparent, collaborative and open with stakeholders about performance.

Continuous improvement and innovation

There were systems and processes for learning, continuous improvement and innovation.

- The provider made use of internal reviews of incidents and complaints. We saw evidence that when incidents and complaints had been raised, learning had been identified and shared at practice level and improvements had been made.

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 Family planning services Surgical procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance **How the regulation was not being met:** The provider did not establish effective systems and processes to ensure good governance in accordance with the fundamental standards of care. In particular we found; • Risks to patients were not effectively monitored. • The provider did not have proper oversight of external safety alerts. • The provider did not conduct quality improvement activity on prescribing practices. • There was not proper monitoring or oversight of processes for communicating with other services regarding patient care and safety. • Systems for obtaining and recording of consent for care and treatment was not embedded. This was a breach of regulation 17(2) of the Health and Social Care Act 2008 (Regulated Activities 2008) Regulations 2014.