

Centennial Healthcare Ltd

Centennial Medical Care

Inspection report

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Overall summary

We carried out an announced comprehensive inspection on 2nd February 2016 to ask the service the following key questions; Are services safe, effective, caring, responsive and well-led?

Our findings were:

Are services safe?

We found that this service was not providing safe care in accordance with the relevant regulations.

Are services effective?

We found that this service was not providing effective care in accordance with the relevant regulations.

Are services caring?

We found that this service was providing caring services in accordance with the relevant regulations.

Are services responsive?

We found that this service was providing responsive care in accordance with the relevant regulations.

Are services well-led?

We found that this service was not providing well-led care in accordance with the relevant regulations.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?

We found that this service was not always providing safe care in accordance with the relevant regulations. We have told the provider to take action (see full details of this action in the Requirement Notices at the end of this report).

- Patients were at risk of harm because Centennial Medical Care (CMC) lacked systems and processes to keep them safe.
- CMC did not have a sufficiently well-developed approach to clinical risk management. There were no documented actions to mitigate risk and no contingency plans in place. Staffing numbers and skill mix were not formally assessed.
- The provider did not have ready access to the records of patients' consultations or risk assessments. The notes were retained by the consultants and there was no system for accessing them in a timely way.
- The service lacked a comprehensive approach for dealing with a clinical or medical emergency in its MIU and had not formalised emergency arrangements for its day to day appointments:
 - Incomplete range of emergency equipment, for example, masks not available in all four sizes, including children's sizes, there was no spare oxygen cylinder available or spare defibrillator pads.
 - Clinical staff had not finalised the type and location of emergency medicines.
 - Lack of formal skills or staffing assessment for emergencies or regular training on how to locate or use equipment.
 - No formalised arrangements to transfer patients to accident and emergency departments.
- Senior leaders did not assess or mitigate risks to their main service development which was the minor injuries unit. They had not assessed staffing required or skill mix in relation to the type of scenarios which could occur, for example competency to triage or act in an emergency. They had not assessed equipment needs or agreed a full list of medicines, their location or patient group directions (PGDs), which define the medicines which can be given without a doctor, and who can give them.

However, our inspection also found that:

- The service reported that there had been no harms to patients. There was an effective system in place for reporting and recording adverse events and to share lessons learnt in order to improve safety in the service.
- The service publicised and offered trained chaperones to patients. Chaperones were given high quality training on their role.
- There were clear procedures for safeguarding children.
- The premises were visibly clean with arrangements for infection prevention and control.

Are services effective?

We found that this service was not providing effective care in accordance with the relevant regulations. We have told the provider to take action (see full details of this action in the Requirement Notices at the end of this report).

- CMC could not show that it delivered care in line with evidenced based guidelines, standards, best practice and current legislation.
 - There was no measurement of patient outcomes.
 - No clear protocols for referring patients to other healthcare organisations.
 - No clinical skills or staffing assessment for the full range of skills required to deliver current services.
 - No leadership arrangements for adult safeguarding or Mental Capacity Act training.
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Summary of findings

However, our inspection also found that:

- The practice manager had processes in place to ensure that non-clinical staff had the right qualifications, skills, knowledge and experience.
- The service had clear processes for gaining consent; however, this was not routinely recorded.

Are services caring?

We found that this service was providing caring services in accordance with the relevant regulations.

- Patients said they were treated with compassion, dignity and respect and they were involved in decisions about their care and treatment.
- Information for patients about the service was easy to understand and accessible.
- We saw that staff treated patients with kindness and respect, and maintained confidentiality.

Are services responsive to people's needs?

We found that this service was providing responsive care in accordance with the relevant regulations.

- Premises were suitable and child friendly.
- There was a clear complaints process.
- Patients had timely access to treatment.

However, we also found that:

- Tackling equity and adapting services for the needs of different people was underdeveloped.
- The service did not monitor waiting times, delays or cancellations.

Are services well-led?

We found that this service was not providing well-led care in accordance with the relevant regulations. We have told the provider to take action (see full details of this action in the Requirement Notices at the end of this report).

- There was a lack of clinical leadership with regards to patient safety issues at board level which meant that this did not receive priority in planning the MIU.
- There was no continuity of effective clinical governance leadership on the medical advisory committee.
- The organisation had an incomplete approach to identifying challenges to quality and safety.
- There was no track record of clinical audit for adult or child patients to ensure continuous improvement.

However, we also found that:

- Staff enjoyed working at CMC, and felt supported. Consultants felt there was a good team spirit.
- Non clinical staff were clear about their responsibilities and were led by a competent registered manager.
- Staff understood their responsibility to raise concerns and there were systems for learning from complaints and adverse events.

Centennial Medical Care

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was a pilot for services provided by independent doctors and was planned to check whether the service was meeting the legal requirements and regulations associated with the Health and Social Care Act 2008. We would like to thank all managers, clinicians and staff at Centennial Medical Care for their help and co-operation in this inspection, and for responding quickly to our informal feedback.

Centennial Medical Care (CMC) opened in February 2014 as an independent provider of GP and specialist consultant services. The registered manager is the practice manager. There is a board of three directors, two of whom are directly involved in the running of the business.

CMC is based in Elstree in Hertfordshire. There are 238 registered patients in total of whom 136 are adults and 133 are children and young people. CMC had 306 patient visits a month on average in 2015. Of these 183 were for consultant appointments, 35 were for GPs, 28 were for physiotherapy, 25 for minor procedures and the rest for diagnostics. Consultants working at CMC carry out a range of minor treatments and consultations. The most predominant specialities are gynaecology, sports injuries, dermatology, physiotherapy and paediatric specialities such as gastroenterology, rheumatology and allergies.

There is a practice manager, one full-time and two part-time receptionists, an accounts administrator and a part-time healthcare assistant. The GPs are on call, and attend if a patient makes an appointment. CMC has arrangements with 45 consultants to cover 21 specialities

and attend clinics based on patient demand. These consultants work under practising privileges (the process to grant a medical practitioner permission based on their competency, to work within a private healthcare provider).

The patients who are patients under the care of a GP are considered to be CMC patients and their medical history and notes are kept on site. The patients who are considered consultant's patients, could be seen at more than one location. The service does not keep consultant patient's medical records on site and there was no service level agreement to obtain them quickly. Any diagnostic test results were scanned onto the patient management system for reference if needed.

CMC generates its income from renting consulting rooms to consultants, receiving facilities fees from medical insurance companies for procedures, ultrasound and blood tests, and direct payment for diagnostics. They have a revenue share agreement with GPs.

CMC's premises, over two floors, comprise seven consulting rooms (one with ultrasound machine), a minor operations room, two reception areas, a retail pharmacy and an administration office.

Opening hours are 8 am to 7 pm Monday to Friday and 9 am to 2 pm on Saturday.

CMC launched a walk-in minor injuries unit (MIU) on 18th January 2016, staffed by a paramedic, who saw eight patients before 4th February. CMC closed the MIU on a voluntary basis on the 6th February, and has since stated that it does not intend to re-open it.

The inspection on 2nd February 2016 was led by a CQC inspector who visited with four specialist advisors.. This was the first inspection of CMC.

As part of our inspection we asked for CQC comment cards to be completed by patients prior to our inspection. We

Detailed findings

received two comment cards, both with positive comments about care. We also interviewed six patients at CMC on the day of the inspection. Patients told us they were pleased with the level of care and communication.

We informed Healthwatch and the local clinical commissioning group that we were inspecting the service; however we did not receive any information from them.

During the inspection we:

- Collected CQC comment cards to be completed by patients prior to our inspection. Three patients responded and their feedback was positive.
- Spoke with a range of staff including, a GP, management and reception staff, a healthcare assistant, three consultants and a paramedic.
- We reviewed information and record systems including treatment records and patients' written consent.

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.

Our key findings were:

- Clinical governance was underdeveloped - quality assurance systems and Information about the quality of care and treatment was limited. There was no adult safeguarding lead.
- As CMC did not have ready access to medical records, there was no audit trail to show that patients' care and treatment was delivered in line with current evidence based guidance or that risks to patients were recorded.

- There were no in-house agreed clinical protocols or agreed care pathways, including formalised arrangements with other care providers.
- Waiting times and appointment cancellations were not monitored.
- Arrangements to deal with medical emergencies were not formalised.
- The service did not proactively seek feedback from patients and record it in order to make improvements
- Services were not fully adapted for the needs of different people – for example, there was no hearing induction loop.
- CMC did not prepare fully for the opening of its minor injuries unit (MIU) – it lacked clinical risk assessments, clinical protocols, formalised arrangements with other healthcare providers and staffing assessments. Although preparation of patient group directions was in line with National Institute for Health and Care Excellence (NICE) guidance, the lead GP and Medical Advisory Committee had not authorised them in time for the opening of the MIU.
- There was little knowledge of the Mental Capacity Act 2005.

However, we also found that:

- Patients were treated with kindness and respect and they were involved in their care and decisions about their treatment.
- Facilities were attractive and adapted to children's needs
- Effective and clear safeguarding arrangements were in place for children
- CMC had an effective system in place for reporting and learning from significant events, and there had been no reported harms to patients.
- CMC had a range of policies and procedures to govern non-clinical activity, but some were missing or overdue a review.

Full details at the end of this report of the regulations that were not met. Since our inspection, Centennial has responded with action plans to meet the regulations, and many of the actions we requested are already in place.

Are services safe?

Our findings

Reporting, learning and improvement from incidents

- Centennial Medical Care (CMC) had an effective system for learning from adverse events, and had an incident reporting policy. Staff showed us that they knew how to raise concerns and how they were reported. CMC had ten adverse events in the year February 2015 to February 2016. The practice manager investigated and shared the learning with the relevant consultants and MAC (Medical Advisory Committee). The organisation learnt from these reported events. For example, it took action to train staff about the correct disposal of sharps when it found that larger (non sharp) syringes were being disposed of in the wrong waste bag. It ensured that throat anaesthetic spray was always in stock in the pharmacy after finding that it was not there for an endoscopy on one occasion. There were no incidents during the reporting period, in which a patient had been harmed.
- The service responded to patient safety alerts. The practice manager explained that they had received very few, but they had been reviewed and then passed them on to the relevant therapist or clinician. There was a procedure for alert letters and hazard notices for staff to refer to. The practice manager gave us the example of an alert concerning an ultrasound process which had been given to the radiologist. The practice manager checked to see if action had been taken afterwards.
- Staff understood the need to apologise and admit mistakes when they happened in line with the duty of candour regulation. The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain notifiable safety incidents and provide reasonable support to that person. We saw evidence of this in a letter to a patient when there had been confusion over an appointment time. CMC has since strengthened this approach with formal training on the duty of candour.
- Staff understood health and safety legislation including RIDDOR (Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 2013). The service included relevant policy guidance about RIDDOR in its adverse incidents policy. The practice manager told us that during the two years since CMC opened, there had never been a RIDDOR incident.

- Hazardous substances were not always stored safely in line with Control of Substances Hazardous to Health (COSHH) guidance, or the service's COSHH policy. In one room we found Milton solution (a sterilising fluid) on a work surface and in another we found iodine, hazardous histology pots and unused syringes in an unlocked cupboard at a child accessible height. Staff took action immediately to store these correctly when we alerted them.

Reliable safety systems and processes (including safeguarding)

- CMC had arrangements to safeguard children from abuse which reflected the latest legislation. CMC had taken action to safeguard children on three separate occasions, since it opened in February 2014. It referred the children either to the local NHS acute trust for further investigation or to social services. The outcomes for the children were positive. CMC's children's safeguarding lead was also the safeguarding lead at the local NHS hospital. There were specific children's clinics at CMC.
- There was no adult safeguarding lead nor a mental health/mental capacity lead. CMC had a policy on adult safeguarding, but knowledge of this area, and particularly of the Mental Capacity Act, 2005 was limited.
- CMC had effective processes for maintaining patient confidentiality. Receptionists referred any enquiry to the practice manager and did not give out test results. Patients waited until their meeting with the consultant to receive full information about their test results.
- There were systems in place for reporting concerns such as safeguarding, whistleblowing and complaints, which staff were confident to use. There were policies for these reporting systems and we saw evidence that safeguarding concerns and complaints were addressed in a timely way. There had been no incidences of whistleblowing.
- Staff handled information about diagnostic tests safely and efficiently. They passed test results on to consultants on the same day the external diagnostic service returned them. They recorded and monitored all despatches, ensuring that test results were not overlooked. Staff scanned GP notes, consent forms and diagnostic results into the patient management system so that they were retained centrally. Reception staff did not have the permissions to add to or amend notes but they had read-only access.

Are services safe?

- CMC did not have ready access to patient records or patient risk assessments of the consultant's notes as the consultants kept their own records. Patients did not routinely receive a record of care and treatment. We reviewed six sets of patient notes. Three lacked information about the patient's clinical record. This meant that it was difficult to audit in-house consultations against best practice, undertake reviews or follow up on complaints.
- Information systems did not enable a full picture of patient care. Clinicians told us that the patient record system was limited in that it recorded only GP notes and would not produce post consultation reports. It was also limited in that it did not contain records of consultant's consultations.

Medical emergencies

Arrangements for medical emergencies were not in place in the MIU when we inspected:

- CMC did not assess the range of skills staff, consultants or GPs required to deal with emergencies. For example, they had not assessed what level of competency GPs or consultants had achieved in respect of emergency or life support skills. Staff had no training about the location of resuscitation bags and other essential equipment, as this had not been decided. Staff had received training in triage skills. The MIU paramedic practitioner offered a range of practical clinical skills but when CMC suspended their MIU on the 6th February they no longer benefitted from this skill set.
- CMC did not assess emergency equipment needs for its MIU before it opened. At the start, the service lacked an inventory prepared by a clinically trained individual, such as a doctor or the paramedic. There were no spare oxygen cylinders, a nebuliser had been acquired but it was for single use. Emergency face masks were only available in two adult sizes. There were no spare adult or child pads for the defibrillator.
- Staff at CMC did not have appropriate clinical skills to check emergency equipment or locate the correct instruments in an emergency. The MIU paramedic had appropriate clinical knowledge but there was no cover when they were absent.
- We found some out of date items in the resuscitation bag. Some laryngeal masks had expired in November and December 2015. Other equipment including a medicine (saline flush,) and some cannulas had expiry

dates of May 2015 and June 2015 respectively. The practice manager had taken action shortly before our inspection to implement a checklist with expiry dates. However, some items were on order and had not arrived.

- CMC had not finalised appropriate emergency medicines or their location in the MIU for day to day emergencies which could potentially arise. Cardiac and anaphylaxis medicines had been agreed and were kept in the administration office, rather than in an accessible clinical location. However, medication used for patients who had a low blood sugar and for emergency treatment of meningitis was locked in the pharmacy and not easily accessible if the pharmacy was closed. Appropriate emergency drugs were not kept with the resuscitation kit in a clinical room. We told the chairman of the medical advisory committee about our concerns and CMC have since agreed suitable medicines and locations.
- The practice manager and all staff had undergone basic life support training. Protocols and guidelines for child and adult emergencies were displayed on cabinets and staff understood when they had to dial 999.

Staffing

- CMC had a process to agree a consultant's practising privileges. This included a Disclosure and Barring Service (DBS) check, references, General Medical Council (GMC) number, Hepatitis B check and NHS appraisal. This process took three months and during this time it was possible for consultants to work under temporary practising privileges. When we inspected, the staff member responsible for this process had just left the organisation. The practice manager conducted a gap analysis to ensure that consultants had supplied the evidence required about their professional status. There were some gaps in the records for DBS checks, appraisals, Hepatitis B status. The practice manager was working towards completing these checks so that the records were thorough. Paediatricians or doctors working with children had undergone level 3 safeguarding accreditation. Exchanging appraisal-related training and performance information with the doctors NHS practice, if they had one, was not part of this process. As a result, CMC lacked some information about consultants' performance and training.

Are services safe?

- The skill mix or numbers of staff required to run the MIU had not been assessed, which was operating when we inspected. They advertised opening times extending to 68 hours a week, including Saturday and Sunday. One self-employed paramedic was available to deliver the service.
- The service ensured that patients knew that chaperones were available. Notices were displayed prominently on treatment room walls informing patients about chaperones. The practice manager, healthcare assistant and receptionists were trained on why offering chaperones was good practice and how to fulfil the role. Patients signed a form to request a chaperone. All chaperones were DBS cleared in line with CMC policy.
- Staff were familiar with some of CMC's arrangements to respond to emergencies. They knew that when there was an emergency call because a patient had deteriorated or there was a colleague who required urgent help, everyone in the building had to attend the emergency and offer assistance. There was policy guidance for this. However, there had been no such incidents at CMC since it was opened. There was no record of a fire drill having taken place, staff also told us that they could not remember one taking place. However, staff received information when they were inducted about the fire procedure including the assembly point.

Monitoring health & safety and responding to risks

- CMC did not have a sufficiently well-developed approach to clinical risk management. It had no documented actions to mitigate risk, or contingency plans in place.
- CMC did not have a comprehensive range of clinical pathways or protocols in place for its other services. For example, it had not developed formal CMC care pathways for common childhood illnesses. The consultants were all independent practitioners and therefore followed their usual NHS guidelines. All but three consultants also worked in the NHS. This meant that CMC did not have agreed standards about evidence based care or good practice.
- Staff carried out routine environmental risk assessments of consulting rooms and treatment areas annually. The practice manager shared the results with us. These assessments resulted in actions to control any environmental risks, for example, displaying warning notices about hot water above sinks with very hot taps.

- Risks to patient safety from service developments had not been fully assessed. CMC had not clinically risk assessed the new minor injuries unit (MIU) service or put in place pathways for onward referral. In addition there were no clinical protocols or pathways. Staffing skills had not been identified in the MIU. There was no clinical supervision in place for the paramedic.
- The service had not considered appropriate indemnity arrangements.
- During the operation of the MIU in late January and early February 2016, there was no notice on the door indicating the location of the nearest Accident and Emergency department for patients who may have arrived out of hours.

Infection control

- Consulting rooms, utility areas, toilets and patient areas were visibly clean. The healthcare assistant cleaned consulting rooms, toys and children's area twice a week or daily if there were numerous patients. Cleaning was completed in line with clinical need. There were cleaning schedules for the ultrasound machine and other equipment. In addition, there were schedules for toys, weighing scales and the baby changing area.
- Soap, hand cleaning gel and hand towels were available. Soap dispensers were full, as were the hand towel dispensers, all were refilled by the healthcare assistant. We observed staff wearing personal protective equipment appropriately, for example, aprons and gloves.
- CMC used endoscopes for adult naso-pharyngeal examinations which were not disposable. They used specialist chlorine dioxide cleaning wipes to ensure that they were cleaned hygienically. All other equipment was for single use and disposed of after it had been used.
- CMC audited their compliance with infection prevention and control in December 2015. There were three recommendations:
 - Items to be colour coded and separated in the cleaning cupboard.
 - CMC staff to empty all clinical waste bins.
 - Timely replenishment of soap and paper towels. Staff acted on these recommendations and the practice manager continued to monitor them.
- There were annual arrangements for Legionella testing and the review date was February 2016.
- There was no process in place to record staff immunity to infectious blood borne diseases, for example

Are services safe?

Hepatitis B. There was no recorded evidence of immunity or of staff having had relevant vaccinations and no programme for immunisation to meet the national guidelines (Public Health England, 2013).

Premises and equipment

- Clinical equipment purchase was not led by someone with the essential clinical skills, for example the paramedic. CMC provided equipment and instruments for all of the consultants apart from the allergist. Most equipment provided was for single use, which is line with good practice. Most single use equipment was packaged appropriately and was within date for safe use. However, we saw four speculums for gynaecological use which had expiry dates of 15th August 2015.
- There was a sharps injury policy in place. This policy had expired and should have been reviewed in January 2015.
- Sharps bins were available in all treatment rooms. There was a lockable wheeled bin for storage of used sharps.
- There were foot pedal operated clinical waste bins in all treatment rooms and yellow bags for disposal of clinical waste. CMC had waste disposal policies/guidelines and clinical waste bags were labelled and disposed of securely in appropriate locked bins. We saw evidence of a service level agreement and quarterly reports to confirm the collection of waste.
- All electrical equipment had undergone appropriate testing and the test dates met the annual deadline.
- Premises were appropriate for consultation meetings and basic treatment.

Safe and effective use of medicines

- Medicines were obtained, recorded and stored in the dispensing pharmacy, which was not part of the scope of this inspection. There was a secure fridge available in the pharmacy for cold storage of medicines and vaccines.
- The practice manager issued prescription pads to consultants if they were running a clinic during the day.

She locked the pads in the administration office at the end of each day. Pads were identifiable against individual consultants. The pharmacist described how they would take action, if there was a concern about doctor's prescriptions; reporting to the National Pharmacy Association (NPA) in the first instance, but ultimately to the General Medical Council (GMC.)

- The pharmacy received medicine and device alerts from the Medicines and Healthcare products Regulatory Agency (MHRA) but there was no procedure in place to routinely share the information with GPs or consultants.
- Clinicians relied on the information provided by the patient to make safe prescribing decisions. The GPs and other clinicians did not access other patient records (for example, from NHS hospital services or NHS GPs, where there was one). This meant that they depended on patients remembering a full picture of their medical history in order to minimise risk.
- Patient information about medicines to take away depended on the individual doctor. At CMC, consultants did not routinely give patients a treatment card explaining their medicines or their ongoing care to take home.
- CMC did not have a safe medicines management in place when it opened the minor injuries unit (MIU). The GP MAC representative supervised the arrangements for this and had not finalised draft patient group directions (PGDs) for the paramedic to use. PGDs are written instructions for the sale, supply and/or administration of medicines to groups of patients who may not be individually identified before presentation for treatment by specified health care professionals. In this case PGDs would enable the paramedic to treat patients with the previously agreed medicines. The draft PGDs reflected up to date National Institute for Health and Care Excellence guidance (NICE), but the MAC had not authorised them when we inspected. As a contingency, the paramedic practitioner could have asked one of the GPs to write a prescription for the medications when needed. GPs were not routinely on site, so this represented a risk.

Are services effective?

(for example, treatment is effective)

Our findings

Assessment and treatment

- Consultants planned treatment based on what patients told them, the details supplied at registration, records from their previous consultants and from an examination.
 - CMC could not provide evidence that consultants working under practising privileges planned and delivered care and treatment in line with national guidelines or best practice. There was a process in place to grant practising privileges which was partially based on a consultant's track record. However, there was no process in place to monitor how effective ongoing treatment was, or if it had followed best practice guidelines.
 - CMC did not measure patient outcomes for any patients. Consultants kept individual patient's records and there was no system of accessing them to audit patient's outcomes. Patient outcomes were not measured for patients under the care of the GPs. This meant that they could not use this information in order to continuously improve.
 - There was no monitoring of age, disability, gender re-assignment, race, religion, maternity status or belief. Therefore it was unclear if there was any discrimination.
 - Patients did not routinely receive an ongoing written treatment advice card, following consultation.
- was conducting an audit of practising privilege submissions to ensure that key training was recent and for example, clinicians working with children had level three safeguarding training and DBS check.
 - CMC held study days for consultants and GPs to keep up to date with skills relating to the care and treatment of children. The minutes from the January 2016 MAC meeting demonstrated that updates were held to ensure that all doctors held level three children's safeguarding training.
 - There was no policy in place to deal with doctors who were performing at a sub optimal level. Practising privileges were only granted to consultants with a good record. The practice manager, with the support of the MAC was responsible for addressing poor performance with individual consultants. We saw this had happened in one case where inappropriate charges for treatment had been made.
 - There had been no evaluation of clinical competencies to ensure that effective care and treatment had been delivered. The employed paramedic had some skills to respond to a range of needs, however, once the MIU had been suspended, this safeguard was no longer in place.

Staff training and experience

- There was a core of permanent staff in place and an informal process to identify training needs. Non-clinical staff and the healthcare assistant could show that they had the right qualifications, skills, knowledge and experience to do their job and to take on new responsibilities. Staff accessed mandatory training on line, for example, infection control which covered hand washing and sharps management. All staff had undergone basic life support training. The practice manager kept staff training records which showed that staff were up to date. However, staff did not have formal appraisals, so there was no record of meetings on performance and development issues.
- CMC could not be sure that all consultants and GPs were up to date with their continuous professional development. When we visited, the practice manager

Working with other services

- CMC was in the early stages of developing arrangements for working with other health professionals. They did not have formal clinical protocols for referring patients to other specialists or colleagues. This work had started as part of the preparation for the MIU but it had not been formalised.
- Information about ongoing care was shared in a timely way. Receptionists faxed through doctor's referral letters to GPs or consultants within 24 hours. Patients were not routinely given a copy of this information. This depended on the consultants' preference. There were no routine arrangements to follow up patients who had been referred to other services.

Consent to care and treatment

- Patients told us that individual consultants and GPs explained care and treatment options to them. However, CMC did not have a comprehensive process to monitor this. There was a consent policy in place. Staff retained consent forms for GPs and dermatology consultations and there were plans in place to do this for other specialities.

Are services effective?

(for example, treatment is effective)

- Staff understood their responsibilities towards obtaining consent from young people. There was a child consent policy which reflected national guidelines. This included provision for older children to make their decisions if they were deemed to be Gillick competent.
- Understanding of how to apply the Mental Capacity Act 2005, was less clear. Staff were unsure how this would be applied, if for example, when a patient might be temporarily incapacitated.
- CMC provided full detailed information about costs of initial and further consultations. There was an information booklet, dated 2016 which listed the price of consultations for children, GP consultations for weekdays and weekends, physiotherapy, osteopathy, and minor injuries assessment. However, the price of minor injuries treatment and consultant appointments were not listed as they depended on the complexity of the patient's illness or injury, and the differing costs between consultants.

Are services caring?

Our findings

Respect, dignity, compassion & empathy

- We spoke to six patients, four of whom were new CMC patients. All the patients reported that staff and clinicians treated them with dignity and respect. They found the environment bright and friendly and said the receptionists and healthcare assistant had time to talk to them. We observed staff distracting a baby and small child and encouraging them to play. Information about the range of services was clearly on display in the reception area and on the reception desk.
- The environment was mostly conducive to supporting people's privacy. Consultants and GPs saw patients in consulting rooms or treatment rooms. The reception area did not offer much privacy but staff ensured that they observed confidentiality.

- Patients had completed two comment cards in January 2016, before our inspection and they indicated that the treatment they had received was good, caring and efficient.

Involvement in decisions about care and treatment

- Patients reported that the doctors listened to them and explained different treatment choices. They felt that treatment was fully described and they were given enough time to think about their options. Two patients said they would have liked more information to take away with them.
- Most patients we spoke with had health insurance, but two, who were self-funding told us that staff explained the costs clearly to them.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting patients' needs

- The facilities and premises were appropriate for the services that had been planned and delivered. The reception area was light and airy with sufficient room for patients to wait. Treatment and consultation rooms were an appropriate size.
- Waiting areas were colourful and adapted to children's needs, with television screens, books and toys. CMC opening times enabled parents who worked, to bring their children or attend themselves, to evening appointments.
- Patients were generally satisfied with availability and ease of making an appointment. Appointment times depended on consultant availability. We spoke with six patients and one said they would have preferred an evening instead of afternoon clinic.
- Two patients out of the six we spoke with had difficulty in finding parking nearby. For one patient, it was a first visit, and they said that they drove past CMC a few times and reported that they felt it could have been better signposted.
- CMC had no formal process for gathering the views of patients.

Tackling inequity and promoting equality

- Work to adapt services for the needs of different people was in the early stages. CMC had a lift for wheelchair users and a parking space for people with disabilities.
- An interpreting service was available.
- There was an equality and diversity policy in place and staff had undergone diversity training. However, when we inspected, there was no induction loop or provision for patients with difficulty hearing, alternative formats of information and no adapted equipment for obese patients.
- CMC tailored services to children. A paediatric phlebotomist was available with special training to take blood samples from children. A paediatric nurse assisted the consultant allergist.
- Leaflets and information sheets were available in reception which explained the full range of CMC services

including maternity care. They included clear indicative pricing. In addition, there were leaflets available which gave information about other providers in the locality, who provided treatments such as addiction recovery, baby massage and emotional freedom technique.

- The minor injuries unit (MIU) flyer was incorrect as it stated that there was a nurse practitioner in addition to the paramedic. The flyer did not make it clear that the MIU was a private service and therefore there was a charge for using this facility.

Access to the service

- We observed that consultant clinics did not always run to time and appointments were sometimes around 20 minutes late. CMC did not monitor waiting times or cancellations, which meant that there was no oversight of late running clinics.
- When clinics had to be cancelled, for example if the doctor was unwell, the consultant's secretaries who were not based at CMC would telephone patients to ensure they were given an alternative appointment or booked into the next available clinic.
- Patients had timely access to treatment. As the consultants did not work exclusively at CMC, they offered patients an appointment time regardless of location if they needed to be seen quickly.

Concerns & complaints

- There had been two complaints in the last two years. The complaints I had been investigated in a transparent manner and there had been learning to prevent a similar situation occurring. For example, one of the complaints surrounded a challenge about the cost of a consultation. As a result, CMC improved its processes to ensure that patients received full information about costs before a consultation.
- Patients reported that the procedure for complaints was clear. They said they would speak to the receptionist in the first instance. The receptionist explained to us that she would then ask the patient to complete a complaint form. The practice manager would then investigate the complaint, keep the patient informed with progress and let them know the outcome.

Are services well-led?

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

Our findings

Governance arrangements

- Clinical governance arrangements were not effective when. CMC was led by three directors, none of whom was a doctor. This board assessed business opportunities but did not develop a strategic or comprehensive approach to ensuring patient safety, including, for example: clinical risk assessment, quality monitoring arrangements or planning of care pathways and protocols including formal arrangements with other providers. As a result, clinical governance arrangements were not integral to the day to day running of CMC or to its MIU venture.
- Senior clinical leadership with regards to clinical governance lacked continuity. The Medical Advisory Committee (MAC) met quarterly. Early in 2014, the MAC appointed a clinical governance lead who resigned in April 2015. In October 2015 the appointed another consultant to take the governance lead role.
- There was no action plan to develop clinical governance or quality management when we inspected.
- CMC had an inadequate approach for identifying where quality or safety was being compromised. Staff reported adverse events to the practice manager who investigated them. Staff audited infection prevention and control. However, there were no audits of clinical risk, patient outcomes or clinical care. There was no formal monitoring of outcomes for children.
- The practice manager circulated paper versions of specific policies and ensured that they were implemented. The policies provided guidance on a range of matters including information security, child confidentiality, consent, manual handling and procedures for safety alerts and hazards. Not all policies were reviewed in a timely manner.
- The registered manager was competent and understood their responsibilities. However, CMC lacked skills for developing clinical processes. The paramedic, who ran the MIU had been employed on a casual basis to operate the minor injuries unit before it had clinically risk assessed or planned the service fully.
- The practice manager supported and managed the receptionists and healthcare assistant. The practice manager held monthly team meetings with staff to discuss developments and respective roles and

responsibilities. However, these discussions were not recorded. Records relating to employed staff included information relative to their recruitment. We saw three records of staff qualifications and DBS checks.

- Care and treatment records for GP patients were complete, legible and accurate and were kept secure. We did not see full care and treatment records for consultants as CMC did not routinely keep a record of these. There was no plan to ensure that all records were available in a timely manner.

Leadership, openness and transparency

- CMC's values were not explicit, but all staff knew that they were expected to deliver high quality care. CMC lacked mechanisms to monitor the quality of this care, such as reporting care outcomes or performance. There were no monitoring or reporting mechanisms to indicate poor clinical practice or excellence.
- Consultants told us they communicated well and there was a good team spirit. However, there was no formal monitoring of care or treatment arising from multidisciplinary solutions for patients.
- Staff understood the duty of candour and the need to be open. They had never applied this knowledge as there had been no reported patient harms. Complaints were handled in a very open, apologetic manner.

Learning and improvement

- CMC had limited quality assurance processes in place to encourage continuous improvement. They had no track record of clinical audit work. CMC did not retain medical records for consultant's patients. This limited their review of their own consultant's processes and ability to improve clinical practice.
- Information about the quality of care and treatment was limited. The practice manager took action on concerns and adverse events, and made changes to the service if a patient complained. However, there was no feedback on clinical performance through performance monitoring, working towards quality objectives, ensuring best practice was in place, clinical audits, benchmarking etc.

Provider seeks and acts on feedback from its patients, the public and staff

Are services well-led?

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

- The service lacked processes to gather feedback from its patients. It did not proactively seek written feedback, and did not collect informal feedback. As a result, the CMC did not involve the patients and public in improving or developing services.
- Staff told us that they enjoyed being part of a supportive, entrepreneurial organisation. There were informal processes to gather their views, such as the practice manager's monthly meeting. However, the meetings were not recorded.
- Staff understood the value of raising concerns in helping the organisation solve problems and improve service. One member of staff told us that a consultant spoke to her disrespectfully and she raised it as a concern. The practice manager investigated and explained to her the action she had taken. However, staff were unable to give us any examples of clinical concerns.

We identified regulations that were not being met and the provider had to:

Develop an approach to clinical risk management and patient safety, including quality assurance and thorough research before any service developments.

Put arrangements in place to take appropriate action if there was a clinical or medical emergency, including staff skills assessment, correct medicines and equipment and up to date training plans.

Ensure that there are documented care and treatment pathways for patients including any relevant health and safety concerns.

Implement formal governance arrangements including systems for assessing and monitoring risks.

Carry out ongoing improvement activity such as clinical and organisational audits including re-audits, to improve patient outcomes.

Ensure compliance with relevant reports issued from the Medicines and Healthcare products Regulatory Agency.

Ensure that a programme of ongoing appraisals is implemented and monitor ongoing training requirements and updates for all staff. Ensure for medical practitioners that appraisals link to their appraisal for revalidation.

Ensure that training is updated to include Mental Capacity Act 2005 and adult safeguarding. Certificates of training must be actively sought and updated in personnel files, including training undertaken external to the provider.

Seek feedback from patients and the public and incorporate the ideas in service improvement

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 9 HSCA (RA) Regulations 2014 Person-centred care Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2014 Person centred Care How the regulation was not being met: 9 (3) (h) The provider had not developed a full range of reasonable adjustments to enable patients with diverse needs service users to receive their care or treatment.
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 Regulation 12 HSCA 2008 (Regulated Activities) Regulations 2014 Safe care and treatment How the regulation was not being met: Regulation 12(2)(b) Arrangements to take appropriate action if there is a clinical or medical emergency were not clear. When opening the MIU, relevant Health and Safety concerns were not included in people's care and treatment plans and pathways and the service lacked care plans and pathways for staff to follow. Regulation 12 (2) (e) The provider did not have comprehensive training plans for the safe operation of premises and equipment in an emergency.

This section is primarily information for the provider

Requirement notices

Regulation 12 (2) (f)

The provider did not have arrangements to ensure that there were sufficient quantities of the correct types of equipment and medicines to deal with emergencies.

Regulated activity

Diagnostic and screening procedures
Family planning services
Surgical procedures
Treatment of disease, disorder or injury

Regulation

Regulation 17 HSCA (RA) Regulations 2014 Good governance

Regulation 17 HSCA 2008

(Regulated Activities) Regulations 2014

Good Governance

How the regulation was not being met:

Regulation 17(2) (a) (b) (c) (e) (f)

Regulation 17 (2) (a)

The provider did not have systems in place to improve quality, for example, regular clinical audits.

Regulation 17 (2) (b)

The provider did not have a risk assessment process around service development

Regulation 17 (2) (c)

The provider did not have prompt access to an accurate and contemporaneous record in respect of consultant's patients, including a record of care and treatment provided to the patient.

Regulation 17 (2) (e)

The provider did not proactively seek feedback from patients in order to improve services

Regulation 17 (2) (f)

The registered provider did not have effective governance and audit systems to ensure that they were assessing, monitoring or improving quality of service. This was due to a lack of a programme of clinical audits.

Regulated activity

Regulation

This section is primarily information for the provider

Requirement notices

Diagnostic and screening procedures

Family planning services

Surgical procedures

Treatment of disease, disorder or injury

Regulation 18 HSCA (RA) Regulations 2014 Staffing

Regulation 18 HSCA 2008

(Regulated Activities) Regulations 2014

Staffing

How the regulation was not being met:

Regulation 18(1)

The provider did not have procedures to follow in an emergency to ensure that sufficient and suitable people were deployed to cover both routine and emergency work.

The registered provider did not assess staffing levels to be able to operate its MIU over the hours advertised for both routine and emergency circumstances