BHSF Medical Practice Ltd

BHSF Medical Practice

Inspection report

Cornerblock
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Ratings

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

Overall summary

This service is rated as Requires improvement overall.

The key questions are rated as:

Are services safe? – Requires improvement

Are services effective? – Good

Are services caring? – Good

Are services responsive? – Good

Are services well-led? – Requires improvement

We carried out an announced comprehensive inspection at BHSF Medical Practice as part of our inspection programme.

The service was previously inspected in June 2018 as Newhall Medical Practice - Newhall Street under the provider organisation,The Newhall Medical Practice Limited. We found the service was not providing safe and well led services and there were breaches in regulation 13 and 17 for which we issued requirement notices.

Summary of findings

The service became part of the provider organisation, BHSF Medical Limited in 2015, and moved address in May 2018, to Cornerblock, 2 Cornwall Street, Birmingham B3 2DL, this had resulted in some changes to the senior management team as the service operated the BHSF corporate governance structure. At the time of our inspection in June 2018, these changes had not been reflected in the CQC registration. Following our inspection, the practice updated its registration. BHSF Medical Practice registered with CQC as a location for the provider BHSF Medical Practice Ltd in October 2018.

The Chief Medical Officer is 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 also asked for CQC comment cards to be completed by patients prior to our inspection. We received 27 completed comment cards where people who used the service shared their views and experiences of the service. All comments received were positive about the service.

Our key findings were:

- There were some systems and processes in place to keep people safe. However, these were not always identified, sufficiently well managed or embedded to ensure their effectiveness.
- The service reviewed the effectiveness and appropriateness of the care it provided. It ensured that care and treatment was delivered according to evidence based guidelines.
- Staff dealt with patients with kindness and respect and involved them in decisions about their care, feedback we received from patients was positive.
- The service took account of patient needs and preferences. Patients could access the service in a timely manner.
- There was a lack of effective leadership oversight to ensure good governance. Systems and processes were not always embedded to ensure risks were identified and managed.

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

- Ensure care and treatment is provided in a safe way to patients.
- Establish effective systems and processes to ensure good governance in accordance with the fundamental standards of care.

(You can see full details of the regulations not being met at the end of this report).

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

- Develop a systematic programme of ongoing quality monitoring and improvement activity.
- Review the arrangements in place for supporting patients who may experience barriers to accessing the service, to ensure they can access and use services on an equal basis to others.
- Consider ways to increase patient feedback to help improve the service.

Dr Rosie Benneyworth BM BS BMedSci MRCGP Chief Inspector of Primary Medical Services and Integrated Care

BHSF Medical Practice

Detailed findings

Background to this inspection

BHSF Medical Practice is an independent health care provider which provides the general public with private travel health services including Yellow Fever (registered location with NaTHNac) and private GP consultations which are registerable with CQC. The service is available to people over the age of 18 years.

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 types of service and these are set out in Schedule 2 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At BHSF Medical Practice services are provided to patients under arrangements made by their employer. These types of arrangements are exempt by law from CQC regulation. Therefore, at BHSF Medical Practice, we only inspected the services delivered under the regulated activities.

The service is registered with CQC under the Health and Social Care Act 2008 to provide the regulated activities of diagnostic and screening procedures and for the treatment of disease, disorder or injury.

BHSF Medical Practice is located in central Birmingham at Cornerblock, 2 Cornwall Street, Birmingham, West Midlands, B3 2DL. The practice is based on the fifth floor of a multi-storey building which is accessible by lifts. The service is open for appointments Monday to Friday between 8.30am and 5pm. Staffing consists of two sessional GPs and two nurses supported by an administrative team. There is a Chief Medical Officer a Clinical Standards Manager, Operations Manager and Director of Strategy who also support the running of the service.

When we visited the service on the 12 June 2019, the inspection team consisted of a lead CQC inspector and a GP Specialist advisor to CQC.

Before visiting, we reviewed information we gathered from the provider through the provider information return and other information we hold about the service. During the inspection we spoke with the Chief Medical Officer, the Director of Strategy, a GP, nurse and administrative staff.

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:

The provider had some systems and processes in place to keep people safe. However, these were not sufficiently well managed or embedded to ensure their effectiveness. This included risks in relation to infection control, fire, health and safety and medical emergencies.

Safety systems and processes

The service had some systems to keep patient safe and safeguarded from abuse, but safety systems needed to be improved

- There was a lead GP for safeguarding. A vulnerable adults policy was in place and we saw that the policy also included reference to safeguarding children as well as details of who to contact regarding any safeguarding concerns. Contact numbers were also available on the computer and there were posters displayed in the service raising awareness of childrens safeguarding. There was a safeguarding lead and staff had received training and knew how to identify and report concerns. However, not all clinical staff had completed level three safeguarding children's training in line with revised published guidance. The service was aware and working towards this.
- The service worked with other agencies to support patients and protect them from neglect and abuse. We saw an example of staff acting on concerns for a vulnerable adult.
- We reviewed three staff files including recently appointed staff. 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).
- Staff who acted as chaperones were trained for the role and had received a DBS check.
- The premises were visibly clean and tidy. Cleaning was carried out by an external company. However, oversight of the system to manage infection prevention and control was not fully effective. For example, there were no records to confirm the cleaning of equipment used for patients care and treatment. Staff we spoke with stated that equipment was cleaned between patients although this was not recorded.
- There was evidence that staff had received some vaccinations relevant to their role and in line with current Public Health England (PHE) guidance. However, there were no risk assessments in place in the absence of relevant vaccinations.
- An infection prevention and control policy were in place however, this was not comprehensive for example, there was no details in the policy or reference to areas such as clinical waste or sharps injury. Following the inspection, the service provided us with standard operating procedures for clinical waste and sharps injuries although there was no reference to these in the infection prevention and control policy.
- Staff spoken with were aware of what to do in the event of a spillage and spill kits were in place; however, no policy was in place. Cleaning equipment such as mops, and buckets were stored in a cupboard alongside staff coat
- Staff spoken with were aware of infection prevention and control procedures and infection control updates were discussed regularly in team meeting. However, staff had not completed recent training in line with the providers own policy which stated this should be completed every year. There was no infection control audit. An infection prevention and control checklist was completed monthly, the most recent check was conducted in May 2019, this mainly focused on the cleanliness of the general environment and did not for example include staff training, there was no overall score and no action plan generated as a result of the completed checks.
- There were systems for managing healthcare waste, however, there was no central place to store clinical waste awaiting collection. The provider told us that this was not required as the practice did not produce sufficient clinical waste requiring storage and clinical waste bins were emptied during two weekly collections. However, this was not risk assessed.
- Legionella risk assessments had been carried out at by an external contractor in January 2018. (Legionella is a term for a bacterium which can contaminate water systems in buildings).

Requires improvement

Are services safe?

- There was a risk assessment and data sheets for the control of substance hazardous to health (COSSH) However, the risk assessment was generic, lacked detail and was not specific to any COSHH products stored on the premises.
- The provider ensured that equipment was safe and maintained according to manufacturers' instructions.
- The practice was based in a shared building, fire drills and fire alarms testing were undertaken by management services contracted by the landlord and we saw evidence to support this. Staff had completed fire training and there were fire marshals in place. However, there were no fire risk procedures on display in the practice to alert visitors on what to do in the event of a fire. A fire risk assessment was completed in March 2018 by an external company with a number of actions identified there was no evidence of completed actions and the risk assessment had not been reviewed. The senior management team told us that a new fire contractor was appointed, and a meeting was due to take place soon.
- The provider had contracted an external company to undertake health and safety risk assessments and a facilities team working for the provider maintained oversight. A health and safety risk assessment was undertaken in May 2019, there were a number of actions which required completing. The senior management team told us that a meeting was due to take place shortly with the estates department to discuss the actions.
- We saw blind cords in place in patient accessible areas these had not been risk assessed.

Risks to patients

There were systems to assess, monitor and manage most risks to patient safety. However. there were gaps in the arrangements for responding to a medical emergency.

- There were arrangements for planning and monitoring the number and mix of staff needed.
- There was an effective induction system for agency staff tailored to their role.
- 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.
- The practice had a defibrillator and some of the medicines that may be required in the event of a medical emergency although, medical oxygen was not available as suggested by the Resuscitation Council UK guidelines. A risk assessment was in place however, this was not comprehensive as the timely response time of the ambulance services was viewed as mitigating the risk. Following the inspection we received confirmation from the service that oxygen had been ordered.
- When there were changes to services or staff the service assessed and monitored the impact on safety.
- There were appropriate indemnity arrangements in place.
- Professional indemnity arrangements were in place for GPs and nurses.
- The provider had a business continuity plan which was held by senior staff. However, senior staff advised that this was not shared with all staff as it contained personal information. Staff were aware of the escalation process to report major incidents and a reporting system was in place in the event of a major incident. Staff spoken with confirmed the arrangement.

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 for example any known allergies.
- The service had systems for sharing information with staff and other agencies to enable them to deliver safe care and treatment including the usual GP if appropriate.
- The service 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.
- Clinicians made appropriate and timely referrals in line with protocols and up to date evidence-based guidance.

Safe and appropriate use of medicines

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

Requires improvement

Are services safe?

- The systems and arrangements for managing medicines, including vaccines and emergency medicines and equipment minimised risks. The service kept prescription stationery securely and monitored its use.
- The service carried out regular reviews of all of clinicians prescribing as part of a peer to peer reviews to ensure prescribing was in line with best practice guidelines for safe prescribing. No overall prescribing audit had been completed due to the limited number of patients seen at the practice and the service had been operational under the new provider since May 2018.The practice was looking to undertake formal audits of prescribing.
- Staff prescribed, administered or supplied medicines to patients and gave advice on medicines in line with legal requirements and current national guidance. 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.

Track record on safety and incidents

The service did not have a good safety record

- There were risk assessments in relation to safety issues. However, these were not always comprehensive or sufficiently well managed or embedded to ensure their effectiveness. For example, in areas such as infection prevention and control, fire safety and health and safety.
- The service monitored and reviewed activity. This helped it to understand risks and gave a clear, accurate and current picture that led to safety improvements. For example, in the management of significant events.
- Staff who administered travel vaccinations were aware of reporting systems for any adverse events or side effects from medicines.

Lessons learned and improvements made

The service learned and made improvements when things went wrong.

- There was a system for recording and acting on significant events. Staff understood their duty to raise concerns and report incidents and near misses. Leaders and managers supported them when they did so. Significant events were discussed in team meetings
- There were adequate systems for reviewing and investigating when things went wrong. The service learned, and shared lessons identified themes and took action to improve safety in the service. A full review was completed for each incident and this was documented including action required to prevent reoccurrence and timescales for completing actions. We saw an example of a positive significant event where the service did not proceed with a request due to a lack of information on the patients history.
- The provider was aware of and complied with the requirements of the Duty of Candour. The provider encouraged a culture of openness and honesty. The service had systems in place for knowing about notifiable safety incidents
- The service acted on and learned from external safety events as well as patient and medicine safety alerts. The service had an effective mechanism in place to disseminate alerts to all members of the team including sessional and agency staff.

Good

Are services effective?

(for example, treatment is effective)

Our findings

We rated effective as Good because:

The service reviewed the effectiveness and appropriateness of the care it provided. It ensured that care and treatment was delivered according to evidence based guidelines.

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.
- Clinicians had enough information to make or confirm a diagnosis, any gaps in required information were acted on before treatment proceeded.
- Staff utilised a range of relevant on-line resources to support their work which were regularly updated on the practices computer system. For example, NaTHNac (National Travel Health Network and Centre), a service commissioned by Public Health England and the Green Book, information published by the government containing the latest information on vaccines and vaccination procedures, for vaccine preventable infectious diseases in the UK.
- We saw no evidence of discrimination when making care and treatment decisions.
- Arrangements were in place to deal with repeat patients. All records were clearly documented and contained information such as history, consultation and allergies providing a clear audit trail. Patients name, and date of birth were confirmed prior to consultations.
- Staff assessed and managed patients' pain where appropriate.

Monitoring care and treatment

The service was involved in some quality improvement activity.

- Quality assurance activity relating to clinical practice were limited to peer to peer review meetings for clinicians. This provided the opportunity to discuss significant events, review prescribing and undertake reflective practice. There was evidence to demonstrate learning and development opportunities as a result of peer reviews undertaken. However, there was limited quality monitoring and improvement activity on the effectiveness of the clinical care provided.
- The service was operational at the current address in May 2018, all staff were newly appointed, and the service was still developing. At the time of the inspection there was evidence of audits completed in areas such as cold chain, administering vaccinations and clinical notes. Prescribing audits had been completed for individual clinicians however, staff had not revisited the clinical audits to establish whether changes made achieved quality improvement, the senior managers recognised this was an area for further improvement.

Effective staffing

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

- All staff were appropriately qualified. The provider had an induction programme for all newly appointed staff.
- Relevant professionals (medical and nursing) were registered with the General Medical Council (GMC)/ Nursing and Midwifery Council 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 worked well with other organisations, to deliver effective care and treatment.

- Patients received coordinated and person-centred care. Staff referred to, and communicated effectively with, other services when appropriate for example secondary care services both in the NHS and private sector.
- Before providing treatment, doctors at the service ensured they had adequate knowledge of the patient's health, any relevant test results and their medicines history.

Good

Are services effective?

(for example, treatment is effective)

- The provider had risk assessed the treatments they offered. They had identified medicines that were not suitable for prescribing if the patient did not give their consent to share information with their GP, or they were not registered with a GP. For example, medicines liable to abuse or misuse, and those for the treatment of long-term conditions such as asthma. Where patients agreed to share their information, we saw evidence of letters sent to their registered GP in line with GMC guidance.
- Care and treatment for patients in vulnerable circumstances was coordinated with other services. We saw an example of referral to mental health services for a vulnerable patient.
- Patient information was shared appropriately (this included when patients moved to other professional services), and the information needed to plan and deliver care and treatment was available to relevant staff in a timely and accessible way. There were clear and effective arrangements for following up on people who had been referred to other services.

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. During consultations for travel vaccinations people were given health advice to help minimise the risk of contracting travel related diseases.
- Where patients need could not be met by the service, staff redirected them to the appropriate service for their needs including the NHS.

Consent to care and treatment

The service 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.
- The service monitored the process for seeking consent appropriately.
- Staff understood the requirements of legislation and guidance when considering consent and decision making. Staff had received training on the Mental Capacity Act and a policy was in place provide additional guidance.

Good

Are services caring?

Our findings

We rated caring as Good because:

Staff dealt with patients with kindness and respect and involved them in decisions about their care.

Kindness, respect and compassion

Staff treated patients with kindness, respect and compassion.

- Feedback from patients was positive about the way staff treat people
- Staff understood patients' personal, cultural, social and religious needs. They displayed an understanding and non-judgmental attitude to all patients.
- Consulting room and treatment room doors were closed during consultations and conversations taking place in them could not be overheard.
- The service 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.

- The provider did not have any specific arrangements for patients whose first language was not English. There were no information alerting patients that this service could be requested. Staff advised us there had not been any demand for interpreting services however, that this was something they needed to consider as the service developed and patient numbers increased.
- 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.

Privacy and Dignity

The service 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:

The service was responsive to patients' needs and took account of patient needs and preferences. Patients could access the service in a timely manner.

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

- The provider understood the needs of their patients and improved services in response to those needs. For example, travel risk assessments were undertaken to identify people's individual needs. Travel consultation appointments were made for thirty minutes to allow time for the assessment.
- The facilities and premises were appropriate for the services delivered.
- The practice had not completed an equality access audit. However, we saw some adjustments had been made. For example, there was a hearing loop system for patients with a hearing impairment. The service could be accessed via a lift and there were accessible toilet facilities were available within the premises. There was a fire evacuation chair and staff were trained in its use. There were no interpreting services due to lack of demand however, the service acknowledged this was an area for review.

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.
- Patients reported that the appointment system was easy to use.
- Referrals and transfers to other services were undertaken in a timely way. We saw an urgent referral made for a patient with mental health needs. Staff followed up referrals to review progress.

Listening and learning from concerns and complaints

The service took complaints and concerns seriously and had systems in place to respond to them appropriately to improve the quality of care.

- At the time of the inspection the practice had not received any complaints in the last year, this was due to the low number of patients currently using the service and general positive feedback which was aligned with the feedback that we received.
- Information about how to make a complaint or raise concerns was available. Staff told us they would treat patients who made complaints compassionately.
- There were arrangements in place to inform patients of any further action that may be available to them should they not be satisfied with the response to their complaint.
- The service had complaint policy and procedures in place.
- There were arrangements in place to ensure the service learned lessons from individual concerns, complaints and from analysis of trends and take action improve the quality of care.

Are services well-led?

Requires improvement

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

Our findings

We rated well-led as Requires improvement because:

There was a lack of effective leadership oversight to ensure good governance. Systems and processes were not always embedded to ensure risks were identified and managed.

Leadership capacity and capability;

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

- The service was part of a wider organisation led by an executive group board. At a local level the local staff team was supported by the Chief Medical Officer, an Operations Manager and a Clinical Standards Manager who were shared across some of the providers other sites.
- Leaders were knowledgeable about issues and priorities relating to the quality and future of services. They understood the challenges and were addressing them.
- Leaders were visible and approachable. They worked closely with staff and others to promote inclusive leadership.

Vision and strategy

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

- There was a clear vision and set of values. The service had a realistic strategy and supporting business plans to achieve priorities.
- Staff were aware of and understood the vision, values and strategy and their role in achieving them
- The service 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 service focused on the needs of patients.
- Leaders and managers acted on behaviour and performance inconsistent with the vision and values.
- Openness, honesty and transparency were demonstrated when responding to incidents and we saw evidence of this in learning from significant events. The provider was aware of and had systems to ensure compliance with the requirements of the duty of candour.
- Staff told us they could raise concerns and were encouraged to do so. They had confidence that these would be addressed.
- There were processes for providing all staff with the development they need. All the staff were new in post and had received a probationary review within three months of commencement to their post. Staff were supported to meet the requirements of professional revalidation where necessary. Clinical staff, including nurses, were considered valued members of the team. They were given protected time for professional time for professional development and evaluation of their clinical work. Peer to peer reviews provided opportunity for support amongst peers
- There was emphasis on staff well-being.
- The service promoted equality and diversity. Staff had received equality and diversity training. Staff felt they were treated equally.
- There were positive relationships between staff and teams.

Governance arrangements

The systems of accountability to support good governance lacked effective oversight in some areas.

- Structures, processes and systems to support good governance and management were in place however, they were not always clearly set out, understood and effective. For example, there was a lack of oversight in areas relating to health and safety as well as fire safety.
- Staff were clear on their roles and accountabilities including in respect of safeguarding and patient care. However, there was lack of effective quality monitoring systems to ensure staff were adhering to practice processes relating to the management of infection prevention and control procedures.
- Practice leaders had established policies, procedures and activities to ensure safety and assured themselves that they were operating as intended. However, policies

Are services well-led?

Requires improvement

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

were not always comprehensive or embedded resulting in gaps inconsistencies. For example, there were no details in the infection prevention and control policy in areas such as clinical waste or sharps injury. There was no policy for spillage.

- There was no ongoing programme of quality monitoring and improvement activity, and limited monitoring of the effectiveness of the clinical care provided.

Managing risks, issues and performance

There were gaps in the processes for managing risks, issues and performance.

- Processes for managing risks, issues and performance were not consistently well implemented. Not all risks were assessed and managed effectively such as health and safety, fire, the absence of medical oxygen and the use of blind cords in patients accessible areas.
- The service had processes to manage current and future performance. Performance of clinical staff could be demonstrated through audit of their consultations, prescribing and referral decisions. Leaders had oversight of safety alerts, incidents, and complaints.
- Peer to peer reviews had a positive impact on quality of care and outcomes for patients. There was clear evidence of action to change services to improve quality.
- The provider had plans in place for major incidents. Staff had not received formal training however, they were aware of what to do in the event.

Appropriate and accurate information

The service acted on appropriate and accurate information.

- Records seen contained appropriate information to support care and treatment provided. The provider had undertaken records audits to check the quality of information recorded.
- Quality and sustainability were discussed in regular governance and staff meetings where all staff had sufficient access to information.
- The service used performance information which was reported and monitored, and management and staff were held to account for example, through the peer review process.
- The service submitted data or notifications to external organisations as required such a notifiable infection.
- There were robust 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 service encouraged and heard views and concerns from the patients, staff and external partners and acted on them to shape services and culture.
- The service sent patients an email or text message requesting feedback following every consultation. At the time of our inspection the feedback received from patients was low and we saw the feedback received was all positive, this was aligned with the feedback we received from completed comment cards. However, the service had not considered other options to help improve patient feedback.
- Clinical staff had received feedback as part of their annual appraisal process and they shared this with us, we saw the feedback was very positive.
- Staff could describe to us the systems in place to give feedback for example, during staff meetings, appraisals and peer reviews. We saw evidence of how staff feedback was acted on.

Continuous improvement and innovation

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

- There was a focus on continuous learning and improvement.
- The service made use of internal and external reviews of incidents and complaints. Learning was shared and used to make improvements.
- Leaders and managers encouraged staff to take time out to review individual and team objectives, processes and performance.

Are services well-led?

Requires improvement

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

There were systems to support improvement and innovation work. This included detailed reviews of significant events and peer to peer reviews for clinical staff.

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 12 CQC (Registration) Regulations 2009 Statement of purpose **Regulation 12 HSCA (RA) Regulations 2014** **Care and treatment must be provided in a safe way for service users to ensure compliance with the requirements of the fundamental standards as set out in the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.** **How the regulation was not being met:** **There was a lack of effective systems and processes to assess the risk of, and preventing, detecting and controlling the spread of, infections, including those that are health care associated** **In particular:** • There were no records to confirm the cleaning of equipment used for patients care and treatment. • There were no risk assessments in place in the absence of relevant vaccinations for staff. • The infection prevention and control policy was not comprehensive. There was no reference to the management of clinical waste and spillage. • Cleaning equipment was not stored in a manner that reduced the risk of cross infections. • No infection prevention and control audits were undertaken to demonstrate monitoring and improvements.

Regulated activity	Regulation
Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance **Regulation 17 HSCA (RA) Regulations 2014 Good governance**

This section is primarily information for the provider

Requirement notices

Systems or processes must be established and operated effectively to ensure compliance with the requirements of the fundamental standards as set out in the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

How the regulation was not being met:

There were a lack of effective systems and processes that enabled the registered person to assess, monitor and mitigate the risks relating to the health, safety and welfare of service users and others who may be at risk.

In particular:

- Risks relating to fire safety had not been identified and addressed.
- Risks relating to health and safety were not always assessed and managed effectively. This included risks associated with hazardous products, the use of blind cords, and the absence of evidence confirming staff had received all vaccinations relevant to their role and in line with current Public Health England (PHE) guidance.

This section is primarily information for the provider

Enforcement actions

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.