Multimed Limited

Ascroft Medical

Inspection report

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Overall summary

We carried out an announced comprehensive inspection on 15 November 2017 to ask the service the following key questions; are services safe, effective, caring, responsive and well-led? We planned the inspection to check whether the registered provider was meeting the legal requirements within the Health and Social Care Act 2008 and associated regulations.

This was a joint dental and medical inspection of an independent healthcare service. This report relates to the medical services only. A separate report has been written for the dental service provided by the clinic. You can read the report by selecting the 'all reports' link for the Ascroft Medical- HSCA.

Our findings were:

Are services safe?

We found that this service was not 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 the report).

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 the report).

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. We have told the provider to take action (see full details of this action in the requirement notices at the end of the report).

Background

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 planned to check whether the service was meeting the legal requirements and regulations associated with the Health and Social Care Act 2008.

Ascroft Medical is registered with the Care Quality Commission (CQC) as an independent provider of dental and medical services for children and adults and is located in Oldham, Greater Manchester. Patients are primarily Polish people with English as a second language who live in the United Kingdom and the service is accessed through pre-booked appointments.

Summary of findings

The clinic is registered with the CQC to provide the following regulated activities:

- Diagnostic and screening procedures
- Surgical procedures
- Treatment of disease, disorder and injury
- Maternity and midwifery services

Doctors and other health professionals such as nurses and dieticians are employed on a sessional basis. The service offers specialist care in the fields of gynaecology, internal medicine, defined as dealing with the prevention, diagnosis, and treatment of adult diseases, dermatology, orthopaedics and psychiatry. Medical consultations, diagnostic tests and minor surgery are provided by the clinic.

This service is registered with CQC under the Health and Social Care Act 2008 in respect of the provision of advice or treatment by, or under the supervision of, a medical practitioner. At Ascroft Medical HSCA the aesthetic cosmetic treatments that are also provided are exempt by law from CQC regulations.

The health care team consists of:

- Five dentists
- Three dental nurses
- One dental hygienists
- Six doctors (including an internal medical specialist, gynaecologists, a dermatologist, orthopaedist and psychiatrist).
- One speech and language therapist
- Three non-clinical staff including the registered manager and receptionists.
- One phlebotomist

All the doctors and dentists are registered with either the General Medical Council (GMC) or the General Dental Council (GDC).

The owner of the service is the registered manager. A registered manager is a person who is registered with the CQC to manage the service. Like registered providers, they are 'registered persons'. Registered persons have a legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated regulations about how the service is run.

We received feedback about the service from 18 patients. All comments were positive and indicated that the service was accessible, patients had confidence in the doctors and felt involved in planning their care and treatment. They told us the staff were caring and the clinic was always clean.

Our key findings were:

- Child protection and paediatric services were not provided in line with best practice guidance.
- There was no clinical governance oversight of the medical services provided.
- The consulting rooms were clean and tidy. However the provider needs to take action to make sure the minor surgery room meets best practice infection control standards.
- Protocols relating to consent in minor surgery did not meet best practice guidance.
- Meetings to discuss patient outcomes did not take place and the doctors employed by the service did not attend team meetings.
- Patient's records did not always contain sufficient detail to show what treatment had been provided and why.
- Processes for reporting incidents were not well established and systems for dealing with safety alerts were not reliable.
- Medicines for dealing with medical emergencies were incomplete, however all emergency medication was in date and systems were in place to monitor their use and expiry dates.
- Antibiotic prescribing and monitoring was not based on local or national guidance.
- Policies and procedures in place, for example the clinical significant event policy, were not always understood by staff. Policies and procedures were only available in English which was the second language for a significant number of staff.
- Information about making a complaint was available and detailed. However information about how to escalate a complaint to an independent body was incorrect.
- The whistleblowing policy did not support staff because they were not signposted to contact an independent organisation.
- The provider could not demonstrate a clear understanding of responsibilities under the Duty of Candour regulation.
- Information about the range of services and fees was available.

Summary of findings

- Systems were in place to follow-up blood and other test results.

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

- Ensure medicines are managed according to best practice protocols and comply with national and local guidance about prescribing antibiotics.
- Ensure all doctors employed in the provision of the regulated activity receive the appropriate support, training, professional development, supervision and appraisal necessary to enable them to carry out their duties.
- Ensure children and young people are protected from abuse and improper treatment.
- Introduce effective systems and processes to ensure good governance in accordance with the fundamental standards of care.
- Ensure processes are in place to support compliance with the duty of candour regulation.

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

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

- Review consent processes for minor surgery.
- Review how staff summons assistance when they are lone-working.
- Review risk assessments that have been completed.
- Review the system for signposting patients to the most appropriate out of hours provision when the service is closed.
- Review the process for reflecting feedback from the main social media websites.
- Review the processes for dealing with safety alerts.

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 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).

- The provider did not routinely carry out checks to verify a patient's identity.
- The provider did not take steps to assure themselves that adults accompanying children had parental authority.
- The provider did not have a system in place to identify children at risk or vulnerable adults.
- The provider had not ensured appropriate health assessments were always completed or that patients care and treatment, including prescribed medication, was always based on up-to-date best practice guidance.
- Medical records did not always conform to the 'Records Management Code of Practice for Health and Social Care 2016'.
- A chaperone policy was in place and staff who acted as chaperones received training to enable them to carry out the role safely and effectively.
- All medication was provided from pharmacies local to the clinic or patient, however the provider did not have a prescribing protocol in place. Antibiotics and other medication were not always prescribed in line with best practice guidance.
- The incident reporting policy did not support staff to understand their responsibilities to raise concerns, and to report incidents and near misses. When things went wrong reviews and investigations were not formally discussed to ensure actions and lessons learned were then communicated to the wider team to mitigate risks.
- The clinic had good arrangements in place to respond to emergencies. Staff had received basic life support training.
- With the exception of the minor surgery room, there were effective systems in place to ensure the premises and equipment was clean, well maintained and safe to use.

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).

- There was no evidence that medical staff were aware of current evidence based guidance. When requested we were not provided with any evidence of clinical audit or quality improvement activity.
- The provider did not have any systems in place for monitoring the outcomes of care and treatment provided at the clinic.
- Recruitment and induction processes were in place. However, the provider did not have a system in place to ensure that medical staff were fully competent in the specialist area of work they carried out at the clinic.
- We did not see evidence that the provider supported doctors in their continuing professional development.
- Patients were not signposted to out of hours medical services when the clinic was closed.
- Systems were in place to inform patients of laboratory test results but this did not include informing the patients NHS GP.
- There were no links with specialist NHS services such as mental health or learning disability services.

Are services caring?

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

Summary of findings

- Patient feedback was positive and staff we spoke with were caring and knew how to be kind to patients.
- Privacy screens were provided in consulting rooms to maintain patients' privacy and dignity during examinations, investigations and treatments.
- A private room was available if patients appeared distressed or wanted to discuss sensitive issues.

Are services responsive to people's needs?

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

- Information about the services and how to complain was available and we saw that complaints were dealt with in a timely way. However, the complaints policy contained the incorrect route of escalation for independent health care related complaints.
- The provider did not provide individual patient information leaflets about procedures, however information about the different treatments was held in a patient folder.
- Individual leaflets about the cost of each treatment and consultation was provided in Polish and English versions were available on their website.
- The registered manager was accessible at all times.
- The practice had good facilities.
- All practice staff spoke Polish and English.
- There was no time limit to the length of consultations.

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 an open culture and the registered manager was visible to staff.
- The registered manager cooperated and engaged fully with the inspection process.
- The leadership structure was understood by staff however extra responsibilities allocated to staff with lead roles, such as infection control and safeguarding, were not clearly defined.
- Governance arrangements were not in place and there was no evidence of a programme of continuous clinical audit or quality improvement activity.
- Team meetings were held but there was no opportunity for the doctors to attend and no system in place to ensure they were involved in clinical governance arrangements. There was no formal route of sharing information with doctors.
- There was no clinical leadership in place to drive quality improvement or ensure adherence to relevant best practice guidance.
- There was no evidence of local clinical supervision, mentorship, peer review or support for the doctors.
- There was no overarching risk assessment for identifying, recording and managing the risks and issues associated with running the business.
- A business continuity plan was in place but this did not provide clear guidance about what action was needed in different emergency situations such as flood; computer breakdown or mechanical faults.
- There was a broad range of policies and procedures and these had been reviewed, however, there was no evidence that these had been shared with staff.
- Patient medical records were stored securely in an electronic medical record system. Paper records were stored in a fire proof cabinet kept in a locked cupboard.
- The provider sought patient feedback and responded to concerns and suggestions on an individual basis.

Ascroft Medical

Detailed findings

Background to this inspection

We carried out an announced inspection on 15 November 2017 under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. We planned the inspection to check whether the registered provider was meeting the legal requirements within the Health and Social Care Act 2008 and associated regulations.

Our inspection team was led by a CQC Lead Inspector and included one dental inspector, a second CQC inspector, a CQC specialist GP advisor, a dental specialist advisor and a Polish-language interpreter.

During our inspection we spoke with the registered manager, a business advisor for the service, two specialist doctors, a dentist, two dental nurses and two receptionists. We received feedback from 18 patients. We reviewed personnel files, training records, practice policies and procedures and other records concerned with running the service. We reviewed the records of 27 patients.

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.

Are services safe?

Our findings

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

Safety systems and processes

- The systems in place did not fully protect against abuse and arrangements for safeguarding did not fully reflect relevant legislation.
- Safeguarding policies were accessible to all staff and outlined who to contact if there were concerns. However the policy did not include information about PREVENT the initiative for recognising and taking steps to deal with political or religious extremism, protecting against female genital mutilation (FGM) or modern human trafficking and slavery.
- Administration staff had completed on-line level two child protection and adult safeguarding training. The safeguarding lead had completed level three training.
- Clinical staff did not know the identity of the safeguarding lead and records indicated that clinical staff did not always recognise and deal correctly with symptoms that could be a sign of abuse.
- Following the inspection visit, the provider reviewed the safeguarding policy and completed level four training themselves and provided level two and three child protection and safeguarding training to clinical and administration staff as appropriate.
- We saw that patients were always offered a chaperone, information offering chaperones was on display and staff had completed chaperone training.
- A lone working policy was in place however staff did not have means of summoning help if they were on their own with a patient.
- The practice had a whistleblowing policy but this did not inform staff about which external organisations they could go to.
- Disclosure and Barring Service (DBS) checks had been completed for all staff.
- The premises were clean and tidy and the provider had a service level agreement with a cleaning firm. A general cleaning schedule for each room was in place and this was complete and up to date. Clinical waste was appropriately stored and a specialist clinical waste company collected waste bins and sharps boxes.
- Control of Substances Hazardous to Health Regulations (COSHH) risk assessments had been completed but these did not provide enough information about the risk and mitigation for individual substances.
- A range of infection prevention and control policies and procedures were in place and readily available to staff. Certificates and maintenance records indicated that all general equipment was cleaned, calibrated and serviced in keeping with the manufacturer's instructions. We saw for example the fixed electrical wiring safety certificates for the premises. A Legionella risk assessment and certificate were in place and water temperature checks had been recorded regularly and were up to date.
- In September 2017 the infection control lead completed an environmental cleanliness observational tool. The information was generalised and the report did not comment on all areas. A recommendation that all taps were changed to hands free was made. However no improvement plan had been put in place to facilitate the change, a risk assessment relating to the findings had not been developed.
- Infection prevention measures for the minor surgery needed to improve. Work surfaces and flooring in the minor surgery room were not fully sealed in order to minimise infection, the hand wash sink and taps did not meet best practice because the sink had an over flow outlet and plug, and the taps were not hands free. There was no dedicated cleaning schedule or a record of when this room was deep cleaned. Microbial swabs had not been taken to make sure cleaning was effective. In relation to outcomes for patients, audits were not completed to check whether patients experienced wound site infections post-surgery.
- The Hepatitis B immunisation status was known for all staff.

Risks to patients

- The clinic had arrangements in place to respond to medical emergencies.
- Staff received annual basic life support training; however the provider had not assured themselves that all clinical staff working with children had completed paediatric life support training.
- A first aid kit was available and defibrillator was in place.
- Emergency medicines were in a secure area of the clinic and accessible to staff who knew where they were. Oxygen with adult and children masks was in place.

Are services safe?

- The medicines available were suitable for dealing with the dental medical emergencies. Emergency medicines were regularly checked and all medicines were in date. We noted that additional medication was needed to ensure compliance with best practice for a general medical emergency, for example the kit held aspirin but this was not soluble as required.
- Staff had medical and nursing indemnity certificates on file.

Information to deliver safe care and treatment

- There was no system in place to verify the identification of patients (adult or children) and the provider did not take steps to assure themselves that adults accompanying a child had parental authority. The provider did not have systems in place to assess whether a child was at risk. There were no systems in place for shared care or information sharing with statutory services in keeping with child protection best practice. Following the inspection the provider put in place systems for verifying the identity of adult patients and agreed to signpost all patients under 18 years to NHS GPs or other NHS services until their child protection protocols met best practice.
- Patient records did not always contain a detailed medical history and doctors did not respond in relation to patients who gave permission to liaise with the patients NHS GP before or after a consultation to make sure care was based on up to date information.
- The service used an established electronic medical records system for dentists and this had been modified to use for recording medical records for general patients. The system was password protected and the server was backed up and saved daily. Paper records were filed in a fire resistant cabinet in a locked area.

Safe and appropriate use of medicines

We checked the arrangements for the management of medicines at the clinic.

- Medicines were stored securely and were only accessible to authorised staff. Patients were able to choose which pharmacy to obtain their medicine after a consultation. If medication was needed for a procedure the patient received a prescription and they collected the medication prior to the consultation.
- The clinic issued private prescriptions, these were stored securely, however, these were not monitored for use.
- The clinic did not have a prescribing protocol and doctors did not use national antibiotic prescribing protocols, for example we saw that a licensed antibiotic that was not typically used had been prescribed and a risk assessment or rational for its use was not documented. The provider told us audits of medicines to monitor the quality of prescribing were not completed.

Track record on safety

- The registered manager stated there had been no incidents in the service in since registration in May 2015.
- There was a clinical incident reporting policy which stated staff must report incidents, however this was not supported by service specific guidance and reporting protocols related to Ascroft Medical. The provider and staff did not understand the breadth of events that could constitute an incident. For example a needle-stick injury had been reported in the accident book. The injured person had reviewed the event, however there was no evidence the findings had been shared with the wider team.

Lessons learned and improvements made

- The provider was not aware of the requirements of the Duty of Candour regulations.
- Systems for dealings with information were informal and were not reviewed so that trends or possible lessons identified.
- A system was in place to receive national patient safety alerts from the Medicines and Healthcare Products Regulatory Authority (MHRA). However the process in place for sharing these with staff did not include arrangements for ensuring relevant action had been taken.
- Processes were not in place to identify patients who may have received care which needed to be reviewed in response to safety alerts. The medical record system did not filter information according to treatment or diagnosis.

Are services effective?

(for example, treatment is effective)

Our findings

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

Effective needs assessment, care and treatment

- The clinic was unable to provide evidence of assessing needs and delivering care in line with relevant and current evidence based guidance and standards, for example, National Institute for Health and Care Excellence (NICE) best practice guidelines for care and treatment provided. Records made about patient consultations did not always include an up to date medical history or information about the guidance provided to the patient.
- We reviewed the medical records and consultation notes for a number of children and none of the children who presented with febrile conditions had been examined or treated in accordance with best practice guidance. For example temperatures had not been recorded and there was no comment about whether a rash was present. In response to this the provider agreed to signpost children aged 0-18 to NHS GP or out of hours services until they were satisfied that all care would be provided according to the appropriate paediatric best practice guidance.
- Arrangements were not in place to refer patients who required additional support if they were experiencing poor mental health. There was inconsistent evidence regarding advice offered, monitoring arrangements or follow-up arrangements for some patients.

Monitoring care and treatment

- The registered provider did not collect and monitor information on the outcomes of care and treatment provided by the service.
- There were no clinical audits or clinical quality improvement activity in relation to the medical side of the operation.
- The provider had not ensured that a clinician took responsibility for medical oversight of the service and the decisions made by doctors were not discussed or reviewed.

Effective staffing

- Revalidation for medical staff was not effectively managed because the provider did not seek assurance that doctors were competent to work with specific patient groups at the clinic. Following the inspection the provider put systems in place to liaise with responsible officers and review the skills of doctors in relation to the patient user groups they treated.
- The clinic had an induction programme for newly appointed staff. This covered safeguarding, infection prevention and control, fire safety, health and safety and confidentiality.
- We saw documented evidence that administration staff had received appraisals. There was no evidence to confirm doctors who worked at the clinic had completed appraisals. Administration staff told us they could ask for training or additional support whenever it was needed. A member of staff was been trained to act as a deputy manager. This training included shadowing the provider while they carried out managerial duties.
- Staff completed mandatory training in 2017 which had covered: safeguarding, basic life support, fire safety awareness, Mental Capacity Act 2005, consent and information governance which included confidentiality.
- Staff had completed training in preparation for specialist roles for example infection control and chaperone training.

Coordinating patient care and information sharing

- Patients completed a medical history form that included patient consent to share information with the patients' registered GP. Records showed that information was not being routinely shared and this was confirmed by the registered manager. This was not in accordance with General Medical Council (GMC) guidance on sharing information.
- Arrangement for receiving laboratory tests results was effective. A service level agreement was in place with a reputable laboratory. Specimens were collected daily and a 24 hour turnaround for results was expected. Results were reviewed by the doctor and the results given directly to the patient. The results were not, however, routinely shared with the patients NHS GP.

Supporting patients to live healthier lives

- The service did not identify patients who needed support and consultation records did not indicate that advice on healthy living was given. For example smoking cessation advice was not offered to smokers.

Consent to care and treatment

Are services effective?

(for example, treatment is effective)

- Systems were in place for consent to care and treatment. We saw evidence that consent could be verbal or written. The consent policy was generalised and not specific to the service. However information was based on best practice in relation to the Mental Capacity Act and Gillick competency in relation to children and young people. We saw that treatment fees were explained to the patient prior to the procedure and the schedule of fees was displayed in the waiting room.
- The consent process for minor surgery did not show that patients had been fully informed about the risks, benefits and post-operative care before giving consent. Consent for minor surgery had been documented as verbal consent. Information in the medical records did not include what the doctor discussed with the patient, any specific requests made by the patient or information regarding decisions made about care and treatment such as pain control or post-operative recovery. Records did not confirm whether information had been provided about the procedure.

Are services caring?

Our findings

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

Kindness, respect and compassion

- Staff we spoke with were aware of their responsibility to respect people's diversity and human rights.
- All staff spoke English and Polish. The clinic provided most information in Polish.
- We noted that staff treated patients respectfully, appropriately and kindly and were friendly towards patients over the telephone.
- Patients had access to information about the clinicians working for the service and could book a consultation with a GP of their choice.
- We received feedback from 18 patients and all were positive about the service and social media feedback was also positive in respect of kindness and compassion.
- The service had completed a patient satisfaction survey. The latest survey results completed in September 2017 showed that 99% out of 61 patients were satisfied with staff attitude.

Involvement in decisions about care and treatment

- The provider did not have leaflets about each procedure but a patient information folder was available in the waiting room. This held detailed information about the procedures that took place at the clinic. These could be photocopied for the patient on request.
- Information to help patients make informed choices was also available in Polish and English on the company's website. The information included details of the specialist doctors and the scope of services offered.
- Patients were also able to access information on a social media site.

Privacy and Dignity

- Privacy screens were provided in consulting rooms to maintain patients' privacy and dignity during examinations, investigations and treatments.
- A private room was available if patients wanted to discuss sensitive issues or appeared distressed.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

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

Responding to and meeting people's needs

- The provider did not collect information about ethnicity, however anyone who chose to pay could access the service.
- Baby changing facilities were available and there were play tables for children in the reception area.
- Staff told us that the majority of patients attending the clinic were either Polish or English speaking. We were told translation services were not necessary as staff spoke both Polish and English.
- A clinic information booklet was available in the clinic waiting room. This included arrangements for dealing with complaints, arrangements for respecting dignity and privacy of patients and also services available. The information about dealing with complaints needed to be reviewed so that patients were directed to the correct organisation if they were unhappy with an investigation carried out by the provider.
- All patients attending the clinic had self-referred; none were referred from NHS services.

Timely access to the service

- Clinic opening hours were displayed on the premises.
- The doctor's service was pre-bookable and operated Monday to Friday 6.30pm to 8pm. The gynaecology consultation service operated every Saturday 10am to 2pm. Other specialist doctors were also available at monthly intervals.
- Urgent medical appointments were not provided however this was not made clear to patients and the registered manager reported taking calls requesting medical treatment outside of opening hours.

Listening and learning from concerns and complaints

- The clinic had a complaints policy available in the patient information folder kept in the waiting room. This provided clear information about how to make a complaint and the time scales for investigation and response. However, the policy did not provide the appropriate signposting for patients to raise their complaints to independent health adjudication services. This was raised with the provider during the inspection.
- The registered manager handled all complaints in the service. We saw evidence of complaints being investigated appropriately and outcomes were discussed with staff to share learning and improve the service.
- The provider did not routinely review and respond to concerns raised on the intranet or social media sites.

Are services well-led?

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

Our findings

We found that in some areas this service was not providing a well led service in accordance with the relevant regulations.

Leadership capacity and capability;

- The registered manager was one of the providers and responsible for the day to day running of the service. The registered manager appeared open to new ideas and staff told us there was a positive culture. All staff said they enjoyed working at the service and the manager listened to their opinions and was approachable.
- There was a clear leadership structure and staff were aware of who to approach for advice. There was a succession plan in place and staff had received training to enable them to provide management cover in the registered manager's absence.
- Formal systems were not in place to ensure continual learning and professional development and staff employed did not always understand what was needed to carry out the responsibilities they had been allocated.

Vision and strategy

- The vision of the service was to provide the best possible clinical care from doctors and nurses and a courteous and efficient service from administration and reception staff.
- Team meetings took place and information about service development and changes was shared with administration staff. Doctors were not formally involved in planning the vision and strategy for the clinic.

Culture

- The provider did not have a separate Duty of Candour policy and this topic was not included in any other policy such as the complaints policy. 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. However the registered manager and staff stated any incident would be discussed openly and support given to the patient concerned.
- Staff described an open culture and felt confident about reporting any issues to the registered manager or the senior dentist. However this was not underpinned by clear policies and processes which could be checked and monitored for effectiveness.

Governance arrangements

- Appropriate arrangements for identifying, recording and managing non clinical risks, were in place but the effectiveness of assessments had not been checked and an action plan to deal with findings was not always put in place. For example, health and safety risk assessments had highlighted that taps in the minor surgery room were not appropriate but an action plan had not been put in place.
- Policies and procedures were mostly generic and did not relate specifically to the service. During the inspection we noted that when these were requested staff often had to ask the registered manager how to access them.
- There was a clinical incident policy but staff were not aware of this and no significant events had been reported since the service opened in 2015. There were no formal processes in place to report, record or learn from incidents or significant events.
- The registered manager held team meetings, and staff were able to add additional items for discussion. Meetings were not regular but booked as required. Meetings did not include the doctors and there was no evidence that they were involved in clinical governance arrangements. There was no formal process of sharing information with doctors or staff who did not attend meetings.
- A quality improvement programme or continuous clinical and internal audit process was not in place. Monitoring systems to drive improvements were not in place. There were no audits to improve the quality of prescribing or check outcomes for patients.

Managing risks, issues and performance

- An organisational risk assessment had not been developed.
- There was a business continuity plan but this was not specific to the service and directed staff to contact the manager in most eventualities. Staff were not provided with a contingency plan to action if the registered manager was not available.

Are services well-led?

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

- The doctors provided a wide variety of specialist services on a sessional basis and there was no formal clinical leadership or oversight of the activities they undertook. We saw no evidence that clinical leadership was provided or external expertise sought to drive quality improvement.

Appropriate and accurate information

- Patients' medical records were held electronically and also handwritten. Patients' medical records were stored in a fire retardant cabinet located in a secure area of the clinic.
- Medical records were not audited and checked to make sure the information provided met best practice guidance and standards. We reviewed 27 medical records and important information was missing in 14 cases. Missing information included baseline clinical observations and the patient's previous medical history. There was no system of clinical peer review of records; cases were not discussed and considered in respect of possible improvements in care and treatment.

Engagement with patients, the public, staff and external partners

- The service held open days and encouraged potential customers to visit the service, get to know staff and learn about the services on offer.

Continuous improvement and innovation

- The provider identified the engagement with regulatory bodies such as the independent regulator was an important component in improving the standard of the service.
- The provider had a vision to improve diagnostic and screening service provided.

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 Maternity and midwifery services Surgical procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment Care and treatment must be provided in a safe way for service users. **How the regulation was not being met:** Assessments of the risks to the health and safety of patients receiving care and treatment were not being carried out. In particular; • The registered person did not do all that was reasonably practicable to assess, monitor, manage and mitigate risks to the health and safety of service users. • Management of medicines was not always safe. • The provider had not given any consideration to the risk of not sharing information with a patient's own GP. • The provider was not taking sufficient steps to verify patient identity. · The provider did not take steps to assure themselves that adults accompanying children had parental authority.

Regulated activity	Regulation
Diagnostic and screening procedures Maternity and midwifery services Surgical procedures Treatment of disease, disorder or injury	Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment Systems and processes must be established and operated effectively to prevent abuse of service users. **How the regulation was not being met**

This section is primarily information for the provider

Requirement notices

- The safeguarding policy was incomplete because information about all types of abuse for example Female Genital Mutilation (FGM) and modern slavery was not included.
- Processes in place did not identify and protect children or adults at risk

Regulated activity	Regulation
Diagnostic and screening procedures Maternity and midwifery services Surgical procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance **Systems or processes must be established and operated to ensure compliance with the requirements in this Part.** **How the regulation was not being met:** • There were no formalised systems in place to assess, monitor and improve the quality and safety of the service provided. • Staff performance was not checked against clear and formal standards. No clinical oversight for the doctors working at the practice was in place. • A comprehensive program of risk assessments had not been developed for the service. • Risk assessments in place lacked detail or were incomplete. • Policies and procedures were not readily available or always understood by staff. • Records did not provide complete information about the care and treatment provided to the service user and decisions taken in relation to the care and of treatment provided.

Regulated activity	Regulation
Diagnostic and screening procedures Maternity and midwifery services Surgical procedures Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing **Sufficient numbers of suitably qualified, competent, skilled and experienced persons must be deployed in order to meet the requirements of this Part.**

This section is primarily information for the provider

Requirement notices

How the regulation was not being met:

- Patients were at risk because the provider did not have systems in place to make sure that medical doctors had received appropriate support, training, professional development, supervisions and appraisal as was necessary to enable them to carry out the specialist duties they were employed to perform.

Regulated activity	Regulation
Diagnostic and screening procedures Maternity and midwifery services Surgical procedures Treatment of disease, disorder or injury	Regulation 20 HSCA (RA) Regulations 2014 Duty of candour **How the regulation was not being met:** • The provider did not have processes in place to review care or identify whether a duty of candour incident had occurred. • A policy relating to duty of candour was not in place.