Mistvale Limited

# 7 Day Healthcare

**Inspection report**

142-146 Bellegrove Road
Welling
Kent
DA16 3QR
Tel: 020 8301 4664
Website: www.7dayhealthcare.co.uk

Date of inspection visit: 12 June 2019
Date of publication: 19/08/2019

## Ratings

| | |
|---|---|
| Overall rating for this service | Inadequate |
| Are services safe? | Inadequate |
| Are services effective? | Inadequate |
| 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 Inadequate overall.** (Previous inspection – January 2018)

The key questions are rated as:

Are services safe? – Inadequate

Are services effective? – Inadequate

Are services caring? – Good

Are services responsive? – Good

Are services well-led? – Requires improvement

We carried out an announced comprehensive inspection of the private doctor service at 7 Day Healthcare on 12 June 2019 as part of our inspection programme, and to follow up on breaches of regulations.

CQC inspected the service in January 2018 and asked the provider to make improvements to ensure care and treatment is provided in a safe way to patients, and to establish effective systems and processes to ensure good

# Summary of findings

governance in accordance with the fundamental standards of care. We checked these areas as part of this comprehensive inspection and found they had been partly resolved.

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. At 7 Day Healthcare, private doctor and dental services are provided which are within the scope of CQC regulation.

There are some exemptions from regulation by CQC which relate to particular types of service and these are set out in Schedule 2 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At 7 Day Healthcare, intense pulse light (IPL) treatments are provided for hair removal, and there is a foot care service. These services are not within the remit of this Act and CQC regulation.

The nominated individual 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.

17 people provided feedback about the service; 16 people completed comment cards and we spoke with one person using the service.

**Our key findings were:**

- The service received positive feedback about patients' care and treatment experiences. The service treated patients with care and compassion and involved them in decisions about their care.
- The service delivered services to meet patients' needs that took account of their preferences, and they listened to and responded to concerns and complaints.
- The service was not providing safe services as they had poor safety systems and processes, poor management of patient safety risks and a lack of reliable systems for appropriate and safe handling of medicines.
- The provider had made improvements since our last inspection in the provision of effective care as they had better arrangements to ensure training and peer support for their staff team and had started carrying out quality improvement activities in relation to clinical care. However, they did not consistently work effectively with other organisations to deliver services.
- The provider has partly made improvements in the arrangements to support good governance and management. But there were inconsistencies in the processes for managing risks.

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

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

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

- Review their arrangements to protect patients' privacy and dignity in the minor surgery operations room.

I am placing this service in special measures. Services placed in special measures will be inspected again within six months. If insufficient improvements have been made such that there remains a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating the service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve.

The service will be kept under review and if needed could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement we will move to close the service by adopting our proposal to remove this location or cancel the provider's registration.

Special measures will give people who use the service the reassurance that the care they get should improve.

**Dr Rosie Benneyworth BM BS BMedSci MRCGP**

Chief Inspector of Primary Medical Services and Integrated Care

# 7 Day Healthcare

**Detailed findings**

## Background to this inspection

The registered provider, Mistvale Limited, provides private doctor consultation and treatment services and dental services from its location, 7 Day Healthcare at 142-146 Bellegrove Road

Welling Kent DA16 3QR. Mistvale Limited is CQC registered to provide the regulated activities of Treatment of disease, disorder or injury, Diagnostic and screening procedures and Surgical procedures. Other services are provided at this location, but we did not review these as they are out of scope of CQC regulations; these included intense pulse light (IPL) treatment for hair removal.

We carried out an announced inspection visit to the private doctor service at 7 Day Healthcare on 12 June 2019.

At the time of our inspection there were approximately 2000 patients registered in the GP service, with most of them also being registered with an NHS GP. GP services are primarily provided to adults; however, the service also provides treatments for minor illnesses to children age six

and older. The provider confirmed that 70% of their GP service are for employee medicals and travel vaccinations. The dental service provides private dental treatments to patients of all ages.

The service opening times are Monday, Tuesday, Thursday and Friday: 8.30am-7pm, Wednesday 8.30am – 5pm, Saturday: 9am-2pm, and a reception service is available on Sundays.

**How we inspected this service**

Before visiting, we reviewed a range of information we hold about the service.

During our visit we:

- Spoke with the staff - the doctor, registered manager, reception and administrative staff, and managers.
- Reviewed a sample of the personal care and treatment records of patients.
- Reviewed comment cards where patients shared their views and experiences of the service.
- Reviewed service policies, procedures and other relevant documentation.
- Inspected the premises and equipment in use.

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.

Inadequate

# Are services safe?

## Our findings

**We rated safe as Inadequate because:**

- The provider did not have suitable arrangements to keep people safe because staff chaperone training and DBS checks were not all up to date, and they did not have suitable systems for safely managing healthcare waste.
- Some arrangements to manage patient safety risks were operating effectively, as the provider did not hold stocks of recommended medicines for treating medical emergencies or have risk assessments in place to mitigate medicines not stocked.
- The provider did not have reliable systems for appropriate and safe handling of medicines as they did not carry out medicines audits or have access to and follow up to date travel medicines guidance.
- The service had partial arrangements to learn and made improvements when things went wrong, as they were not acting patient safety alerts and events.

**Safety systems and processes**

**The service had clear systems to safeguard from abuse, but they did not have suitable arrangements to keep people safe.**

- The provider conducted safety risk assessments. It had appropriate safety policies, which were regularly reviewed and communicated to staff including locums. They outlined clearly who to go to for further guidance. Staff received safety information from the service as part of their induction and refresher training. The service had systems to safeguard children and vulnerable adults from abuse.
- The service had systems in place to assure that an adult accompanying a child had parental authority.
- The service worked with other agencies to support patients and protect them from neglect and abuse. Staff took steps to protect patients from abuse, neglect, harassment, discrimination and breaches of their dignity and respect.
- The provider carried out
- All staff received up-to-date safeguarding and safety training appropriate to their role. They knew how to identify and report concerns. Staff who acted as chaperones were trained for the role and had received a DBS check. However, at the time of our inspection, the receptionist on duty had not completed up to date chaperone training. The service was aware of this and the staff member concerned was completing the module during the inspection day.
- There was an effective system to manage infection prevention and control. We saw reports of legionella risk assessments and legionella testing on the water system.
- The provider did not have suitable systems for safely managing healthcare waste. The service did not have the correct bins for all the different types of clinical waste generated, and staff were not aware of, or have access to, correct guidelines on the safe and appropriate disposal of different types of waste. One of the clinical rooms did not have a clinical waste bin in it. The provider also provided a clinical waste bin for the disposal of sanitary waste in their patient toilet facility. During our inspection, the provider printed posters and displayed them close to their clinical waste bins indicating what materials should or should not be placed in them. The provider sent us evidence, an invoice dated 27 June 2019, confirming that they had ordered a sanitary bin.
- The provider ensured that facilities and equipment were safe, and that equipment was maintained according to manufacturers' instructions.
- The provider carried out appropriate environmental risk assessments, which considered the profile of people using the service and those who may be accompanying them.

**Risks to patients**

**There were systems to assess, monitor and manage risks to patient safety. However, some arrangements to manage patient safety risks were not operating effectively.**

- There
- There was an effective induction system for agency staff tailored to their role.

Inadequate

# Are services safe?

- 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 provider was aware of the guidance for emergency equipment in the Resuscitation Council UK guidelines and the guidance on emergency medicines in the British National Formulary (BNF). Some medicines recommended for treating medical emergencies were not stocked on the day of our inspection, and the provider had not completed risk assessments to justify not holding them in stock. The registered manager informed us that he would get those necessary for their service in stock: Atropine (as they had started to carry out minor surgery two months prior to our inspection), Dexamethasone (for the treatment of croup in children), furosemide or bumetanide (for the treatment of heart failure (left ventricular failure)) and diazepam rectal (for treatment of epileptic fit). The registered manager informed us that they did not intend to stock Naloxone or Opiates as they did not consider the scope of their services to necessitate these medicines. The provider sent us a copy of the pharmacy request they had made, dated the day following our inspection, for furosemide and diazepam rectal 5mg. They also sent us evidence that the other items were included in their emergency medicines stock later.
- When there were changes to services or staff the service assessed and monitored the impact on safety.
- There were appropriate indemnity arrangements in place to cover all potential liabilities.

**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 provider used a mixture of electronic and paper records. Both were maintained securely. The care records we saw showed that information needed to deliver safe care and treatment was available to relevant staff in an accessible way.
- The service had systems for sharing information with staff and other agencies to enable them to deliver safe care and treatment.
- The service had a system in place to retain medical records in line with Department of Health and Social Care (DHSC) guidance if 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 did not have reliable systems for appropriate and safe handling of medicines.**

- The systems and arrangements for managing medicines, including vaccines, controlled drugs, emergency equipment minimised risks. The service kept prescription stationery securely and monitored its use. Medicines were appropriately stored. However, some medicines recommended for treating certain medical emergencies were not stocked in the service.
- The service did not carry out regular medicines audit to ensure prescribing was in line with best practice guidelines for safe prescribing. We raised this as a concern at our last inspection of this service. They included actions they would take to address this in their action plan following their last inspection: monthly prescribing audits to cover a wide range of medicines prescribed, with a focus on a different medicine each month. However, we found at this inspection they had not carried out those actions.
- Staff prescribed, administered or supplied medicines to patients and gave advice on medicines in line with legal requirements, but not always in line with current national guidance. Processes were in place for checking medicines. However, we found that staff did not always keep accurate records of medicines. We saw an example of a medicine administered but the batch number was not recorded in the patient record.
- Travel vaccinations were administered in the service. However, we saw that out of date vaccinations guides were displayed in the reception area (dated December 2018) and in the doctor's room (dated March 2016), which reception and clinical staff may refer to as part of arranging and providing care and treatment to patients. These guides are subject to frequent changes in response to disease outbreaks and other public health concerns, and it would be better practice to refer to the

Inadequate

# Are services safe?

most up to date vaccinations guides available online at the time of patient consultation. The provider took down the displayed out of date guides before the end of our inspection.

- The service was a registered yellow fever vaccination centre. Clinicians who provided yellow fever vaccinations had training and certification to carry out this treatment.
- There were effective protocols for verifying the identity of patients including children.

**Track record on safety and incidents**

**The service had a good safety record.**

- There were comprehensive risk assessments in relation to safety issues.
- 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.

**Lessons learned and improvements made**

**The service had partial arrangements to learn 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.
- 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. For example, the service had recorded a recent incident where a patient had fainted following a vaccination. They had documented the incident, reviewed how staff concerned had responded to care for the patient concerned, and shared examples of good practice in managing the incident with the staff team.
- The provider was aware of and complied with the requirements of the Duty of Candour. The provider encouraged a culture of openness and honesty.
- At our last inspection, we found that the service did not have a system to act on and learn from external safety events as well as patient and medicine safety alerts. At this inspection, we found they were still not acting on safety events and alerts. The service now had arrangements to receive information on safety events and alerts. These were stored, but we saw no evidence that they were reviewed and acted on. The registered manager told us these were discussed in clinical meetings, but we saw no notes of these discussions in clinical meetings minutes.

Inadequate

# Are services effective?

(for example, treatment is effective)

## Our findings

**We rated effective as Inadequate because:**

The provider had made some improvements since our last inspection in the provision of effective care, as they now had better arrangements to ensure training and peer support for their staff team. However there remained several areas where they had not properly addressed previous regulatory breaches. They had started carrying out quality improvement activities in relation to clinical care, but these were minimal and had not led to demonstrated improvements in clinical outcomes for their patients. They did not consistently work effectively with other organisations to deliver services. The service had no arrangements for follow up of pathology tests for people receiving minor surgery procedures.

**Effective needs assessment, care and treatment**

- Patients' needs were assessed. The doctor had access to relevant and current guidance and standards, such as from the National Institute for Health and Care Excellence (NICE)

  best practice guidelines and local antibiotics guidelines.
- Clinicians had enough information to make or confirm a diagnosis
- We saw no evidence of discrimination when making care and treatment decisions.

**Monitoring care and treatment**

- The service used information about care and treatment to make improvements. The provider presented three clinical audits, but each of these had one cycle. The second cycles had not been completed to determine if the changes made had led to improvements in patient outcomes and / or experiences.
- The service did not carry out reviews of medicines prescribed. This matter had been raised at our last inspection of the service, following which the provider had stated they would carry out these reviews but had not undertaken them.
- The provider also had examples of non-clinical quality improvement activities. These included a patient experience audit and follow up calls made on a sample of patients who use the service each month.

**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.
- Clinical staff had received specific training and could demonstrate how they stayed up to date. For example, one of The service doctors was completing a returning to GP practice programme, as part of their development in the role, and the nurse has completed update training in ear syringing, which was the main treatment she provided in the service.
- There was a clear approach for supporting and managing non-clinical staff performance. We saw evidence of annual appraisals for staff.

**Coordinating patient care and information sharing**

**Staff worked together to deliver effective care and treatment. However, they did not consistently work effectively with other organisations.**

- Patients received coordinated and person-centred care. Staff referred to, and communicated effectively with, other services when appropriate. For example, the service provided care and treatment to pregnant women who were not entitled to NHS treatment. They arranged for blood tests to be done for them, and foetal scans. These patients were referred to a local private hospital for obstetrics and gynaecology care as required.
- Before providing treatment, doctors at the service ensured they had adequate knowledge of the patient's health, any relevant test results and their medicines

Inadequate

# Are services effective?

## (for example, treatment is effective)

history. We saw examples of patients being signposted to more suitable sources of treatment where this information was not available to ensure safe care and treatment.

- All patients were asked for consent to share details of their consultation and any medicines prescribed with their registered GP when they used the service. However, we saw that the relevant information, to allow their consultation details to be shared, was not obtained from the patient. The provider explained that patients said they agreed to it, but often failed to give them their registered GP's full details.
- Patient information needed to plan and deliver care and treatment was not consistently available to relevant staff in a timely and accessible way. This was because the provider did not have clear and effective arrangements for following up on people's results when tests were carried out by other services. The provider had started providing minor surgery procedures in the two months prior to our inspection. We found that the service followed some guidelines and good practice in minor surgery provision; such as they maintained a log of minor surgical procedures completed, and that all tissues removed by minor surgery were sent for histological examination. However, there were gaps in the follow up of the pathology reports of the histological examinations. We found that five patients who had had post-surgery tissue samples sent for histological examination in April and early May did not have them documented as having the results returned. Further review of patients' notes showed that one of the five patients had had their results returned from the pathology lab, but these had not been shared with the doctor, or the patient informed of the outcome. We highlighted this to the provider and the patient was informed on the day of our inspection. The other four patients' results were also followed up, and the pathology lab had them available, but had not shared them with the service. The service had not picked this up or followed up on these four patients' results with the pathology lab. All these results were received by the service on the day of our inspection and the patients concerned were informed of the outcome. None of these pathology results which were delayed in being followed up indicated any clinical concerns. The provider sent us a written statement two days following our inspection that they intend to carry out monthly follow up with the pathology labs of results not received. We highlighted to the provider that this interval for follow up may be too long and still place patients at risk of delayed care and treatment.

**Supporting patients to live healthier lives**

**Staff empowered patients and supported them to manage their own health and maximise their independence.**

- Where appropriate, staff gave people advice, so they could self-care.
- Risk factors were identified, highlighted to patients and where appropriate highlighted to their normal care provider for additional support.
- Where patients' needs could not be met by the service, staff redirected them to the appropriate service for their needs.

**Consent to care and treatment**

**The 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.

Good

# Are services caring?

## Our findings

**We rated caring as Good because:**

The service received positive feedback about patients' care and treatment experiences. The service treated patients with care and compassion and involved them in decisions about their care. The service carried out monthly patient feedback calls for a sample of their patients who had received care and treatment in that period. They had wholly positive feedback from patients they contacted.

**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.
- The service gave patients timely support and information.
- The service carried out monthly patient feedback calls for a sample of their patients who had received care and treatment in that period. They had wholly positive feedback from patients they contacted.

**Involvement in decisions about care and treatment**

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

- Interpretation services were available for patients who did not have English as a first language, via a phone line service.
- Patients told us through comment cards, that they felt listened to and supported by staff and had enough time during consultations to make an informed decision about the choice of treatment available to them.
- Staff communicated with people in a way that they could understand.

**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.
- However, there was no privacy curtain in the room used for minor surgery or examinations. The provider informed us two days after our inspection that they had arranged for a builder to install a privacy curtain in the room.

Good

# Are services responsive to people's needs?

(for example, to feedback?)

## Our findings

**We rated responsive as Good because:**

The service delivered services to meet patients' needs that took account of their preferences, and they listened to and responded to concerns and complaints.

**Responding to and meeting people's needs**

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

- The provider understood the needs of their patients and improved services in response to those needs. They were usually able to offer same day or next day appointments and had flexible opening hours.
- The facilities and premises were appropriate for the services delivered.
- Reasonable adjustments had been made so that people in vulnerable circumstances could access and use services on an equal basis to others. They had automatic opening doors, a hearing loop and all consulting rooms were wheelchair accessible. Baby changing facilities were available, and The service told us they were able to offer a breastfeeding mother a private room if they required it. The service had an accessible toilet with hand rails and a call bell.

**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. However, we found the service had delayed providing pathology results to some patients who had undergone minor surgery procedures.
- Waiting times, delays and cancellations were minimal and managed appropriately. Patients told us they had enough time during their appointment and did not feel rushed. Appointments ran smoothly on the days of the inspection and patients were not kept waiting.
- Patients with the most urgent needs had their care and treatment prioritised.
- Patients reported that the appointment system was easy to use.
- Referrals to other services were undertaken in a timely way.
- Appointments are available to meet patients' needs: the service was open from 8.30am to 7pm Monday to Friday except Wednesday. On Wednesdays, they were open from 8.30am to 5pm, Saturdays 9am to 2pm, and Sundays 9am to 11am. Appointments were available on Mondays to Saturdays, and on Sundays only the reception was open. Walk in appointments were not offered as standard, but if an appointment was available that a walk-in patient wanted it would be offered.
- Information was available in the service and on their website about what to do when the service was not opened. Patients were provided aftercare information as part of their care and treatment experiences.

**Listening and learning from concerns and complaints**

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

- Information about how to make a complaint or raise concerns was available. Staff treated patients who made complaints compassionately.
- The service informed 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. The service learned lessons from individual concerns, complaints and from analysis of trends. It acted as a result to improve the quality of care. The private doctor service had received two verbal complaints in the last year. The doctor contacted the patients concerned and resolved the issues. In addition, they reviewed and improved the points of entry for the patient complaint process.

# 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:**

The provider has partly made improvements in the arrangements to support good governance and management. But there were inconsistencies in the processes for managing risks.

**Leadership capacity and capability**

- The registered manager had overall responsibility for the management and clinical leadership of the practice.
- Leaders were visible and approachable. They worked closely with staff and others to make sure they prioritised compassionate care.
- There was no practice manager in place; the registered manager told us they were still planning to recruit a practice manager but, in the meantime, the registered manager had increased their working hours in the service.

**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 strategy and supporting business plans to achieve priorities.
- The strategy was in line with health and social priorities. The service planned its services to meet the needs of The service population.

**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.
- Openness, honesty and transparency were demonstrated when responding to incidents and complaints. The provider was aware of and had systems to ensure compliance with the requirements of the duty of candour.
- Staff told us they could raise concerns and were encouraged to do so. They had confidence that these would be addressed.
- There were processes for providing all staff with the development they need. This included appraisal and career development conversations. All staff received regular annual appraisals. Staff were supported to meet the requirements of professional revalidation where necessary.
- The service actively promoted equality and diversity. It identified and addressed the causes of any workforce inequality. Staff felt they were treated equally.

**Governance arrangements**

**At our last inspection, we found that there were improvements needed in the arrangements in place to support good governance and management. These have been partly addressed.**

- Staff were clear on their roles and accountabilities, including in respect of safeguarding and infection prevention and control
- The service had established proper policies, procedures and activities to ensure safety and assured themselves that they were operating as intended.
- The service had information governance arrangements and staff were aware of the importance of these in protecting patients' personal information.
- The service had started a programme of quality improvement activities and had carried out the first cycle on three clinical audits. The doctors had access to clinical peer support through regular clinical meetings.
- However, healthcare was not consistently delivered in line with current guidelines. We saw examples of this in medicines prescribing, and the delivery of the minor surgery service.
- The service had submitted an action plan in response to breaches we identified at their last inspection. Their action plan had only been partly completed at the time of this inspection.

**Managing risks, issues and performance**

**There were inconsistencies in processes for managing risks, issues and performance.**

# Are services well-led?

Requires improvement

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

- The provider had plans in place and had trained staff for major incidents.
- In the private doctor service, employed clinical staff were now engaging in clinical meetings, where consultations, prescribing and referral decisions were discussed.
- The service did not have an effective process to identify, understand, monitor and address current and future risks including risks to patient safety. They were not responding to patient safety alerts and events, or appropriately following up on minor surgery pathology results.
- The service did not have processes to manage current and future performance. Performance of clinical staff could not be demonstrated through audit of their consultations, prescribing and referral decisions. Leaders had oversight of incidents and complaints, but not safety alerts and events.
- The service could not demonstrate that clinical audit had a positive impact on quality of care and outcomes for patients. They had only recently started carrying out these quality improvement exercise and could not yet evidence the impact of changes made because of clinical audits.
- Risks to patient safety were not being consistently mitigated. Some medicines recommended for treating medical emergencies were not stocked at the time of our inspection. Pathology results for tissue samples from minor surgery procedures were not being consistently followed up and acted on.
- Practice leaders had oversight of incidents. Since our last inspection, the service now has a system in place to receive patient safety alerts, recalls and rapid response reports issued from the Medicines and Healthcare products Regulatory Agency (MHRA) and through the Central Alerting System (CAS), as well as from other relevant bodies, such as Public Health England (PHE). However, there was no evidence they were disseminating and acing on these alerts.

**Engagement with patients, the public, staff and external partners**

**The service involved patients and staff in service developments.**

- The service encouraged and heard views and concerns from patients and staff. It acted on this feedback to shape services and culture.

**Continuous improvement and innovation**

**There were systems and processes for learning and continuous improvement.**

- There was a focus on continuous learning and improvement.
- The service made use of internal reviews of incidents and complaints. Learning was shared and used to make improvements. However they needed to act on external information such as patient safety alerts, recalls and rapid response reports issued by relevant bodies.

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.

| Regulated activity | Regulation |
|---|---|
| Diagnostic and screening procedures<br>Surgical procedures<br>Treatment of disease, disorder or injury | Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment<br>Care and treatment was not provided in a safe way for service users, as the registered provider did not assess and mitigate the risks to the health and safety of service users of receiving the care or treatment in the private doctor service; specifically in relation to the proper and safe management of medicines, suitable staffing, ensuring equipment is used in a safe way (particularly clinical waste management equipment) and mitigating risks by responding to relevant patient safety alerts, recalls and reports. |

| Regulated activity | Regulation |
|---|---|
| Diagnostic and screening procedures<br>Surgical procedures<br>Treatment of disease, disorder or injury | Regulation 17 HSCA (RA) Regulations 2014 Good governance<br>The provider did not have suitable systems and processes in place that assess, monitor and mitigate risks relating the health, safety and welfare of people using services and others; specifically, the processes for managing patient safety risks, and the arrangements to support good governance and management (adherence to good practices and guidelines or having established alternatives) needed improvement. |