Old Orchard Consulting Rooms

Inspection report

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This report describes our judgement of the quality of care at this service. It is based on a combination of what we found when we inspected, information from our ongoing monitoring of data about services and information given to us from the provider, patients, the public and other organisations.

Ratings

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

Are services caring? – Good

Are services responsive? – Good

Are services well-led? – Requires improvement

We carried out this announced comprehensive inspection of Old Orchard Consulting Rooms on 20 February 2023, under Section 60 of the Health and Social Care Act 2008. 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. This was the provider's first inspection of the service since it registered with the Care Quality Commission (CQC).

How we carried out the inspection:

This inspection was carried out in a way which enabled us to spend a minimum amount of time on site.

This included:

- Speaking with staff in person, on the telephone and using video conferencing.
- Requesting documentary evidence from the provider.
- A site visit.

We carried out an announced site visit to the service on 20 February 2023. Prior to our visit we requested documentary evidence electronically from the provider. We spoke to staff on the telephone and using video conferencing prior to and following our site visit.

Old Orchard Consulting Rooms is an independent service providing consultation and examination with consultant surgeons, specialising in urology, colorectal and general surgery. Treatment for haemorrhoids, using haemorrhoid banding is provided by one colorectal surgeon. (Banding is an outpatient treatment wherebya special rubber band is placed round the base of the haemorrhoid which constricts and cuts off the blood supply.)

Old Orchard Consulting Rooms is registered with the Care Quality Commission to provide the following regulated activities: Treatment of disease, disorder or injury; Diagnostic and screening procedures.

The medical director of the service, although no longer involved in the delivery of clinical care, 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.

Our key findings were:

Overall summary

- There were safeguarding systems and processes to keep people safe. However, some staff had not completed training in the safeguarding of children and vulnerable adults at an appropriate level to support their role, in line with current guidance.
- There were processes in place for the induction and monitoring of training of administration staff. There was a lack of evidence of completed training for consultants.
- There were records to demonstrate that recruitment checks had been carried out in accordance with regulations for administration staff. However, there was a lack of checks undertaken of clinical consultants.
- Arrangements for chaperoning were displayed. However, the offer or attendance of a chaperone was not recorded within the patient's clinical record.
- There were some processes to assess the risk of, and prevent, detect and control the spread of infection. However, there was no formal assessment of the risks associated with legionella bacteria.
- Staff immunisation status was not monitored in line with current guidance.
- There were governance and monitoring processes to ensure the safety of premises, including fire safety. However, there was a lack of a documented fire risk assessment for the premises.
- There were effective administrative processes in place to ensure patients had timely access to consultation and treatment.
- Patient consent to treatment and risks and complications of treatment were not recorded in clinical records.
- There was a lack of monitoring and audit of clinical record keeping.
- The service was not registered to receive safety alerts.
- There was effective and open communication and information sharing amongst the small staff team. There were regular team meetings and staff felt motivated to contribute to driving improvement within the service.
- Staff were subject to regular review of their performance and felt well supported by managers.
- Written policies did not always provide accurate and clear information to staff in line with current guidance.
- Service users were asked to provide feedback on the service they had received and there were high levels of patient satisfaction across the service.
- Complaints were managed appropriately.

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.
- Ensure persons 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.

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

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

- Further review COSHH risk assessment and take action to ensure the safe use of chemicals used to decontaminate suction device.
- Secure external clinical waste storage to prevent improper use or access.

Dr Sean O'Kelly BSc MB ChB MSc DCH FRCA

Chief Inspector of Hospitals and Interim Chief Inspector of Primary Medical Services

Our inspection team

Our inspection team was led by a CQC lead inspector and included a second CQC inspector and a GP specialist advisor.

Background to Old Orchard Consulting Rooms

Old Orchard Consulting Rooms is an independent service providing consultation and examination with consultant surgeons, specialising in urology, colorectal and general surgery. Treatment for haemorrhoids, using haemorrhoid banding is provided by one colorectal surgeon.

Services are provided to patients of all ages, including children under the age of 18 years.

The Registered Provider is ENT Eastbourne Limited.

Old Orchard Consulting Rooms is located at 7B Old Orchard Road, Eastbourne, East Sussex, BN21 1DB.

The service is open from 9am to 5.00pm from Monday to Friday.

The service is run from self-contained premises which are owned by the provider. Services are provided to patients on the ground floor only. The premises include a combined consultation and treatment room, an administration office and a reception and waiting area. Patients are able to access toilet facilities on the ground floor. Access to the premises at street level, is available to patients with limited mobility. The service shares premises with a medical legal business also owned by the provider.

The service is led by the medical director, who no longer provides clinical care to patients, in conjunction with the practice manager who is responsible for day to day running of services. A medical secretary/receptionist provides support to the practice manager and 3 consultant surgeons who work on a sessional basis under practising privileges arrangements. Another 2 consultant surgeons provide services from the premises on a room rental basis only.

How we inspected this service

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

• Is it safe?

• Is it effective?

• Is it caring?

• Is it responsive to people's needs?

• Is it well-led?

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

Requires Improvement

Are services safe?

Safety systems and processes

The service had some systems to keep people safe and safeguarded from abuse.

- The service had some systems and processes to safeguard children and vulnerable adults from abuse. The provider's safeguarding policy provided appropriate guidance for staff. Staff we spoke with had a clear understanding as to how to raise safeguarding concerns about a patient. However, not all staff had received training in the safeguarding of children and vulnerable adults at an appropriate level to support their role. Training undertaken by consultant surgeons and completed externally, had not been monitored.
- The provider had carried out all required checks of administrative staff at the time of recruitment, including DBS checks. (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). Where clinical consultants worked on a sessional basis, the provider had obtained evidence of external appraisal, professional registration status and medical indemnity. However, some required checks, including DBS checks, references and employment history, were not completed for those consultants.
- The service offered treatment to patients of all ages, including children under 18 years of age. However, no children had been treated by the service since the provider registered with CQC, in August 2020. Patients were asked to confirm they were age 18 years or over. The service had a policy to ensure staff carried out identification checks if a patient appeared to be under the age of 18 years.
- We saw there was signage on display within the service which invited patients to request a chaperone. Staff who acted as chaperones were trained for the role and had undergone a DBS check. However, we reviewed patients' clinical records and found that the offer of a chaperone was not recorded within the record. We found no instances where the offer or attendance of a chaperone had been recorded. Staff told us that there had never been an occasion when a patient had requested a chaperone, including for intimate examination and treatment, such as haemorrhoid banding where a male consultant may treat a female patient.
- There were effective systems to manage infection prevention and control within the service. Cleaning and monitoring schedules were in place and all cleaning was carried out by a cleaner employed by the service. The premises were maintained to a high standard. There were sufficient stocks of personal protective equipment, including masks, aprons and gloves, available to staff.
- Auditing of infection prevention processes had been undertaken and staff had received training in infection prevention and control. However, the provider was unable to demonstrate that they held appropriate records relating to staff immunisations including clinical consultants, in line with current guidance. The provider did not request evidence of immune status for the clinical consultants.
- There were systems for safely managing healthcare waste and no sharp items were used. We saw that clinical waste disposal was available in the clinical room. A locked bin, located outside of the premises, was used to store healthcare waste awaiting collection by a waste management company. However, we noted that the bin was not secured to a wall or floor to prevent improper use or access.
- The service had some systems to manage health and safety risks within the premises. There were effective policies and procedures in place which set out fire safety procedures and a series of general health and safety risk assessments undertaken by the provider. However, the provider had not formally assessed the risks associated with legionella and had not undertaken any monitoring or sampling of water supplies to minimise the risk of legionella bacterial growth. (Legionella is a particular bacterium which can contaminate water systems in buildings). The provider told us they had been informed by a plumber that risks associated with legionella bacteria were low as there was no cold-water storage and patients were not offered drinks. We saw that these reasons were noted within the provider's health and safety records.
- There was guidance and information, including safety data sheets, available to staff to support the control of substances hazardous to health (COSHH). We noted that a risk assessment had been undertaken relating to each

hazardous substance. This included a corrosive liquid used to decontaminate a suction cylinder, used as part of a haemorrhoid banding procedure. However, we noted that the documented process and risk assessment for use of this liquid did not accurately reflect the process undertaken by staff, due to limited space within the sink unit in the clinical room. Therefore, further review of the substance and risk assessment was required to ensure its safe use.

- Single use items were used in the examination and treatment of patients. For example, disposable proctoscopes were used to examine patients and to facilitate haemorrhoid banding procedures. (A proctoscope is a tube-like instrument with an integral lamp for examining the anus and lower part of the rectum or carrying out minor medical procedures.)
- There was appropriate fire-fighting equipment and a fire alarm located within the premises which were regularly serviced and maintained. The provider had utilised a specialist company to advise them on the equipment required and its positioning. We noted that fire extinguishers had last been serviced in August 2022 and the fire alarm in November 2022. There was a comprehensive fire safety policy which set out fire safety arrangements and an emergency plan. We saw that a review of the premises had been undertaken by an external supplier in 2015, prior to the installation and commissioning of a fire alarm and detection system. However, there was no documented fire risk assessment for the premises and no annual review of fire safety risks. We noted that the provider's fire safety policy made repeated reference to a fire risk assessment.
- The provider ensured that facilities and equipment were safe for use. Equipment was maintained according to manufacturers' instructions. We reviewed records to confirm that electrical equipment had undergone portable appliance testing in 2019.

Risks to patients

There were some systems in place to assess, monitor and manage risks to patient safety.

- There were planned induction processes in place and a plan of required training for staff to complete as part of the induction process.
- Staff, including the practice manager and the medical secretary, were required to complete training in key areas via an online platform. There were some monitoring processes to ensure leaders had oversight of all training completed. However, we noted that one staff member had not completed training in health and safety or safeguarding training at the required level, for which they were the lead within the service. The medical director, who was also the registered manager for the service, had not completed updated training in several areas, for example safeguarding vulnerable adults and children, fire safety, health and safety, information governance, infection prevention and control, since February 2020. The provider had not monitored training of consultants employed on a sessional basis who completed their required training externally.
- We reviewed arrangements to respond to medical emergencies. We found that staff had completed training in basic life support. There was some equipment available to staff in the event of a medical emergency. For example, there was a defibrillator on site. The provider had assessed the level of risk to patients in the event of a medical emergency and taking into consideration the nature of services provided, had concluded that an oxygen supply and emergency medicines were not required to be held.
- The service had a first aid kit in place which was appropriately stocked, and its contents regularly checked.
- The provider had in place a public and employer's liability insurance policy.

Information to deliver safe care and treatment

Staff did not have all of the information they needed to deliver safe care and treatment to patients.

- We reviewed clinical records relating to 12 patients who had received treatment within the service. The care records we saw showed some information needed to deliver safe care and treatment was available to relevant staff in an accessible way.

Requires Improvement

Are services safe?

- Individual care records were mainly written and managed in a way that kept patients safe. However, consent processes were not always clearly applied or documented.
- We found that where patients underwent haemorrhoid banding procedures, consent to treatment was not recorded in their clinical records. Clinicians did not record the information provided to patients about the risks and benefits of treatment prior to proceeding with a haemorrhoid banding procedure.
- The provider utilised a cloud-based, password protected, electronic system to ensure security of clinical record keeping.
- The service had systems for sharing information with staff and other agencies where necessary, to enable them to deliver safe care and treatment.
- Patients were referred to the service by their NHS GP or directly by an insurance provider. Patients were also able to self-refer to the service. Where referral had not been received directly from a GP, medical history information was requested by the service prior to treatment, with the patient's consent. Treatment information was routinely shared with the GP, in a timely manner, where the patient had provided their consent.
- 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 they ceased trading.

Safe and appropriate use of medicines

- There was a very limited amount of prescribing carried out within the service and no medicines were administered directly to patients. Our review of clinical records confirmed that consultants prescribed medicines to patients, in line with legal requirements and current national guidance. Prescriptions were provided in hard copy format via a prescription template and given directly to the patient by their consultant.
- There were no supplies of medicines held within the service and no emergency medicines held.

Track record on safety and incidents

- There were general premises risk assessments in place in relation to safety issues to support the management of health and safety within the premises.
- There was some monitoring and review of activities to support the provider in identifying potential risks within the service. The practice manager maintained a register of all risk assessment activity. Staff responded promptly when safety concerns or risks were identified. However, fire safety risks had not been subject to annual review and there was a lack of formal review of risks associated with legionella bacteria.
- There were some monitoring and auditing processes in place to provide assurance to leaders that systems were operating as intended. However, the provider had not adequately monitored clinical consultants who provided services under practising privileges.
- The provider monitored incidents and complaints in order to ensure effective corrective or preventive actions were taken to reduce the risk of recurrence. We saw incidents were discussed and reviewed within regular team meetings.

Lessons learned and improvements made

The service had some systems to ensure they learned when things went wrong.

- There was a system for recording and acting on significant events. Staff clearly understood their duty to raise concerns and report incidents and near misses. Leaders and managers supported them when they did so.
- 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 was not registered to receive safety alerts and there was a lack of systems in place for knowing about notifiable safety incidents. We saw no evidence that patient and medicine safety alerts had been responded to, acted upon or learned from.

Requires Improvement

Are services effective?

Effective needs assessment, care and treatment

The provider had some systems to keep clinicians up to date with current evidence-based practice.

- The provider had good personal knowledge of the specialist clinical consultants employed by the service under practising privileges arrangements. Those consultants had high levels of skills, knowledge and experience to deliver the care and treatment offered by the service. The provider held a copy of those consultants' appraisal summaries which were completed externally but had not monitored specific training completed externally by the consultants. The provider was therefore unable to confirm that required training was up to date. There was no formal record of previous employment history or professional qualifications held in relation to those consultants.
- The medical director provided clinical leadership and oversight across the service and was also the registered manager for the service. However, the medical director required updated training in many areas.
- Clinicians kept up to date with current evidence-based practice. We found clinicians assessed needs and delivered care and treatment in line with relevant current legislation, standards and guidance. For example, clinicians provided appropriate non-surgical treatment of patients with haemorrhoids which was in line with guidance issued by the National Institute for Health and Care Excellence (NICE).
- We saw no evidence of discrimination when making care and treatment decisions.

Monitoring care and treatment

The service was able to demonstrate some quality improvement activity.

- The service used information about care and treatment to assess the need to make improvements.
- Staff employed by the service were subject to regular review of their performance.
- There was some quality improvement activity and auditing processes within the service. For example, the provider undertook auditing of infection prevention and control processes. However, there was no auditing or review of clinical record keeping completed by clinical consultants, to ensure compliance with the provider's expected standards of record keeping.
- It was noted that a very limited number and range of treatments were provided within the service and therefore clinical auditing opportunities were limited. Indeed, the service provided only a very small number of haemorrhoid banding treatments. The provider told us that less than 10 patients had undergone this treatment within the previous 12 months. However, there was no review or audit of treatment outcomes relating to those patients.

Effective staffing

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

- There were planned induction processes in place and a staff handbook to provide guidance to staff. There was a plan of required training for staff to complete as part of the induction process.
- The provider was not always able to demonstrate that staff had the appropriate skills and training to carry out their roles. We noted the medical director and registered manager had not completed many required training updates; one staff member had not completed training in health and safety or safeguarding training at the required level, for which they were the lead within the service; training of clinical consultants was not adequately monitored.
- There was regular review of individual performance of staff employed by the service. Staff underwent regular review meetings with the practice manager and annual appraisal. Staff who had completed their probationary period were subject to a probationary review.
- The service held records which confirmed medical professionals were registered with the General Medical Council (GMC) and were up to date with revalidation.

Requires Improvement

Are services effective?

Coordinating patient care and information sharing

Staff worked well with other organisations, to deliver effective care and treatment.

- Patients who used the service received coordinated and person-centred care. Staff referred to, and communicated effectively with, other services when appropriate.
- Patient information needed to plan and deliver care and treatment was stored and available to relevant staff in a timely and accessible way.
- Due to the nature of treatments provided, patients did not require referral by their NHS GP to access services. However, before providing treatment, doctors at the service ensured they had adequate knowledge of the patient's health, previous medical and medicines history. We noted that where patients were not initially referred to the service by a GP, medical history information was obtained from the GP, prior to treatment, with the patient's consent. Treatment information was routinely shared with the GP where the patient had provided their consent.
- Staff told us that they had established connections with local independent hospitals where support or onward referral was deemed necessary to provide optimum support to patients.

Supporting patients to live healthier lives

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

- The service provided access to timely advice and support to patients, at all stages of their treatment.
- Patients were provided with an individual treatment plan to consider prior to proceeding with treatment. However, we were unable to confirm that patients were always provided with clear information about treatments, including the benefits and risks.
- Staff told us patients attending for haemorrhoid banding treatments were advised to attend accompanied by another adult and were given the opportunity to recover within the service, for a short time following treatment.
- Following treatment, patients were provided with a follow up consultation to confirm their satisfaction with the treatment outcome and to discuss any concerns.

Consent to care and treatment

The service did not always adequately document consent to care and treatment in line with legislation and guidance.

- Staff we spoke with understood the requirements of legislation and guidance when considering consent and decision making. Staff described processes for the assessment of patients' suitability for treatment which included their psychological well-being, mental capacity and vulnerability. Staff told us they would not agree to treat patients about whom they had any concerns.
- We reviewed clinical records relating to patients who attended the service and found that mainly clear, accurate and contemporaneous clinical records were kept. However, we found that consent processes were not always clearly applied or documented.
- We found that where patients underwent haemorrhoid banding, consent to treatment was not recorded in their clinical records. Clinicians did not record the information provided to patients or discussions between the clinician and patient about the risks and benefits of treatment, prior to proceeding with a haemorrhoid banding procedure. Staff told us there was no separate information sheet given to patients which provided this information. Staff told us patients could access information they required via the internet.

Requires Improvement

Are services effective?

- There was a documented consent policy which clearly described the importance of informed consent and the difference between verbal, written and implied consent. The policy did not specify which means of consent the provider would expect to be implemented for patients undergoing haemorrhoid banding.

Good

Are services caring?

Kindness, respect and compassion

Staff treated patients with kindness, respect and compassion.

- Staff understood patients' personal, cultural, social and religious needs. They displayed an understanding and non-judgmental attitude to patients.
- The service actively invited feedback on the quality of care patients received, via a variety of means to suit the needs of the patient. We noted that feedback forms were provided to patients in hard copy format immediately following their consultation or treatment. Patients were able to receive an electronic copy of the feedback form via email where this was preferred.
- The feedback form listed 20 patient satisfaction indicators which patients were asked to score from 1 to 6. The form provided patients with the opportunity to provide feedback and make suggestions for improvements to services. The service collated this information in order to identify areas for improvement and feedback which may require a direct response to the patient.
- We reviewed feedback information collated in February 2023 and found that patient feedback was consistently positive in all areas.

Involvement in decisions about care and treatment

Staff told us how they helped patients to be involved in decisions about care and treatment.

- We saw the service provided comprehensive information about the service on their website, including the provider's complaints procedure.
- Staff told us that patients who underwent haemorrhoid banding were provided with the information they required to make decisions about their care prior to undergoing treatment. However, this information was provided to the patient verbally and was not documented in the patient's clinical record.
- Translation services were available for patients who did not have English as a first language.

Privacy and Dignity

The service told us how they respected patients' privacy and dignity.

- Staff told us they recognised the importance of people's dignity and respect. Consultations and treatments took place behind closed doors and conversations could not be overheard.
- Patients were collected from the waiting area by the clinician and escorted into the consultation room.
- Front of house staff were aware that if patients wanted to discuss sensitive issues or appeared distressed, they could offer them a private room to discuss their needs.
- There was a free-standing privacy screen available for use within the consultation room. We noted however, that the door to the consulting room could not be locked in order to provide additional privacy to patients during an intimate examination or treatment.
- Staff told us that chaperones were available should a patient choose to have one and signage offering patients a chaperone was displayed within the service. All staff who provided chaperoning services had undergone required employment checks and received training to carry out the role. However, we reviewed patients' clinical records and found that the offer of a chaperone was not recorded within the record. We found no instances where the attendance of a chaperone had been recorded. Staff told us there had never been an occasion when a patient had requested a chaperone, including for intimate examinations, despite all patients being offered one.
- Staff complied with the service's information governance arrangements. Processes ensured that all confidential electronic information was stored securely on computers. Hard copy patient records were held securely.

Good

Are services responsive to people's needs?

Responding to and meeting people's needs

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

- The provider understood the needs of their patients and arranged services in response to those needs.
- The facilities and premises were maintained to an appropriate standard for the services and treatments delivered. The consulting room was located on the ground floor of the premises and access to the premises at street level, was available to patients with limited mobility.
- Reasonable adjustments were made so that people in vulnerable circumstances could access and use services on an equal basis to others. For example, translation support services were available.

Timely access to the service

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

- Appointments could be booked by telephone. Appointment enquiries could also be made via the provider's website. Patients usually received appointments within a short time from their request. There were no evening and weekend appointments available.
- Waiting times, delays and cancellations were minimal and managed appropriately.
- Patients were provided with a highly personalised administration and booking service. Appointment scheduling and patient liaison was managed by one secretary and enabled patients to answer any queries they may have.
- Where patients required onward referral to other services, these were managed in a timely manner.

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 within the service. There was clear and comprehensive information about how to make a complaint on the provider's website.
- The service received low numbers of complaints and staff treated patients who made complaints compassionately. We noted that 1 complaint had been received in the 12 months prior to our inspection. We found that patient had received a timely and appropriate response to their complaint.
- There was evidence complaints had been discussed and the learning shared within the team. Complaints were discussed at regular operational management meetings.
- The service clearly informed patients that further action may be available to them should they not be satisfied with the response to their complaint. The service's written complaints policy included up to date information to support patients should their complaint remained unresolved.

Requires Improvement

Are services well-led?

Leadership capacity and capability:

Leaders had some skills to deliver high-quality, sustainable care.

- Leaders had not always demonstrated the capacity to implement systems and processes to support the delivery of high-quality care. There was a lack of organisational strategy in some key areas, such as clinical governance and monitoring.
- Leaders had some awareness and understanding of the issues and priorities relating to the quality and future of the service.
- Leaders expressed a clear desire to address issues raised on inspection and to make improvements to deliver high quality care.
- Leaders within the service were visible and approachable. They worked closely with the small team of staff and told us they prioritised compassionate and inclusive leadership.
- There was a staffing structure in place across the service and staff were aware of their individual roles and responsibilities. The medical director and practice manager were keen to further develop quality and governance processes.
- There were effective formal and informal lines of communication between staff working within the service. Staff spoke of team meetings they attended, and we saw records of those meetings.
- Where additional specialist advice and support was required, the provider employed the services of external consultants. For example, in human resource policy development and fire safety management processes.

Vision and strategy

- The provider had a vision and desire to provide high-quality services which promoted good outcomes for patients.
- Staff were aware of and understood the vision, values and strategy of the organisation and their role in achieving them. Staff felt motivated to contribute to driving improvement within the service

Culture

There were some systems and processes to support a culture of high-quality sustainable care.

- Leaders and managers encouraged behaviour and performance consistent with the vision and values.
- The service was focused upon the needs of patients.
- Staff we spoke with told us they felt respected, supported and valued. Staff told us they could raise concerns and suggestions for improvement within the small staff team and were encouraged to do so.
- The provider was aware of and had systems to ensure compliance with the requirements of the duty of candour.
- There were some processes for providing staff with the development they needed. There were planned induction processes in place and a plan of required training for staff to complete as part of the induction process.
- There were some processes to ensure staff completed training in key areas via an online platform. However, we noted there were gaps in required training for leaders within the service, which had not been identified.
- Staff employed by the service had received regular review of their performance in the form of one-to-one review and annual appraisal.
- The service actively promoted equality and diversity. Staff had received equality and diversity training. Staff felt they were treated equally.
- There was a culture of promoting positive relationships and prompt and effective communications between staff.

Governance arrangements

Requires Improvement

Are services well-led?

Responsibilities, roles and systems of accountability to support good governance and management were not always effective.

- Structures, processes and systems to support good governance and management were set out and understood for some areas of the service only.
- There was a staff meeting structure and systems for sharing information within the team. For example, staff participated in team meetings and regular one-to-one discussions. There were regular meetings to ensure management review of service delivery.
- Leaders had mainly established appropriate policies, procedures and activities to ensure the safety of staff and patients, across all services, and assure themselves they were operating as intended. However, there were some policies which did not always clearly or accurately set out the provider's position. For example, the consent policy did not specify which means of consent the provider would expect to be implemented for patients undergoing treatment; the fire safety policy made reference to regular review of a fire risk assessment document which was not in place. We noted the provider's infection control policy stated that staff were not required to have immunisations as sharp items were not used within the service. This statement did not reflect current guidance in the monitoring of staff immunisations.
- We noted the provider utilised the services of an external supplier to provide support with human resource policy development.
- There was a range of monitoring processes in place across the service to ensure the safety of the premises and equipment. For example, regular testing of the fire alarm and monitoring of emergency equipment. External organisations were utilised in an advisory capacity where required, such as in the management of fire safety equipment.
- There were some monitoring and auditing processes in place to provide assurance to leaders that systems were operating as intended. However, the provider had not adequately monitored clinical consultants who provided services under practising privileges. For example, recruitment information had not been obtained; training completed externally by those consultants had not been monitored; there was no auditing or review of standards of clinical record keeping completed by those consultants.
- The provider monitored incidents and complaints in order to ensure actions were taken to reduce the risk of recurrence. We saw incidents were discussed and reviewed within regular team meetings.
- Staff understood their individual roles and responsibilities and were well supported by the practice manager and the medical director in fulfilling those roles. Appropriate role-specific guidance and training was provided for staff. For example, we saw that a cleaner employed directly by the service had received appropriate training in COSHH and health and safety to support the role.
- The service submitted data and notifications to external organisations as required.

Managing risks, issues and performance

There were some processes for managing risks, issues and performance.

- There were some governance processes to ensure leaders were able to identify, understand, monitor and address some current and future risks including risks to patient safety. The provider maintained a risk register for the service which was regularly reviewed and updated.
- However, the provider had not adequately identified or addressed risks in several areas. These included: legionella monitoring; staff training; monitoring of clinical consultants; staff immunisation monitoring; consent processes; chaperone processes; clinical record keeping.
- Leaders had a lack of oversight of safety alerts. The service was not registered to receive safety alerts.
- There was a lack of monitoring and review of patient records in order to ensure compliance with the provider's expected standards of clinical record keeping.

Requires Improvement

Are services well-led?

- There was a system for recording and acting upon significant events. Staff understood their duty to raise concerns and report incidents and near misses. Leaders and managers supported them when they did so.
- The provider had a business continuity plan in place.

Appropriate and accurate information

The service did not always hold all required appropriate and accurate information.

- The service used feedback from patients to drive improvement. Collated information was reviewed within the staff team.
- The provider had carried out all required checks of administrative staff at the time of recruitment. However, some required checks, were not completed for clinical consultants working on a sessional basis.
- Individual care records were mainly written and managed in a way that kept patients safe. Clear, accurate and contemporaneous patient records were kept. However, the care records we saw showed that information needed to deliver safe care and treatment was not always available. Consent to treatment was not recorded in patients' clinical records. Clinicians did not record the information provided to patients, or discussions between the clinician and patient, about the risks and benefits of treatment, prior to proceeding with a haemorrhoid banding procedure. However, some information about the risks and benefits of treatment was included in a letter sent to the patient's GP following consultation.
- Staff told us they had attended regular staff meetings. We saw documented evidence of staff meetings, where for example, patient feedback and operational issues had been discussed.
- There were arrangements in line with data security standards for the availability, integrity and confidentiality of patient identifiable data, records and data management systems. Processes ensured all confidential electronic information was stored securely on computers.
- The provider ensured document management protocols were followed, which included version control, author and review dates.

Engagement with patients, the public, staff and external partners

The service involved patients, staff and external partners to support sustainable services.

- The service encouraged and valued feedback from patients, the public and staff. Feedback was closely monitored and acted upon to shape services.
- Staff could describe to us the systems in place for them to give feedback.
- The service was transparent and open with stakeholders about the feedback received.

Continuous improvement and innovation

- Leaders and managers encouraged staff to review individual and team objectives, processes and performance.
- There was some evidence of quality improvement activity.

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 17 HSCA (RA) Regulations 2014 Good governance The provider was unable to demonstrate that systems and processes were implemented effectively to assess, monitor and improve the quality and safety of the services provided in the carrying on of the regulated activities. The provider was unable to demonstrate that systems and processes were in place to assess, monitor and mitigate the risks relating to the health, safety and welfare of service users and others who may be at risk which arise from the carrying on of the regulated activity. In particular: • To adequately assess and monitor risks to ensure premises are safe and suitable for use, with regard to the management of legionella and fire safety. • To implement processes for the monitoring of clinical record keeping. • To implement processes for the monitoring of patient treatment outcomes. • To ensure policies provide accurate and clear information to staff in line with current guidance. This was in breach of regulation 17(1)(2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Regulated activity	Regulation
Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing The provider had failed to ensure that persons employed in the provision of a regulated activity received such appropriate support, training, and professional development, as was necessary to enable them to carry out the duties they were employed to perform. In particular:

This section is primarily information for the provider

Requirement notices

- To ensure monitoring of training undertaken by all staff working within the service, including clinical consultants.
- To ensure staff complete training in all required areas in a timely manner.
- To provide training for staff who lead areas of governance within the service, such as safeguarding and health & safety, at an appropriate level to support their role.

This was in breach of regulation 18(1)(2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Regulated activity	Regulation
Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment The provider had not done all that was reasonably practicable to ensure care and treatment was provided in a safe way for service users. In particular: • To ensure staff have training in the safeguarding of children and vulnerable adults at a level appropriate to their role, in line with current guidance. • To ensure required recruitment and monitoring checks are carried out for clinical consultants. • To ensure the monitoring of staff immunisations in line with current guidance. • To ensure appropriate chaperoning arrangements. • To ensure consent procedures are applied in line with current guidance. • To ensure safety alerts are received and appropriately actioned. This was in breach of regulation 12(1)(2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.