The Northway Clinic

Inspection report

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Date of inspection visit: 7 April 2022
Date of publication: 25/05/2022

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	Inspected but not rated
Are services safe?	Inspected but not rated
Are services effective?	Inspected but not rated
Are services well-led?	Inspected but not rated

Overall summary

This service was inspected and not rated overall.

We carried out an announced inspection of The Northway Clinic on 7 April 2022 as part of our inspection programme. The inspection commenced as a full comprehensive inspection but was changed to a focused risk-based inspection, this was in response to multiple clinical risks we found on the inspection day. As a result the key following key questions were partly inspected but not rated.

Are services safe? – Inspected but not rated

Are services effective? – Inspected but not rated

Are services well-led? - Inspected but not rated

The Northway Clinic is an independent health service based in front of Canning Town transport hub, that is approximately 5 minutes away from Canary Wharf financial district.

Our key findings were:

- There were no effective systems to keep people safe and safeguarded from abuse.
- Patients' clinical needs assessment, care and prescribing was not always in line with evidence-based guidance, and some patients were at risk of harm.
- The service did not identify or learn from significant incidents.
- The appropriateness of clinical care and treatment was not reviewed effectively, through quality improvement activity or by any other means.
- Staff felt supported by management, but leadership and governance arrangements were ineffective.

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.

The areas the provider should improve are:

- Review and improve communication and access arrangements for patients that may need this, such as translation services.
- Review and improve arrangements for patients informed consent.
- Review and improve arrangements for staff checks such as immunity status and DBS checks.
- Review and improve arrangements such as storage and documentation for medicines dispensed.

On 8 April 2022, the Nominated individual of The Baltic Medical Centre Limited that is also the Registered Manager of The Northway Clinic was issued with an urgent notice to suspend their registration as a service provider for six months; in respect of regulated activities undertaken at The Northway Clinic, under Section 31 of the Health and Social Care Act 2008. This notice of urgent suspension of the provider's registration was given because we believed that a person will or may be exposed to the risk of harm if we did not take this action. The provider has the right to make an appeal to the First-tier Tribunal. The provider will be inspected again prior to the expiry of the suspension to assess whether sufficient improvements have been made.

Overall summary

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

Our inspection team

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

Background to The Northway Clinic

The Northway Clinic is an independent health service based in front of Canning Town transport hub, that is approximately 5 minutes away from Canary Wharf financial district. The service provides consultations and treatment for children and adults of all nationalities and ages.

The service directly employs a practice manager, sales and marketing manager, clinical lead, three receptionists, two phlebotomists, and three nurses. A number of self-employed clinicians also work for the service on a contractual basis including two general practitioners, one general internal medicine specialist, one dermatologist, one otorhinolaryngologist, two gynaecologists, one urologist, one cardiologist, one neurologist, two physiotherapists, one orthopaedic specialist, one anti-ageing specialist and two sonographers.

The provider, Baltic Medical Centre Limited, undertakes regulated activities from two locations and is registered with the CQC to provide the following regulated activities: diagnostic and screening procedures; family planning; surgical procedures; and treatment of disease, disorder or injury.

The Northway Clinic service was open from Monday to Saturday (except on bank holidays), with appointments available from 9am to 7pm.

The registered manager that is also the nominated individual of the service had been on extended leave from the service since October 2021 and the provider had appointed cover for these roles. 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. A nominated individual is a person who is registered with the CQC to supervise the management of the regulated activities and for ensuring the quality of the services provided.

How we inspected this service

Throughout the pandemic CQC has continued to regulate and respond to risk. However, taking into account the circumstances arising as a result of the pandemic, and in order to reduce risk, we have conducted our inspections differently.

This inspection was carried out in a way which enabled us to spend a minimum amount of time on site. This was with consent from the provider and in line with all data protection and information governance requirements.

This included:

- Conducting staff interviews using video conferencing.
- Completing clinical searches on the practice's patient records system and discussing findings with the provider.
- Reviewing patient records to identify issues and clarify actions taken by the provider.
- Requesting evidence from the provider.
- A site visit.

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

- Is it safe?
- Is it effective?
- Is it well-led?

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

Inspected but not rated

Are services safe?

Safety systems and processes

The service did not have clear systems to keep people safe and safeguarded from abuse.

- Systems to support patients and protect them from neglect and abuse were ineffective. Safeguarding referrals for children were consistently delayed for a period of weeks and there were no safeguarding alerts on clinical records. There was a facility to put an alert on the system, but the service had failed to do so. The basis of safeguarding referrals was not always clear and there was insufficient consideration of essential factors such immediate family members and the family unit as a whole. We spoke about safeguarding with the safeguarding lead that was also the clinical lead GP and they did not recognise having vulnerable patients in private practice.
- Evidence we saw indicated clinical staff were not trained to an appropriate level in safeguarding. The practice manager told us there were three clinical staff that were not undertaking consultations for children, but we checked consultation records and saw that they were. Training records for those three clinical staff members contained no evidence they were trained to level 3 safeguarding children, which is required.
- Following the inspection, the provider told us it had suspended the clinical lead GP and had plans to review all safeguarding cases.
- Staff who acted as chaperones were trained for the role and had received a DBS check.
- The service had a patient identity policy that stated photo ID must be checked at the first appointment to demonstrate that an adult accompanying a child had parental authority; and if not, then ID checks must be made at each appointment. The provider audited its patient records on 11 March 2022 and found there were gaps in patients ID checks, including checks for parental authority. The provider had a list of recommendations for improvement and a deadline for improvements date by the end of April 2022.
- The provider carried out staff DBS and immunity checks at the time of recruitment but there was no system for ongoing checks where necessary. For example, the most DBS recent check for one clinician dated back to June 2018 and another clinician to 2014, and there was no assessment of risk. (DBS checks identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable). Staff immunity checks were generally in place, but some dated back to 2009 and the provider was not clear which staff should have which immunisations in accordance with clinical and non-clinical roles.
- There was an effective system to manage infection prevention and control. The provider undertook an Infection Prevention and Control (IPC) audit in December 2021. Areas which were identified as requiring action had been or were being addressed in line with risk level. For example, an IPC audit identified the need for waste arrangements to dispose of nappies which had been implemented. The service was clean and tidy and cleaning schedules were in place for premises, fixtures and fittings, and clinical equipment such as the ear irrigator.
- The provider ensured that facilities and equipment were safe, and that equipment was maintained according to manufacturers' instructions. Portable appliances were tested for electrical safety in January 2022 and clinical equipment was calibrated in March 2022.
- The provider carried out appropriate environmental risk assessments, which considered the profile of people using the service and those who may be accompanying them. A fire safety risk assessment was undertaken in March 2022 and related actions completed to manage risk. For example, twice yearly fire drills most recently in February 2022, and fire extinguisher checks most recently in January 2022.

Risks to patients

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

- There were arrangements for planning and monitoring the number and mix of staff needed.
- There was an effective induction system for temporary staff tailored to their role.

Inspected but not rated

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.
- There were appropriate indemnity arrangements in place including medical indemnity insurance for two members of clinical staff that we asked to see, including the clinical lead GP.
- There were suitable medicines and equipment to deal with medical emergencies which were checked.

Information to deliver safe care and treatment

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

- Individual care records were not written and managed in a way that kept patients safe. We found evidence of missing information such as no consideration regarding the basis for clinical tests. Arrangements were such that patients could book and receive any tests they wanted such as radiology or pathology, without prior clinical consideration or advice. Relevant patient information such as histories and examinations were missing from the clinical record. For example, a patient attended for frequent lithium level blood tests that were normal, but there was no consideration of clinical issues that may have been relevant for the patient.
- The service had systems for sharing information with staff and other agencies to enable them to deliver safe care and treatment but did not always do so. For example, the provider received a critically urgent report from a laboratory regarding a blood test result that indicated the patient had clinical risk that was life threatening. The provider attempted to make contact with the patient but could not reach them and so sent an email to advise them to attend A+E. Staff did not share this information with the patient's own GP and the patient had consented for staff to do so. The service also did not contact the patient's next of kin whose details were on the patient record. There was no evidence of effective follow up for this patient that attended again, had the same blood test that was abnormal again, and no effective action was taken for their care.
- The service had a system in place to retain medical records in line with Department of Health and Social Care (DHSC) guidance in the event that they cease trading.

Safe and appropriate use of medicines

The reliability of systems for appropriate and safe handling of medicines was variable.

- There was little evidence of medicines audits that were limited to ensuring antibiotics prescribing was in line with best practice guidelines for safe prescribing. This auditing was undertaken by the clinical lead GP and found 98% of prescribing was in line with the National Institute for Health and Care Excellence (NICE) and The British Association for Sexual Health and HIV (BASHH) best practice guidelines. However, we random checked two records within the 98% the clinical lead GP deemed appropriate prescribing, and they were not appropriate in line with best practice guidelines. For example, a patient had been prescribed antibiotics with no history of infection or rationale for the prescribing documented in the record.
- We viewed a sample of clinical records and found examples of patients with a HbA1c (a measure of the amount of blood sugar attached to haemoglobin) greater than 48 which indicated clinical risk that were not acted on appropriately, or at all.
- The service did not audit prescribing of high-risk medicines that require monitoring or medicines that have the potential to be misused.
- The service prescribed some controlled drugs, but prescribing was not monitored.

Inspected but not rated

Are services safe?

- Stock medicines were held and dispensed such as joint injections and for treatment of Gonorrhoea. (Gonorrhoea is an infection caused by a sexually transmitted bacterium that infects both males and females). A large proportion of these medicines' advice labels were in the name of a member of the management team. The service kept a record of which patients these medicines were supplied to, and expiry dates and quantities were checked. However, there was no thermometer to monitor that these medicines were stored safely, or stock control to monitor and reconcile use.

Track record on safety and incidents

The service record keeping arrangements to identify incidents and ensure clinical safety were ineffective.

- There were no comprehensive risk assessments in relation to patient's clinical safety. The clinical lead GP told us reception staff sent all test results to patients GPs on a monthly basis for patients who had consented for this to be done. This would ensure test results sharing in line with urgency, where contact with a patients GP may need to occur more rapidly than in within month. We then spoke with three staff that routinely work on reception and none of them were aware of any monthly arrangement to share patients test results with their registered GP, and there was no evidence it occurred. We saw that abnormal results were emailed to patients with advice to contact their GP. Staff told us all abnormal results were seen by a doctor prior to being communicated to the patient.
- The service did not adequately monitor and review activity to understand risks or give a clear, accurate and current picture to lead to safety improvements. For example, there was no reconciliation to ensure patients histology test samples (such as cervical screening samples or biopsies) that were sent and were received by the laboratory. The system was paper-based and risked delays and loss of information, and there was no process to identify errors or gaps. No system was in place to check that results were received by the service or to ensure appropriate follow up.

Lessons learned and improvements made

The service did not learn and make improvements when things went wrong.

- The systems for capturing, reviewing and investigating when things went wrong were not effective. A significant events policy was available, but staff did not identify events which met the threshold within the policy and therefore significant events were not identified, recorded or acted upon. The clinical lead GP described a confidentiality breach which met the threshold within the policy, but this was not identified or followed up as a significant event. No clinically significant events had been identified; however, we found multiple examples of significant clinical concern through routine checks on the day of our inspection, none of which the provider had anticipated or identified as a risk, until we brought it to their attention. Only one non-clinically significant event was recorded regarding a flood that was followed up appropriately to prevent recurrence.
- There was no effective system for monitoring compliance of safety alerts. The clinical lead GP was not signed up to receive safety alerts. The practice manager received safety alerts and cascaded them to all staff to decide for themselves if these were relevant, but there was no process to ensure follow up. The clinical lead GP was not aware of how, or able to show that safety alerts were acted and said they had not had to act on any. We found evidence of prescribing Mirabegron which did not adhere to the requirements of a safety alert released in 2015.

Inspected but not rated

Are services effective?

Effective needs assessment, care and treatment

The provider did not have systems to keep clinicians up to date with current evidence-based practice. We saw evidence that clinicians did not always assess needs and deliver care and treatment in line with current legislation, standards and guidance (relevant to their service).

- Patients' immediate and ongoing needs were not always fully assessed. We found examples of patients who did not have appropriate medical histories documented in their consultations when treatments were provided or medicines prescribed, or appropriate follow up.
- Clinicians did not have enough information to make or confirm a diagnosis and patients were able to walk in and request any blood test without any clinical assessment or basis test being undertaken. For example, cholesterol testing was undertaken for a child that was not necessary or clinically indicated. There was also no effective clinical assessment or treatment of this child which placed them at risk. The child attended with a problem where their temperature should have been taken and chest examined, but there was no evidence on the consultation record that either of these examinations took place. The clinical lead GP told us the child's temperature was taken on entry to the service, but this was not the case because routine temperature checks for patients attending (during Covid-19) ceased weeks prior to the child's consultation which the clinical lead GP and all staff had been notified of, including by email. The clinical lead GP told us the child's other blood results did not show anything of concern and they did not identify a result that could have been a sign of infection. There was no appropriate consideration for the child in relation to sepsis, potential sepsis or tuberculosis.
- A patient saw the clinical lead GP regarding a lump and had some appropriate tests but also had a D-Dimers test when there was no clinical indication or basis for this test. One of this patients' blood test results (eGFR) that was not related to their lump was abnormal and indicated a risk of chronic kidney disease, but this was not considered. An eGFR of 90 or higher is in the normal range, an eGFR of 60 -89 may mean early kidney disease and an eGFR of 15 -59 may mean kidney disease. A creatinine test is a measure of how well your kidneys are performing their job of filtering waste from your blood. A normal result is 0.7 to 1.3 for men and 0.6 to 1.1 for women.
- We asked clinical lead GP for their opinion and they demonstrated no insight the test result was an issue or indicated risk to the patient.
- A further patient that presented with a lump and other symptoms record stated the patient had no fever, but their temperature was not taken. Potential underlying issues were not investigated which placed the patient at risk of harm. For example, there were no queries of relevant risk factors to such as malignancy (cancer), family history, or if breast feeding or pregnant. This patient was given an ultrasound and a steroid injection but there was no consideration to make a referral which would have been appropriate, such as to breast clinic.
- There were no safe or effective arrangements for patients prescribed ACE inhibitors (medicines used to lower blood pressure). Two patient's records we checked showed concerns such as lack of clinical monitoring; for example, blood pressure checks, and insufficient medicines reviews including to consider other medicines prescribed.

Monitoring care and treatment

The service was not actively involved in clinical quality improvement activity, but some auditing of clinical record keeping had been undertaken.

- The provider audited antibiotic prescribing, but this process was ineffective. One audit highlighted a number of issues which needed to be actioned, including improved adherence to prescribing in accordance with the antibiotic prescribing policy, to avoid using some antibiotics if there is no clinical rationale to do so, and to improve clinical record keeping to ensure rationale for prescribing antibiotics is recorded. A second antibiotics audit completed in March 2022 sampled 100 patient records and concluded 98 of 100 antibiotic prescriptions (98%) were issued in

accordance with accepted best practice. However, on review of this audit, we found prescribing which did not meet best practice guidance. For example, doxycycline was prescribed for a cough when the patient did not have a temperature and had a normal oxygen saturation level. The audit identified areas for improvement including recording any instructions given to patients, and to ensure the diagnosis is clearly documented. We also saw a patient with irregular bleeding was prescribed antibiotics with no history of infections or indication to the rationale for prescribing antibiotics.

- There no was no other evidence of clinical quality improvement or system to monitor the quality of clinical practice, such as clinical supervision or individual consultation audits. Clinical meetings were between the clinical lead GP and the practice manager, but the practice manager was not a clinician.
- There was no auditing of surgical procedures such as toenail removal or COILs procedures to check for post procedure complications, such as infection.
- The provider undertook a record keeping audit of 30 patient records in March 2022 to check standards of clinical record keeping. The audit identified areas for improvement including; obtaining patient NHS GP details, patients ID checks, recording if a chaperone was offered and recording of details of the patients next of kin. The provider set a deadline of the end of April 2022 to implement these recommendations.

Effective staffing

Staff did not consistently have or demonstrate they had the skills, knowledge and experience to carry out their roles.

- Staff were appropriately qualified, and 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.
- Staff had received annual appraisals and mandatory training such as fire safety, infection control, GDPR; and role specific training such as chaperoning. We saw clinicians had been training in areas they were practicing such as minor surgery and neurology.
- The clinical lead GP did not have sufficient knowledge or skills to undertake the role and did not demonstrate basic safeguarding insight, or other clinical knowledge. The clinical lead GP did not implement systems to ensure effective clinical oversight such as clinical audit, peer review, or supervision of clinical staff and their consultations.
- Risk factors were not always identified and highlighted to patients and where appropriate. For example, we reviewed two patients being prescribed Mirabegron, one did not have their blood pressure taken and was not given advice about their treatment, and the other did not have the pre-assessments as advised by NICE before the prescribing of this medicine.
- We also saw a patient known to be taking a specific medicine who was not given any advice to manage or abstain from taking it, considering the effect on their kidneys due to their creatinine levels being 126 and eGFR below 60. The estimated Glomerular Filtration Rate (eGFR) is an indicator of kidney damage or disease.

Coordinating patient care and information sharing

Some systems were in place to work with other organisations to deliver effective care and treatment.

- There were weaknesses in systems for patients test results and the co-ordination of patients care. Blood test results arrived electronically onto the service system and were left for the doctor that requested the tests. Staff told us

clinicians could access these results remotely, but many of the doctors did not work regularly or worked ad hoc and no buddy system was in place. Blood test results were checked daily by a nurse to ensure no urgent results had arrived without being dealt with. We found no backlogs of blood test results. There were no fail safes for reconciling or managing histology results.

- There were no effective systems to ensure communication with a patient's own GP, where appropriate. Patient's GP contact details were not captured as part of the service registration but ad hoc during clinical consultations. We saw multiple examples or where a patient had consented for the service to contact their GP, but this had not occurred, including an instance where a patient was at critical clinical risk.
- Before providing treatment, doctors at the service did not always ensure they had adequate knowledge of the patient's health such as taking their temperature or blood pressure, where clinically required.
- Prescribing of medicines liable to abuse or misuse, and those for the treatment of long-term conditions such as asthma were not monitored.
- Referral letters we checked were appropriate and contained sufficient detail.

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. However, the provider had not considered two-stage consent for any of the procedures it undertook to allow patients time to make an informed choice considering the benefits and risks. The provider undertook surgical procedures on a walk-in basis.
- Records we saw indicated consent forms were implemented for procedures such as joint injections, fitting of IUCDs (coils) and minor surgery such as for ingrowing toenails.
- The process for seeking consent was not monitored or audited.

Inspected but not rated

Are services well-led?

Leadership capacity and capability.

Leaders did not have the capacity, knowledge and skills to deliver high-quality, sustainable clinical care. However, non-clinical aspects of service management were generally effective.

- The clinical lead did not understand clinical challenges and risks.
- There were no effective processes to develop clinical leadership capacity and skills. At the end of our inspection we asked the provider if clinical leadership capacity was available to lead urgent management of risks we had found to patient safety and improve patient care, but the provider could not identify any capacity within the organisation. After the inspection the provider appointed a new clinical lead.
- After our inspection the provider told us it had suspended the clinical lead GP and appointed a new clinical lead and was undertaking an external review of all patients we highlighted. The provider advised it had appointed an external auditor, was forming a medical advisory committee, was following up on all safeguarding cases, had held a clinical meeting with all clinicians, and was working on an action plan.
- Managers at all levels were approachable, they worked closely with staff and others and demonstrated a compassionate and inclusive leadership approach.

Culture

The service had a positive working atmosphere and staff wanted to deliver high quality services.

- Staff felt respected, supported and valued and told us they could raise concerns and had confidence that these would be addressed.
- There were processes for providing staff with the development they need such as annual appraisals.
- Clinical staff were supported to meet the requirements of professional revalidation where necessary and were considered valued members of the team.
- There was an emphasis on the safety and well-being of all staff.
- The service promoted equality and diversity staff had received equality and diversity training.
- There were positive relationships between staff and teams.

Governance arrangements

There were no clear responsibilities, roles and systems of accountability to support good clinical governance and management. Non-clinical aspects of the service were generally well run.

- Structures, processes and systems to support good governance and management were not clearly set out, understood or effective. The clinical lead GP did not have the skills and knowledge to fulfil the role and did not appear to have insight this was the case. The practice manager that was the safeguarding lead was at clinical meetings with the clinical lead GP, but the practice manager was not a clinician and had not recognised or acted on clinical risks and performance issues that were clearly apparent during our inspection. No-other clinical or non-clinical staff inside the organisation had identified the multiple and serious concerns that we brought to the attention of the practice manager on the day of our inspection.
- The provider did not follow its own policies on significant events or safeguarding and had not assured itself these policies were operating as intended.
- There were no clear arrangements for translation services for patients that may need it. The lead GP advised us the demographic of its patient cohort was roughly 50% Eastern European with a significant percentage of patients from countries further away such as Pakistan and Bangladesh; and that approximately 20% of patients did not speak

Inspected but not rated

Are services well-led?

English with roughly 10% needing a translator. We noted staff spoke a range of languages that were mostly Eastern European such as Lithuanian and Belarusian. We asked staff what they would do if a patient might need a translation service and they told us the lead GP had details of a language facility, but staff were not able to access this directly. Management staff told us a separate web-based system was available or google translate could be used.

Managing risks, issues and performance

There was no clarity around processes for managing risks, issues and performance.

- There was no process to identify, understand, monitor and address current and future risks such as clinical risks to patient's safety. The clinical lead GP was responsible for clinical governance and was not signed up to receive updates such as NICE best practice guidelines. The clinical lead GP responses to the concerns we identified consistently demonstrated a lack of appropriate insight. For example, in regard to antibiotics prescribing the clinical lead GP stated prescribing was appropriate for private medical practice, which is not accurate. The clinical lead GP was responsible for clinical governance but evidence during our inspection indicated they did not have fundamental competencies including to consult with and examine patients effectively, or to inform, interpret and respond appropriately to diagnostics such as test results, or safeguarding concerns.
- The service submitted notifications to external organisations as required. For example, to notify the CQC of absence of the absence of the registered manager, since October 2021.
- Data security standards for the availability, integrity and confidentiality of patient identifiable data, records and data management systems were not robust. For example, the service did not communicate with a patient's own GP effectively; we saw the lead GP had communicated a patients safeguarding records to the local authority via their personal email account when the providers policy states that patients' records are kept in its IT provider servers; and a confidentiality breach was not acted on in line with the practice significant events protocol. There were also weaknesses in patient ID checks that the provider had identified for improvement.
- The service had no processes to manage current and future performance. Performance of clinical staff was not monitored, there were no audits of consultations, prescribing or referral decisions.
- Leaders had no oversight of safety alerts received and had not followed up historic searches to ensure they were still being adhered to.
- There was little understanding of significant events, including what met the threshold of a clinical event.

Appropriate and accurate information

The service did not always act on or have appropriate and accurate information.

- There was limited of quality and operational information to improve performance.
- The service submitted notifications to external organisations as required. For example, to notify the CQC of absence of the absence of the registered manager, since October 2021.
- Data security standards for the availability, integrity and confidentiality of patient identifiable data, records and data management systems were not robust. For example, the service did not communicate with a patient's own GP effectively; we saw the lead GP had communicated a patients safeguarding records to the local authority via their personal email account when the providers policy states that patients' records are kept in its IT provider servers; and a confidentiality breach was not acted on in line with the practice significant events protocol. There were also weaknesses in patient ID checks that the provider had identified for improvement.

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.

Regulated activity	Regulation
Diagnostic and screening procedures Family planning services Treatment of disease, disorder or injury Surgical procedures	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: • Safeguarding identification and management. • Safety alerts receipt and management. • In response to indicators of clinical risk including test results, eGFR below 60, and HBA1C above 48 and abnormal creatinine. • Safe medicines management such as prescribing including antibiotics, ACE inhibitors, high risk medicines, and controlled drugs. • Post procedural auditing in case of clinical complications. • Significant events identification and management. • Patients test results receipt and management. **The enforcement action we took:** The Northway Clinic was issued with an urgent notice to suspend their registration as a service provider for six months; in respect of regulated activities undertaken at The Northway Clinic, under Section 31 of the Health and Social Care Act 2008. This notice of urgent suspension of the provider's registration was given because we believed that a person will or may be exposed to the risk of harm if we did not take this action.

Regulated activity	Regulation
Diagnostic and screening procedures Family planning services Surgical procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance There were effective no systems or processes that enabled the registered person to assess, monitor and improve the quality and safety and monitor and mitigate the risks. In particular:

This section is primarily information for the provider

Enforcement actions

- System to determine clinical consideration for tests and related patient advice.
- Clinical quality improvement.
- Oversight of individual clinicians' clinical care and trends.
- To identify underlying clinical issues and risks such as potential cancer.
- To ensure accurate, complete and contemporaneous records maintained securely in respect of each service user.
- To ensure effective communication with patients and allied health and social care professionals such as patients own GP, where appropriate.
- To ensure effective antibiotics prescribing and antimicrobial stewardship.
- To ensure policies and procedures are implemented including.

The enforcement action we took:

The Northway Clinic was issued with an urgent notice to suspend their registration as a service provider for six months; in respect of regulated activities undertaken at The Northway Clinic, under Section 31 of the Health and Social Care Act 2008. This notice of urgent suspension of the provider's registration was given because we believed that a person will or may be exposed to the risk of harm if we did not take this action.