Taymount Clinic Limited

Inspection report

Taymount House
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Letchworth Garden City
SG6 1LB
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www.taymount.com

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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 an announced comprehensive inspection at Taymount Clinic Limited on 4 September 2023 as part of our inspection programme. This is the first inspection of this service since registration.

Taymount Clinic Limited is a private clinic which specialises in providing Faecal Microbiota Transplant (FMT). FMT also known as a stool transplant, is the process of transferring fecal bacteria and other microbes from a healthy individual into another individual. FMT involves the transfer of healthy bacteria in a mixture of prepared processed stool from a healthy donor to the intestine of the patient. The purpose of this treatment is to restore a healthy balance of bacteria in the gut. FMT can be used for the treatment of Clostridioides difficile infection. The products used by Taymount Clinic Limited for FMT are supplied by their sister company, which is a separate legal entity regulated by the Medicines and Healthcare products Regulatory Agency.

Taymount Clinic Limited is registered with the CQC under the Health and Social Care Act 2008 to provide the following 2 regulated activities:

- diagnostic and screening procedures
- treatment of disease, disorder or injury.

The provider has a registered manager in place. A registered manager is a person who is registered with the CQC to manage the service. Like registered providers, they are 'registered persons'. Registered persons have 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:

- The service did not have clear systems to keep people safe and safeguarded from abuse across all areas.
- There were systems in place for the management of significant events and incidents.
- Risks to service users were assessed and managed, in most cases.
- There were systems for reviewing and investigating when things went wrong.

Overall summary

- Staff had the skills, knowledge and experience to carry out their roles.
- The service obtained consent to care and treatment in line with legislation and guidance.
- Clinicians helped service users to be involved in decisions about care and treatment.
- Staff treated patients with kindness, respect and compassion.
- Patients were able to access care and treatment from the service within an appropriate timescale for their needs.
- The service did not undertake clinical audits to assess the impact on quality of care and outcomes for patients.
- The service did not have clear responsibilities, roles and systems of accountability to support good governance and management across all areas.

We found breaches of regulations. The provider **must**:

- Establish effective systems and processes to ensure good governance in accordance with the fundamental standards of care.

The provider **should**:

- Continue to embed staff understanding of the recently created safeguarding children policy.
- Continue to implement improvements to the complaints procedure to ensure clients receive information on how they can access support from external bodies.
- Embed the understanding of the duty of candour policy across all staff members.

Dr Sean O'Kelly BSc MB ChB MSc DCH FRCA

Chief Inspector of Healthcare

Our inspection team

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

Background to Taymount Clinic Limited

Taymount Clinic Limited is located at Taymount House, Works Road, Letchworth Garden City, Hertfordshire, SG6 1LB. The telephone number is 0330 2221622. The website addresses is www.taymount.com.

Taymount Clinic Limited is a private clinic which specialises in providing Faecal Microbiota Transplant (FMT). FMT also known as a stool transplant, is the process of transferring fecal bacteria and other microbes from a healthy individual into another individual. The clinic does not offer services to anyone aged under the age of 18.

The clinic is run by two directors and includes a chief medical officer, two senior FMT practitioners and nutrition advisers, a quality assurance manager, a patient liaison officer and an administrator.

The service is open from 9am to 5pm Monday to Friday.

How we inspected this service

Before inspecting, we reviewed a range of information we hold about the service and we reviewed the information we asked the provider to send us.

During our inspection we:

- Spoke with the clinic directors and both clinical and non-clinical staff members.
- Reviewed how care or treatment were being delivered including the associated record.
- Spoke with service users who shared their views and experiences of the service.
- Reviewed a range of policies, procedures and management information held by the 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?

We rated the service as requires improvement for providing safe services because:

- Not all staff members had an adequate record of immunisation relevant to their role.
- The service did not have a system or process in place for managing chaperoning.
- The service did not have a documented risk assessment in place for not storing medicines used in an emergency.
- There was no policy in place for the retention of medical records in accordance with national guidelines.

Safety systems and processes

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

- The provider conducted safety risk assessments. It had appropriate safety policies, which were regularly reviewed and communicated across the clinical team. They outlined clearly who to go to for further guidance. All staff received safety information from the service as part of their induction and refresher training.
- All staff received up-to-date safeguarding and safety training appropriate to their role. They knew how to identify and report concerns. However, at the time of our inspection the service did not have a safeguarding children policy in place. Shortly after our inspection, the service had introduced a safeguarding children policy and we received evidence confirming this.
- The provider carried out checks at the time of recruitment and on an ongoing basis where appropriate. Disclosure and Barring Service (DBS) checks were undertaken for all staff members. (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).
- From the 5 personnel files we checked we found a record of Hepatitis B immunisation was not in place for one clinical member of staff and the service did not have a risk assessment in relation to this. Shortly after our inspection, the service provided us with an action plan and told us a risk assessment would be completed within 2 weeks.
- The staff we spoke with understood their role when chaperoning. However, not all staff members who acted as chaperones had received formal training for the role and the service did not have a chaperone policy in place. The service did not have a documented system in place to record whether a chaperone had been requested, offered or declined. Shortly after our inspection, the service provided us with evidence to confirm all staff members had now completed chaperone training, a chaperone policy had been introduced and the service now had a documented process in place for recording a clients' preferences and requirements in relation to chaperoning.
- There was an effective system to manage infection prevention and control. Cleaning of the premises was carried out by a housekeeper and there were cleaning schedules in place. Infection prevention and control audits were undertaken and there were safety sheets for the Control of Substances Hazardous to Health (COSHH). There were systems for safely managing healthcare waste.
- A legionella risk assessment had been completed and legionella testing and water temperature checks were carried out on a regular basis.
- 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 took into account 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, in most cases.

Requires Improvement

Are services safe?

- There were arrangements for planning and monitoring the number of team members required to meet the needs of service users.
- Staff understood their responsibilities to manage emergencies and to recognise those in need of urgent medical attention. They knew how to identify and manage service users with severe infections, for example sepsis.
- The service had purchased a defibrillator which was located outside the front of the premises. The service did not have oxygen or any emergency medicine available and told us this was due to the nature of the treatments provided, however the service did not have a documented risk assessment in place in relation to this. Shortly after our inspection, the service provided us with an action plan to address the lack of risk assessments.
- When there were changes to services the impact on safety was assessed and monitored appropriately.
- There were appropriate indemnity arrangements in place.

Information to deliver safe care and treatment

Staff had the information they needed to deliver safe care and treatment to patients.

- Individual care records were written and managed in a way that kept patients safe. The care records we checked showed that information needed to deliver safe care and treatment was available to relevant staff in an accessible way.
- We found information within patient records was comprehensive and included all of the information needed in accordance with national guidance.
- The service did not have 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. Shortly after our inspection, the service told us they were in the process of implementing a records retention policy and this would be completed by October 2023.

Safe and appropriate use of medicines

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

- The service had systems and arrangements for managing medicines and medical equipment to minimise risks.
- Staff administered medicines to service users and gave advice on medicines in line with legal requirements and current national guidance. Processes were in place for checking medicines and staff kept accurate records of medicines.
- Medicines were stored securely and all medicines requiring refrigeration were stored in an appropriate, secure medicine fridge. Temperatures were monitored and recorded.
- Service users' health was monitored to ensure medicines were being used safely and followed up on appropriately.

Track record on safety and incidents

The service had a good safety record.

- There were comprehensive risk assessments in relation to safety issues including fire and health and safety.
- The service monitored and reviewed activity. This helped it to understand risks and gave a clear, accurate and current picture that led to safety improvements.

Lessons learned and improvements made

The service learned and made improvements when things went wrong.

Requires Improvement

Are services safe?

- There was a system for recording and acting on significant and adverse 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 had systems in place to learn and share lessons and take action to improve safety in the service. There had been no significant events recorded in the last 12 months.
- They kept written records of verbal interactions as well as written correspondence.
- The service acted on and learned from external safety events as well as patient and medicine safety alerts. The service had systems in place to receive and act on alerts from the Medicines and Healthcare products Regulatory Authority (MHRA) and through the Central Alerting System (CAS).
- The service had an effective mechanism in place to disseminate alerts to all relevant members of the team.

Requires Improvement

Are services effective?

We rated the service as requires improvement for providing effective services because:

- The service did not undertake clinical audits to assess the impact on quality of care and outcomes for patients.
- There was no evidence that the service considered sharing information with a clients' GP.

Effective needs assessment, care and treatment

- The provider had systems to keep clinicians up to date with current evidence based practice. We saw evidence that clinicians assessed needs and delivered care and treatment in line with current legislation, standards and guidance. For example, Medicines and Healthcare products Regulatory Agency (MHRA) guidance.
- A service user's initial consultation included a detailed health screening to ensure any offers for treatment were clinically appropriate.
- Service users immediate and ongoing needs were fully assessed. Where appropriate this included their clinical needs and their mental and physical wellbeing.
- The service had a sister company which produced and supplied their products. The production company was on the UK register of licensed manufacturing sites.
- We saw no evidence of discrimination when making care and treatment decisions.
- Service users were advised what to do if their condition got worse and where to seek further help and support.

Monitoring care and treatment

The service was involved in some quality improvement activity.

- The service had a programme of quality improvement activity which focused on safeguarding, infection prevention and control, complaints, data protection, fire safety and staff training. These audits were regularly repeated for ongoing monitoring.
- Quality audits did not focus on patient outcomes. The service collated patient feedback through a programme of follow ups and this was recorded in individual care records. However, the service did not undertake clinical audits to assess the impact on quality of care and outcomes for patients. The service told us that they had plans to undertake audits to assess patient outcomes on an annual basis and this would commence towards the end of 2023.
- The service monitored national core competencies and its clinic in the Bahamas had participated in a study of Multiple Sclerosis and FMT. The study found FMT interventions were associated with improved microbiome, specifically an increase in anti-inflammatory butyrate-producing bacteria in the subject's stool.

Effective staffing

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

- All of the clinical team were appropriately qualified. The provider had an induction programme for all newly appointed staff members.
- Relevant professionals were registered with the General Medical Council (GMC) and were up to date with revalidation.
- The provider understood the learning needs of the clinical team and provided online training systems to maintain training and access to conferences and workshops. Up to date records of skills, qualifications and training were maintained.

Coordinating patient care and information sharing

Requires Improvement

Are services effective?

There was limited evidence to demonstrate staff worked well with other organisations, to deliver effective care and treatment.

- Service users received person-centred care.
- Before providing treatment, clinicians at the service ensured they had adequate knowledge of the service users health, any relevant test results and their medicines history.
- The service did not share relevant information with other services. For example, with the patient's GP. At the time of our inspection, the service did not have a system in place to request consent to share information with a clients GP. Shortly after our inspection, the service had updated their systems and processes and we received evidence that this was now in place.
- The service clearly displayed consultation and treatment fees in the waiting area and on their website.

Supporting patients to live healthier lives

Staff were consistent and proactive in empowering patients, and supporting them to manage their own health and maximise their independence.

- Where appropriate, staff gave people advice so they could self-care.
- Risk factors were identified and highlighted to service users.
- Where service users' needs could not be met by the service, staff redirected them to the appropriate service for their needs.
- Clinicians provided advice on nutrition and healthy lifestyles and offered advice on local services. The service stocked health related products which were available to purchase.

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 service users to make decisions. Where appropriate, they assessed and recorded a service users mental capacity to make a decision.
- The service monitored the process for seeking consent appropriately.

Good

Are services caring?

Kindness, respect and compassion

Staff treated patients with kindness, respect and compassion.

- The service sought feedback on the quality of clinical care service users received.
- Feedback from service users was positive about the way staff treat people.
- During our inspection we spoke with 4 clients and they were all very positive about the service they had experienced.
- Staff understood service users' personal, cultural, social and religious needs. They displayed an understanding and non-judgmental attitude to all service users.
- The service gave service users timely support and information.

Involvement in decisions about care and treatment

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

- Interpretation services were available for service users who did not have English as a first language.
- Service user feedback online demonstrated service users felt listened to and supported by the clinicians and had sufficient time during consultations to make an informed decision about the choice of treatment available to them.
- Service users had access to information about the clinicians working at the service. Information about each clinician was available on the website.

Privacy and Dignity

The service respected patients' privacy and dignity.

- Staff recognised the importance of people's dignity and respect.
- Staff knew that if service users wanted to discuss sensitive issues or appeared distressed they could offer them a private room to discuss their needs.
- We noted that the consultation room door was closed during the consultation and conversations could not be overheard. Each treatment room had curtains and the door displayed signage to let others know when in use.
- All client records were electronic and held securely. Staff complied with information governance legislation.

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 service users and improved services in response to those needs.
- Service users were routinely advised of the expected fee in advance of any consultation or treatment.
- The services available were made clear on the website as well as through leaflets available.
- 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.
- All consultation rooms were located on the ground floor with easy access for all service users and the service had an accessible toilet.
- Client feedback online showed service users had rated their overall experience highly and the service had scored 4.7 out of 5 from 26 reviews on one website and 4.4 out of 5 from 31 google reviews.

Timely access to the service

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

- Service users had timely access to initial assessment, test results, diagnosis and treatment.
- Appointments were available 5 days a week and the service offered flexibility with appointment times.
- The main client enquiry mailbox was monitored 7 days a week to ensure timely responses to client queries.

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 clients who made complaints compassionately.
- The service did not routinely inform patients of any further action that may be available to them should they not be satisfied with the response to their complaint. Shortly after our inspection, the service told us they had updated their complaints procedure to ensure clients were given information on who to contact should they not be satisfied with the outcome from their complaint.
- The service had complaint policy and procedures in place and information about how to make a complaint or raise concerns was available and easily accessible.
- The service learned lessons from individual concerns, complaints and from analysis of trends. It acted as a result to improve the quality of care. For example, the service had made changes to their initial consultation form to ensure additional information about lifestyle and recreational activities was requested.
- The service encouraged service user feedback and demonstrated a focus on service user engagement and involvement.

Requires Improvement

Are services well-led?

We rated this service as requires improvement for providing well-led services because:

- Some of the safety systems and processes in place required strengthening.
- The service did not have clear responsibilities, roles and systems of accountability to support good governance and management in some areas.
- The service did not routinely inform patients of any further action that may be available to them should they not be satisfied with the response to their complaint.
- The principles of Duty of Candour were not understood by all staff.
- The business continuity plan was not up-to-date.

Leadership capacity and capability;

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

- Leaders were knowledgeable about issues and priorities relating to the quality and future of services. They understood the challenges and were addressing them.
- Leaders at all levels were visible and approachable. They worked closely with all staff members and prioritised compassionate and inclusive leadership.
- The provider had effective processes to develop leadership capacity and skills.

Vision and strategy

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

- There was a clear vision and set of values. The service had a realistic strategy and supporting business plans to achieve priorities.
- The clinical team were aware of and understood the vision, values and strategy and their role in achieving them
- The service monitored progress against delivery of the strategy.
- The service displayed their core values on their website.

Culture

The service had a culture of high-quality sustainable care.

- The service focused on the needs of service users.
- Leaders and managers acted on behaviour and performance inconsistent with the vision and values.
- Systems and processes supported openness, honesty and transparency when identifying and responding to incidents and complaints. The provider had systems to ensure compliance with the requirements of the duty of candour. However, during our inspection we found not all clinical staff members had a clear understanding of the duty of candour requirements.
- There was a strong emphasis on the safety and well-being of staff and clients.
- 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 in the last 12 months.
- Staff had completed equality and diversity training.

Requires Improvement

Are services well-led?

- There were positive relationships between all staff members.

Governance arrangements

The service did not have clear responsibilities, roles and systems of accountability to support good governance and management across all areas.

- Structures, processes and systems to support good governance and management were clearly set out, understood and effective in most cases.
- There were clear roles and responsibilities in place.
- Leaders had established proper policies, procedures and activities in most cases, to ensure safety and assured themselves that they were operating as intended.
- At the time of our inspection, the service did not have a chaperone policy, safeguarding children policy and records retention policy.

Managing risks, issues and performance

There were clear and effective processes for managing risks, issues and performance in most cases.

- There was an effective process to identify, understand, monitor and address current and future risks including risks to patient safety in most cases.
- The service had some processes to manage current and future performance. Leaders had oversight of safety alerts, incidents and complaints.
- The service did not undertake clinical audits on the quality of care and outcomes for service users.
- The provider had plans to manage risks and the clinical team had completed training for major incidents.
- At the time of our inspection, the service did not have an up-to-date business continuity plan. Shortly after our inspection, the service provided us with an updated copy of their business continuity plan.
- We also found a lack of clear and effective processes in relation to the following:
- Not all staff had an adequate record of immunisations,
- There was no system to ensure the arrangements for chaperoning were adequate,
- There were no risk assessments in relation to not storing oxygen or emergency medicines at the clinic, and
- The service had not considered sharing information with service users' GPs.

Appropriate and accurate information

The service acted on appropriate and accurate information.

- Operational information was used to ensure and improve performance. Performance information was combined with the views of service users.
- Quality and sustainability were discussed in relevant meetings where all team members had sufficient access to information.
- The information used to monitor performance and the delivery of quality care was accurate and useful. There were plans to address any identified weaknesses.
- The service submitted data or notifications to external organisations as required.
- There were arrangements in line with data security standards for the availability, integrity and confidentiality of service user identifiable data, records and data management systems.

Requires Improvement

Are services well-led?

Engagement with patients, the public, staff and external partners

The service involved patients, the public, staff and external partners to support high-quality sustainable services.

- There were arrangements to obtain feedback about the quality of care and treatments available to service users.
- The service was transparent, collaborative and open with their service users.
- Both clients and staff were able to provide anonymous feedback in a confidential manner.
- Feedback from clients resulted in improvements, for example the service had made improvements to their parking arrangements following client feedback.
- The service encouraged staff feedback and the service undertook staff development and team building exercises. Staff feedback resulted in the development of a new and improved website.
- Following a review of staff feedback, leaders were in the process of increasing staff annual leave allowances and employee benefits.

Continuous improvement and innovation

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

- There was a focus on continuous learning and improvement.
- The service made use of internal reviews of incidents and complaints.
- Leaders and managers encouraged staff to take time out to review individual and team objectives, processes and performance.
- There were systems to support improvement and service development.

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 Systems and processes were not established or operated effectively to enable the registered person to assess, monitor and mitigate the risks relating to the health, safety and welfare of service users and others who may be at risk. In particular: Although the service had systems and processes relating to staff immunisations, we found that not all staff members had an adequate record of immunisation relevant to their role. There were no systems or processes that enabled the registered person to ensure arrangements for chaperoning were adequate. The service did not have a risk assessment for not storing oxygen or emergency medicines at the clinic. There was no evidence that the service considered sharing information with service users' GPs. The principles of duty of candour were not understood by all staff members. The business continuity plan was not up-to-date. Systems and processes were not established or operated effectively to enable the registered person to assess, monitor and improve the quality and safety of the services provided in the carrying on of the regulated activity. In particular: The service did not undertake clinical audits to assess the impact on quality of care and outcomes for patients. This was in breach of Regulation 17(1)(2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.