Top Medical Clinic LLP

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Inspection report

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Overall summary

We carried out an announced comprehensive inspection on 17 January 2018 to ask the service the following key questions; Are services safe, effective, caring, responsive and well-led?

Our findings were:

Are services safe?

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

Are services effective?

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

Are services caring?

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

Are services responsive?

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

Are services well-led?

We found that this service was not providing well-led care in accordance with the relevant regulations.

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the service was meeting the legal requirements and regulations associated with the Health and Social Care Act 2008. This was a joint dental and medical inspection of an independent healthcare service. This report relates to the medical service only. A separate report has been written for the dental service provided by the clinic. You can read the dental report by selecting the 'all reports' link for Top Medical Clinic at our website at www.cqc.org.uk.

The provider offers specialist services including aesthetic medicine, cardiology, dentistry, dermatology, endocrinology, gynaecology, neurology, orthopaedics, paediatrics and psychology. Services were primarily provided to Polish patients.

This service is registered with CQC under the Health and Social Care Act 2008 in respect of some, but not all, of the services it provides. There are some exemptions from regulation by CQC which relate to particular types of service and these are set out in Schedule 2 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. For example the aesthetic cosmetic treatments that are provided by the service are exempt by law from CQC regulation.

We received 34 Care Quality Commission comment cards from patients who used the service and spoke to two patients during the inspection; all were all positive about the service experienced. Many patients reported that the service provided high quality care.

Our key findings were:

- The service had systems in place to manage risk; however this required further improvement. When

Summary of findings

incidents happen, the service did not always learn from them and improve their processes. The service did not have a clear system in place to manage significant events and did not have a comprehensive business continuity plan. The practice had not made any arrangements to ensure what happens to patient records when they cease to trade.

- The service did not have systems in place to review the effectiveness and appropriateness of the care it provided. It did not ensure that care and treatment was always delivered according to evidence- based guidelines; the provider did not have a clear system in place to keep clinicians up to date with current evidence-based practice.
- There was limited evidence of quality improvement and they had not undertaken any clinical audits.
- Staff involved and treated patients with compassion, kindness, dignity and respect.
- Patients found the appointment system easy to use and reported that they were able to access care when they needed it.
- The clinic had limited accessibility to the patients who are physically disabled and did not have an accessible toilet suitable for disabled patients.
- Information on how to complain was available and easy to understand.
- There were some governance arrangements in place; however there was limited clinical leadership within the service.

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

- The provider had not ensured that care and treatment is provided in a safe way for service users. They did not have a system in place to manage significant events, medicines and safety alerts and emergency medicines; chaperones are appropriately trained; all clinical equipment is regularly calibrated; there is a comprehensive business continuity plan for major incidents such as power failure or building damage, and the identity of patients is checked before registering new patients. Introduce a policy to ensure communication with patients' NHS GP where appropriate.
- The provider had not ensured that effective systems and processes are in place to ensure good governance in accordance with the fundamental standards of care. They did not have a system to demonstrate quality improvement including for example clinical audits; medicines are appropriately prescribed; governance arrangements in place to improve clinical leadership within the service and learning from incidents, significant events and complaints.
- The provider had not ensured that all staff have received appraisal and training to enable them to carry out the duties that they are employed to perform.

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

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

- Review practice procedures to ensure improved access to patients who are disabled.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?
We found that this service was not providing safe care in accordance with the relevant regulations.

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

- The service had systems in place to manage risk; however this required further improvement. When incidents happen, the service did not always learn from them and improve their processes. The service did not have a clear system in place to manage significant events.
- The service did not have a comprehensive business continuity plan.
- Staff received training in safeguarding and knew how to recognise the signs of abuse and how to report concerns.
- Staff were qualified for their roles and the practice completed essential recruitment checks.
- Premises and equipment were clean and properly maintained.

Are services effective?
We found that this service was not providing effective care in accordance with the relevant regulations. We have told the provider to take action (see full details of this action in the Requirement Notices at the end of this report).

- The service did not have systems in place to review the effectiveness and appropriateness of the care it provided. It did not ensure that care and treatment was always delivered according to any evidence- based guidelines; the provider did not obtain assurances to ensure clinicians were up to date with current evidence-based practice.
- There was no evidence of quality improvement as they had not undertaken any clinical audits.
- Appraisals were not regularly undertaken for non-clinical staff; some of the staff had not undertaken relevant training.

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

- Staff involved and treated patients with compassion, kindness, dignity and respect.
- The Care Quality Commission comment cards we received and the patients we spoke with were all positive about the service experienced. Many patients reported that the service provided high quality care.

Are services responsive to people's needs?
We found that this service was providing responsive care in accordance with the relevant regulations. We have told the provider to take action (see full details of this action in the Requirement Notices at the end of this report).

- Patients found the appointment system easy to use and reported that they were able to access care when they needed it.
- The clinic had limited access to the patients who are physically disabled.
- Information on how to complain was available and easy to understand.

Are services well-led?
We found that this service was not providing well-led care in accordance with the relevant regulations. We have told the provider to take action (see full details of this action in the Requirement Notices at the end of this report).

Summary of findings

- There were some governance arrangements in place; however there was limited clinical leadership within the service.
- Structures, processes and systems to support good governance and management were not effective.
- Openness, honesty and transparency were demonstrated when responding to incidents and complaints. The provider was aware of and had systems to ensure compliance with the requirements of the duty of candour.
- The service kept complete patient care records which were, clearly written or typed, and they were stored securely.
- We saw no evidence of any processes to manage current and future performance.
- The registered manager had an oversight of incidents and complaints.

Top Medical Clinic LLP

Detailed findings

Background to this inspection

Top Medical Clinic is an independent provider of medical services and treats adults and children in the London Borough of Croydon. The service is led by the registered manager. Registered managers have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated regulations about how the service is run.

The provider offers specialist services including aesthetic medicine, cardiology, dentistry, dermatology, endocrinology, gynaecology, neurology, orthopaedics, paediatrics, psychology, Services are primarily for Polish patients. Services are available to people on a pre-bookable appointment basis.

The service employs 14 reception and administrative staff. All of the 24 clinical staff who work in the clinic are self-employed; however they have a contract with the provider.

The clinic has four floors with a reception and waiting area and nine consulting rooms. The property is owned by the provider; the clinic has no lift, the second, third and fourth floor consulting rooms are not accessible to people who use a wheelchair or other mobility aids and there is no accessible toilet. The clinic is open between 9am and 9pm Monday to Saturday and from 9am to 6pm on a Sunday.

Top Medical Clinic LLP is registered with the Care Quality Commission to provide the regulated activities diagnostic and screening procedures, family planning, surgical procedures and treatment of disease, disorder or injury.

The inspection was led by a CQC inspector. The inspection team included a GP specialist advisor, dental inspector and a dental specialist advisor.

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

- Is it safe?
- Is it effective?
- Is it caring?
- Is it responsive to people's needs?
- Is it well-led?

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

Are services safe?

Our findings

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

Safety systems and processes

The practice did not have effective systems in place to keep patients safe and safeguarded from abuse.

- The service had systems to safeguard children and vulnerable adults from abuse. Policies were regularly reviewed and were accessible to all staff. They outlined clearly who to go to for further guidance.
- Staff interviewed demonstrated that they understood their responsibilities regarding safeguarding.
- The service did not have a system in place to verify patients' identity during registration of new patients.
- The service had a staff recruitment policy and procedure to help them employ suitable staff. This reflected the relevant legislation. We looked at eight staff recruitment records. The service carried out staff checks, including checks of professional registration where relevant, this was both at the time of recruitment and on an ongoing basis. Disclosure and Barring Service (DBS) checks were undertaken where required. (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).
- All staff received up-to-date safeguarding and safety training appropriate to their role. They knew how to identify and report concerns. The practice had a whistleblowing policy. Staff told us they felt confident they could raise concerns without fear of recrimination.
- The service had a chaperone policy in place; however it did not contain relevant information for example about training of chaperones. The day following the inspection the service sent us a copy of their updated chaperone policy. The service had designated staff who acted as chaperones who had DBS checks; however they had not received any training.
- There was an effective system to manage infection prevention and control.
- The practice ensured that facilities and equipment were safe and that equipment was maintained according to manufacturers' instructions. However some of clinical equipment for example blood pressure apparatus were not regularly calibrated. There were systems for safely managing healthcare waste.
- The service had an up-to date legionella risk assessment and had acted on the recommendations.

Risks to patients

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

- There were arrangements for planning and monitoring the number and mix of staff needed.
- Staff understood their responsibilities to manage emergencies on the premises and to recognise those in need of urgent medical attention.
- When there were changes to services or staff the practice assessed and monitored the impact on safety.
- All clinical members of the staff were self-employed and had their own professional indemnity insurance. We checked this to ensure it was appropriate and in date.

Information to deliver safe care and treatment

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

- The practice did not have clear systems for sharing information with staff and other agencies to enable them to deliver safe care and treatment. For example they did not have a clear policy or protocol to ensure written communication between the service and patients' NHS doctors'.
- Individual care records were written and managed in a way that kept patients safe. The care records we saw showed that information needed to deliver safe care and treatment was available to relevant staff in an accessible way.
- We found that all records were written in English. The service informed us that they provided Polish language notes to patients on their request.

Safe and appropriate use of medicines

Improvements were needed in the systems for appropriate and safe handling of medicines.

- The service had emergency medicines to deal with a range of medical emergencies; however they did not have emergency medicines to deal with infections, inflammatory disorders, allergic disorders, pain, nausea

and vomiting. They had not performed a risk assessment to ascertain what emergency medicines they required. The day following the inspection the service told us they had purchased these medicines; however they had not sent us evidence to support this.
- The practice kept prescription stationery securely and monitored its use.
- They did not have a prescribing protocol in place to include what medicines can and cannot be prescribed. The practice had not audited antimicrobial prescribing and there was no evidence of actions taken to support good antimicrobial stewardship.
- During the inspection we looked at the records of 20 adult patients for specialties including cardiology and gynaecology, and found they were prescribed medicines according to evidence based guidelines. We also reviewed the records of 10 children and found that four were not prescribed antibiotics according to evidence based guidelines.

Track record on safety

- There were risk assessments in relation to safety issues within the premises.
- The practice monitored and reviewed activity which led to safety improvements; however this was not performed in relation to significant events.

Lessons learned and improvements made

The practice did not have an effective system in place to learn and make improvements when things went wrong.

- The service recorded the incidents and significant events in an accident book and there was no clear system in place for acting and learning from incidents and significant events. Some of the incidents and significant events the practice had recorded were not appropriate. The service did not have a clear policy and recording form in place to manage significant events. However staff we spoke to understood their duty to raise concerns and report incidents and near misses. Leaders and managers supported them when they did so.
- The systems for reviewing and investigating when things went wrong were not sufficient; For example the significant events were investigated by the practice manager without sufficient input from other staff.
- The practice had a system in place for receiving and acting on medicines and safety alerts. However they did not have a system in place to evidence the actions they had taken for alerts relevant to the service.

Are services effective?

(for example, treatment is effective)

Our findings

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

Effective needs assessment, care and treatment

We saw that clinicians assessed needs of patients; however they did not always deliver care and treatment in line with current legislation, standards and guidance supported by clear clinical pathways and protocols. The provider did not obtain assurances to ensure clinicians were up to date with current evidence-based practice.

- Patients' needs were fully assessed.
- We saw no evidence of discrimination when making care and treatment decisions.
- Staff advised patients what to do if their condition got worse and where to seek further help and support.

Monitoring care and treatment

- There was no evidence of quality improvement. The service had not undertaken any clinical audits.
- The patient management system used by the service did not support linking patient records to pathology results and did not support in performing clinical audits as the system was non-searchable.

Effective staffing

- Staff had the skills, knowledge and experience to carry out their roles.
- The service understood the learning needs of staff and provided training to meet them. Up to date records of skills, qualifications and training were maintained.
- Staff were encouraged and given opportunities to develop.
- The practice provided staff with on-going support; this included induction and one to one meetings. However the non-clinical staff did not have any appraisals and clinical staff did not have coaching, mentoring and clinical supervision. The service hired an external consultant to perform appraisals and to provide support for revalidation for clinical staff.

Coordinating patient care and information sharing

- There was no evidence of written communication between the service and patients' NHS doctors' and they did not have a clear policy or protocol in place to support this. The service asked for the details of the patients' NHS GP while registering new patients and recorded them; however they did not ask for patients' consent to share details of their consultation. The practice informed us they only sent information to the NHS GP on patient request and did not have routine communication with the patients' NHS GP.
- The registered manager confirmed they referred patients to a range of specialists in primary and secondary care if they needed treatment the practice did not provide.

Consent to care and treatment

The service obtained consent to care and treatment in line with legislation and guidance.

- Clinicians understood the requirements of legislation and guidance when considering consent and decision making. The practice's consent policy included information about the Mental Capacity Act 2005.
- Clinicians supported patients to make decisions. Where appropriate, they assessed and recorded a patient's mental capacity to make a decision; clinical staff had completed Mental Capacity Act training.

Are services caring?

Our findings

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

Kindness, respect and compassion

Staff treated patients with kindness, respect and compassion.

- Staff understood patients' personal, cultural, social and religious needs.
- Reception staff knew that if patients wanted to discuss sensitive issues or appeared distressed they could offer them a private room to discuss their needs.
- We spoke with two patients during the inspection. Both were positive about the service.
- All of the 34 patient Care Quality Commission comment cards we received were positive about the service experienced.

Results from the May 2017 local patient survey (random sample of 15 patients) showed patients felt they were treated with compassion, dignity and respect. The practice treated more than 500 patients a month.

- 100% of patients indicated that the clinician was polite and considerate.
- 93% of patients indicated that the clinician listened to patients.
- 80% of patients indicated that the clinician gave enough opportunity to ask questions.
- 87% of patients indicated that the clinician answered all their questions.
- 93% of patients indicated that the clinician explained things in a way they could understand.
- 100% of patients indicated that they had confidence in the clinician.
- 100% of patients indicated that the clinician respected their views.
- 100% of patients indicated that the clinician obtained their consent before examination.
- 100% of patients indicated they were treated with privacy and dignity.
- 100% of patients indicated that they were able to understand or manage their conditions following consultation.

Involvement in decisions about care and treatment

Staff helped patients be involved in decisions about their care.

- The service did not use interpretation services for patients who did not have English as a first language. The registered manager informed us that 95% of the patients they see were Polish. They informed us that they see a few Russian and Ukrainian patients and they used google translate service to support these patients if necessary.
- The practice gave patients clear information to help them make informed choices; staff listened to them, did not rush them and discussed options for treatment with them.
- The practice's website provided patients with information about the range of treatments available at the practice.

Privacy and Dignity

The service respected and promoted patients' privacy and dignity.

- Staff recognised the importance of patients' dignity and respect.
- Staff password protected patients' electronic care records and backed these up to secure storage. They stored paper records securely.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

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

Responding to and meeting people's needs

- Access to the clinic was not suitable for people with limited mobility and those who used a wheelchair. The registered manager informed us that patients with limited mobility are usually seen in the ground floor consulting room and said that the patients were informed that the clinic had limited access for disabled patients when they book an appointment.
- The clinic did not have an accessible toilet suitable for disabled patients.
- Distressed patients were offered an alternative waiting area in the first floor which was quieter than the general waiting area.
- The service had information available for patients which explained the services offered by the clinic.
- The service had a website which could be accessed both in English and Polish.
- All patients attending the service referred themselves for treatment; none were referred from NHS services. The service informed us they referred patients to other services when appropriate.

Timely access to the service

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

- The clinic is open between 9am and 9pm Monday to Saturday and from 9am to 6pm on a Sunday.
- Patients had timely access to appointments.
- The appointment system was easy to use.
- We confirmed the practice kept waiting times and cancellations to a minimum.

Listening and learning from concerns and complaints

The service responded to complaints appropriately to improve the quality of care.

- Information about how to make a complaint or raise concerns was available in the reception area; however there was no complaints leaflet for patients. The day following the inspection the practice sent us a copy of a new complaints leaflet and informed us that this was made available for patients.
- The complaint policy and procedures were in line with recognised guidance. The service had received four complaints in the last year. We reviewed these complaints and found that they were satisfactorily handled in a timely way. The service recorded both written and verbal complaints.
- The registered manager told us they aimed to settle complaints in-house and invited complainants to speak with them in person to discuss their complaints.
- We did not see any evidence that the service learned lessons from individual concerns and complaints, or carried out and learned from analysis of trends in complaints.

Are services well-led?

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

Our findings

We found that this service was not providing well-led care in accordance with the relevant regulations.

Leadership capacity and capability;

The provider was not visible in the service; the service was managed by the registered manager who is a non-clinical person and had limited capacity and skills to deliver high-quality, sustainable care. However the registered manager showed a willingness to learn.

- There was no clinical leadership within the service. Each clinician worked separately and we saw no evidence of integrated care.
- The registered manager was visible and approachable and staff reported that they are happy with the support they received.
- We did not see any evidence of processes to develop leadership capacity and skills, including planning for the future leadership of the practice.

Vision and strategy

- The service had a vision to deliver high quality care and promote good outcomes for patients. However there was no strategy or business plans in place to deliver the vision.

Culture

- Staff stated they felt respected, supported and valued. They were happy to work in the service.
- Openness, honesty and transparency were demonstrated when responding to incidents and complaints. The provider was aware of and had systems to ensure compliance with the requirements of the duty of candour.
- Staff we spoke with told us they were able to raise concerns and were encouraged to do so. They had confidence that these would be addressed.
- The service did not have a system in place to perform appraisals for non-clinical staff. Clinical staff were supported to meet the requirements of professional revalidation where necessary.
- Staff had received equality and diversity training. Staff felt they were treated equally.

Governance arrangements

There were roles and responsibilities for non-clinical staff; however this was not sufficient for clinical staff in terms of leadership and accountability to support good governance and management. The registered manager had overall responsibility for the management and day to day running of the service and clinical leadership of the practice.

- Structures, processes and systems to support good governance and management were not effective.
- Staff were clear on their roles and accountabilities including in respect of safeguarding and infection prevention and control.
- The service did not have regular governance meetings. Most of the clinical staff did not attend these meetings as they all worked different days and hours. The service did not regularly discuss significant events and complaints.
- The service had policies, procedures and activities to ensure safety and assured themselves that they were operating as intended. However we found that some of the policies had to be improved, for example the incident reporting policy had no information for staff to differentiate between incidents and significant events.

Managing risks, issues and performance

There were processes for managing risks and issues but not performance.

- There was a system to identify, understand, monitor and address risks including risks to patient safety.
- The practice did not have a detailed business continuity plan in place to manage major incidents.
- We saw no evidence of any processes to manage current and future performance. The registered manager had an oversight of incidents and complaints; however there was no system to share these with clinicians.
- There was limited evidence of quality improvement as they had not undertaken any clinical audits or review of the care and treatment provided.

Appropriate and accurate information

The practice acted on appropriate and accurate information.

- The practice had processes in place to submit data or notifications to external organisations as required.

Engagement with patients, the public, staff and external partners

Are services well-led?

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

- The service had a system in place to gather regular feedback from patients. They obtained feedback from patients after each consultation and the patients could also submit their feedback on the service's website. They also used patient surveys to obtain patients' views about the service.
- Following feedback from patients they now kept a water fountain for patients in the waiting area.

Continuous improvement and innovation

- We saw no evidence of continuous improvement.

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 Family planning services Surgical procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment **How the regulation was not being met:** The provider had not ensured that care and treatment is provided in a safe way for service users. The service did not ensure there is a clear system in place to manage significant events, medicines and safety alerts and emergency medicines; chaperones are appropriately trained; all clinical equipment is regularly calibrated; there is a comprehensive business continuity plan for major incidents such as power failure or building damage, and the identity of patients is checked before registering new patients. Introduce a policy to ensure communication with patients' NHS GP where appropriate. This was in breach of regulation 12(1) and 12(12) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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 **How the regulation was not being met:** The provider had not ensured that effective systems and processes are in place to ensure good governance in accordance with the fundamental standards of care. The provider had not ensured to assess, monitor and improve the quality and safety of the services provided in the carrying on of the regulated activity. The service did not ensure a system to demonstrate quality improvement including for example clinical

This section is primarily information for the provider

Requirement notices

audits; medicines are appropriately prescribed; governance arrangements in place to improve clinical leadership within the service and learning from incidents, significant events and complaints.

This was in breach of regulation 17(1) and 17(2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Regulated activity	Regulation
Diagnostic and screening procedures Family planning services Surgical procedures Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing **How the regulation was not being met:** The provider had not ensured that all staff have received appraisal and training to enable them to carry out the duties that they are employed to perform. This was in breach of regulation 18(2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.