Kent Fertility

Inspection report

135-137 Masons Hill
Bromley
BR2 9HT
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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?	Good
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? – Good

Are services caring? – Good

Are services responsive? – Good

Are services well-led? – Requires improvement

We carried out an announced comprehensive inspection at Kent Fertility as part of our inspection programme of a new provider registration for the service. This was a first rated inspection for the service that was registered with the Care Quality Commission (CQC) in November 2021. During this inspection we inspected the safe, effective, caring, responsive and well- led key questions.

Kent Fertility is an independent provider of fertility services, located in Bromley Kent. 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. These include pregnancy scans (post 12 weeks) and a range of women's health and gynaecological consultations and procedures, such as hysteroscopy. (A hysteroscopy is a procedure used to examine the inside of the uterine cavity).

There are some exemptions from regulation by CQC which relate to particular types of regulated activities and services and these are set out in Schedule 1 and Schedule 2 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Kent Fertility provides a full range of fertility services for NHS and private patients and holds a licence with the Human Fertilisation and Embryology Authority (HFEA) to enable them to carry out this work. Fertility services provided are not within CQC scope of registration. Therefore, we did not inspect or report on those services.

Kent Fertility is registered with the Care Quality Commission to provide the following regulated activities: Treatment of disease, disorder or injury; Diagnostic and screening procedures; Surgical procedures.

The service's managing director is the registered manager. A registered manager is a person who is registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

Our key findings were:

- There was a lack of records to demonstrate that recruitment checks had been carried out in accordance with regulations for some staff.
- The monitoring and storage of staff documentation was not well managed and did not ensure leaders had clear oversight of their status.
- Arrangements for chaperoning were effectively managed.
- There were some processes to assess the risk of, and prevent, detect and control the spread of infection. However, staff records of immunisations were not monitored in line with current guidance.

Overall summary

- Record keeping for the use of ultrasound probes were not effectively kept in line with best practice guidance.
- There had been insufficient action taken to address and manage identified risks associated with Legionella bacteria.
- Mop heads and handles were mixed up.
- There were appropriate arrangements to manage medical emergencies and suitable emergency medicines and equipment were in place.
- Clinical record keeping was clear, comprehensive and complete, and in line with best practice guidance.
- There was effective and open communication and information sharing amongst the staff team.
- There were regular team meetings and staff felt motivated to contribute to driving improvement within the service.

The areas where the provider **must** make improvements as they are in breach of regulations are:

- Ensure care and treatment is provided in a safe way to patients.
- Establish effective systems and processes to ensure good governance in accordance with the fundamental standards of care.

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

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

- Review Sepsis awareness training for non-clinical staff.
- Review audits undertaken to demonstrate quality improvement for patients.

Dr Sean O'Kelly BSc MB ChB MSc DCH FRCA

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

Our inspection team

The inspection was led by a CQC inspector and included a second CQC inspector a GP specialist advisor and a Radiographer specialist advisor.

Background to Kent Fertility

Kent Fertility is an independent provider of fertility services, located in Bromley Kent. 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. These include pregnancy ultrasound scans (post 12 weeks) and a range of women's health and gynaecological consultations and procedures, such as hysteroscopy. The service offers consultations and treatments to people over the age of 18. The clinic provides NHS and private funded fertility healthcare.

The Registered Provider is The Hospital Fertility Group Limited, the service recently rebranded to– iTrust Fertility.

Kent Fertility is located at 135-137 Masons Hill Bromley BR2 9HT. The service is open from 8.30am to 5.30pm and Saturday morning. Out of hours support is available 24 hours per day, 7 days per week, for those patients undergoing fertility treatments. The services also sees patients at Sussex Downs Fertility Centre located at 6 Park View, Alder Close, Eastbourne, BN23 6QE, limited services are also available from a satellite centre located at 18 Marine Parade, Kemptown, Brighton BN2 1TL.

The service is run from a self-contained, two storey premises which are owned by the provider. The service comprises a suite of consultation and treatment rooms, an operating theatre and recovery suite, a waiting room and reception area and administrative offices. Patients are able to access toilet facilities on the ground floor. Access to the premises at street level is available to patients with limited mobility.

The service website address is www.thesussexdownsfertility.com

Services are managed by the managing director, a centre manager and a quality manager, supported by a team of administrators. A medical director, who is a consultant gynaecologist and obstetrician, oversees the care provided by a team of specialist fertility consultants, a sonographer and nurses. The service employs consultant anaesthetists on a sessional basis to administer sedation to patients undergoing some procedures. Some staff work across multiple sites, including the satellite location in Brighton and another centre managed by the provider, located in Eastbourne.

How we inspected this service

We visited Kent Fertility on 10 January 2023. The team was led by a CQC inspector, accompanied by a second CQC inspector a GP specialist advisor and a Radiographer specialist advisor. Before the inspection, we reviewed notifications received about the service, and a standard information questionnaire completed by the service. During the inspection, we interviewed staff, made observations and reviewed documents

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 safe as Requires improvement because:

Staff were unsure who the safeguarding lead was, some infection control concerns were identified on the day of the inspection, although comprehensive risk assessments had been undertaken, only some of the recommended actions had been addressed. There was a lack of oversight for staff recruitment checks and the storage of staff recruitment files.

Safety systems and processes

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

- The service had systems to safeguard children and vulnerable adults from abuse. The provider's safeguarding vulnerable adult's policy provided appropriate guidance for staff. Staff were unclear who was the safeguarding lead was, we asked three staff members and they each told us a different member of staff.
- Treatment was offered to those aged over 18 years of age and no children were treated by the service.
- We reviewed personnel files of six staff members employed by the service and found that some recruitment documents could not be found. For example, for three staff members a CV or application could not be found, all staff files had no interview summary, two staff files did not have a signed contract, in four staff files there was no proof of identity, three staff members references could not be found, a DBS check could not be found in four staff members files, in addition to this two staff members employed by the service had commenced work prior to the DBS being issued and no risk assessment had been carried out whilst the staff members had started working at the service. (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). No induction check list could be found for any staff members. When we raised these concerns with two managers they explained they did not usually review staff files as recruitment was managed by Human Resources (HR) and the person responsible for HR was not available on the day of the inspection so had given the managers access to the electronic system used for storing recruitment records. The service was informed they could provide evidence shortly after the inspection of the documents not seen on the day, however no documents were submitted.
- There was a lack of a clear approach to ensure that all required recruitment checks were completed. The monitoring and storage of staff recruitment documentation was not well managed and did not ensure leaders had clear oversight of their ongoing status. There was a lack of an overarching view and monitoring of records held for each staff member.
- The service had some systems to identify and manage health and safety risks within the premises, but these were not always followed up in a timely manner. For example, a Legionella risk assessment had been carried out by an external supplier in October 2022. (Legionella is a particular bacterium which can contaminate water systems in buildings). We found that the provider had taken some steps to address the actions identified, however several outstanding actions had not been addressed. For example, there was a lack of monitoring of water temperatures within the premises and sampling of water supplies, in order to minimise the risk of Legionella contamination. When we raised this with the service, they explained that they had created a spreadsheet and were going to start recording and monitoring, however at the time of the inspection this was not in place.
- On the day of inspection, we found there was a lack of tracking in relation to ultrasound cleaning probes, we found for the theatre this was recorded on charts in the main ultrasound room, however patient details were not being recorded on the form only signed by staff members, this prevented an audit trail which was not in line with best practice guidance. On the day of inspection, we found the service was not appropriately monitoring cleaning equipment, for

example we saw mixed up mop heads and handles, and a mop head left in a bucket full of dirty water. Cleaning schedules had last been signed off November 2022. There was guidance and information, including risk assessments and safety data sheets, available to staff to support the control of substances hazardous to health (COSHH). There were documented risk assessments in place to manage risks associated with the premises and general environment.

- The provider ensured that facilities and equipment were safe and that equipment was maintained according to manufacturers' instructions. There were systems for safely managing healthcare waste.
- 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.
- There was a fire risk assessment in place and appropriate fire-fighting equipment located within the premises which was regularly serviced and maintained. The service had a fire policy in place, however this made reference to a member of staff being a fire warden, however the staff member no longer worked for the service.
- Staff had undertaken fire safety training and had participated in a fire drill.
- The provider mainly ensured that facilities and equipment were safe, and that equipment was maintained according to manufacturers' instructions. We reviewed records to confirm that electrical equipment had undergone portable appliance testing in November 2022.

Risks to patients

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

- There were arrangements for planning and monitoring the number and mix of staff needed.
- We reviewed six staff records, and none of these staff members had a completed induction check in their file, however staff were up to date with role specific training.
- Staff understood their responsibilities to manage emergencies and to recognise those in need of urgent medical attention. Non-clinical staff had not received training to help them identify severe infections, for example sepsis.
- We saw medical indemnity cover for two clinical staff; however, the service could not find the cover for another clinical member of staff. When we raised this with the service, they explained that all staff were covered under a group policy. When we asked to see this the service showed us public and employer's liability insurance, not medical indemnity. The service was informed they could provide evidence shortly after the inspection of the documents not seen on the day, however no documents were submitted.
- We reviewed arrangements within the service to respond to medical emergencies. We found there were appropriate supplies of emergency medicines available to staff in the event of a medical emergency. There was an oxygen supply and a defibrillator available to support the management of medical emergencies, which were subject to regular checks.
- Staff had completed training in basic life support.

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 saw showed that information needed to deliver safe care and treatment was available to relevant staff in an accessible way.
- Individual care records were written and managed in a way that kept patients safe. Clear, accurate and contemporaneous patient records were consistently kept. Treatment planning and information were fully documented. The provider utilised a clinical notes template to promote consistency of clinical record keeping.
- Consent processes were comprehensive and consistently applied. There was a documented consent policy. Patient records clearly documented the consent process and discussions between the practitioner and patient.
- The provider had undertaken auditing of clinical records to ensure completeness and consistency.

Requires Improvement

Are services safe?

- The service had effective systems for sharing information with staff and other agencies, for example, the patient's NHS GP, to enable them to deliver safe care and treatment.
- Patients' NHS GP details were routinely recorded. Our review of clinical records confirmed that the service sought patient consent to share information with their GP and did so at all stages of treatment.
- The provider utilised a cloud-based, password protected, electronic system to ensure consistency and security of clinical record keeping. Historical paper-based records were stored securely in locked cupboards.
- 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 service had reliable systems for appropriate and safe handling of medicines.

- There were systems and arrangements for managing the safe handling of medicines and prescribing practices in a way which minimised risks to patients.
- The service undertook infrequent prescribing in relation to services which fell into scope of CQC registration, but ensured that when required, staff prescribed and administered medicines to patients, and gave advice on medicines, in line with legal requirements and current national guidance.
- Medicines requiring refrigeration were stored in a refrigerator which was monitored to ensure it maintained the correct temperature range for safe storage.
- Appropriate processes were in place for the ordering, receipt and monitoring of stock medicines held and staff kept accurate records of those medicines.
- Emergency medicines were readily available and in date and supplies were regularly checked. There were documented records of those checks.

Track record on safety and incidents

- There were some monitoring and auditing processes in place to provide assurance to leaders that systems were operating as intended. There were risk assessments in place in relation to safety issues to support the management of health and safety within the premises.
- There were some comprehensive risk assessments in relation to safety issues, however actions were not always followed up, for example, risks associated with the management of Legionella bacteria had not been addressed following a risk assessment undertaken.
- There was some monitoring and review of activities to support the provider in identifying potential risks within the service. The provider utilised a corrective and preventive action process (CAPA) in order to identify and investigate risks and incidents and implement effective corrective or preventive actions to reduce the risk of recurrence.

Lessons learned and improvements made

The service learned and made improvements when things went wrong.

- There was a system for recording and acting on significant events. Staff understood their duty to raise concerns and report incidents and near misses. Leaders and managers supported them when they did so.
- There were adequate systems for reviewing and investigating when things went wrong. The service learned and shared lessons identified themes and took action to improve safety in the service.
- The provider was aware of and complied with the requirements of the Duty of Candour. The provider encouraged a culture of openness and honesty. The service had systems in place for knowing about notifiable safety incidents.
- The service gave affected people reasonable support, truthful information and a verbal and written apology.

Requires Improvement

Are services safe?

- 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 an effective mechanism in place to disseminate alerts to all members of the team including sessional and agency staff.

Good

Are services effective?

We rated effective as Good because:

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 (relevant to their service)

- Clinicians employed by the service had high levels of skills, knowledge and experience to deliver the care and treatment offered by the service. For example, the medical director was a consultant gynaecologist & obstetrician, specialising in reproductive health and surgery. Consultant anaesthetists were employed to deliver intravenous sedation to patients undergoing some procedures. Clinicians kept up to date with current evidence-based practice. We found that clinicians assessed needs and delivered care and treatment in line with relevant current legislation, standards and guidance.
- We reviewed clinical records relating to five patients who had received treatment within the service. We found there was a consistent approach to clinical record keeping and risks to the patient were comprehensively assessed, discussed and documented. Clear, accurate and contemporaneous clinical records were kept. Treatment planning and diagnostic information were fully documented.
- The service ensured they provided information to support patients' understanding of their treatment, including pre and post-treatment advice and support. We saw that the service provided a series of comprehensive information leaflets for patients.
- In the event of concerns or complications, patients were able to access post treatment support via follow up appointments and also on the telephone. The service provided access to 24-hour telephone support to patients undergoing treatment.
- Staff assessed and managed patients' pain where appropriate. Patients were prescribed local anaesthetic medicines or intravenous sedation prior to some procedures, where appropriate. For example, patients undergoing hysteroscopy.
- We saw no evidence of discrimination when making care and treatment decisions.

Monitoring care and treatment

The service was involved in some quality improvement activity.

- The service used information about care and treatment to assess the need to make improvements.
- Staff employed by the service and those working on a sessional basis under practising privileges, were subject to review of their performance within the service. There was a programme of clinical supervision of staff which included monitoring and assessment of defined clinical competencies.
- Staff of all levels participated in a weekly clinical, multi-disciplinary team meetings, in which care and treatment of individual patients was reviewed and discussed in order to promote optimum treatment outcomes and to share learning.
- There was a developing programme of quality improvement activity within the service. For example, the service undertook quarterly auditing of infection prevention and control and clinical record keeping processes. The service employed a quality manager who worked in conjunction with the centre manager, medical director and managing director to promote improvement and implement quality monitoring activities.
- Whilst the service had undertaken quality improvement, the audits that we saw were single cycle and non-clinical audits.
- The provider implemented a series of processes and activities which enabled them to identify and monitor incidents, non-conformities and near misses resulting in corrective and preventative actions.

Good

Are services effective?

- The provider was required to implement a comprehensive programme of quality assurance processes in relation to their delivery of fertility services and to meet the requirements of their HFEA licence. These services fell outside of CQC regulation.

Effective staffing

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

- The provider had clearly set out the training all staff were required to complete in key areas, via an online platform. For example: vulnerable adult and child safeguarding, infection control, information governance, health and safety, basic life support, confidentiality, and the Mental Capacity Act 2005.
- We reviewed training records of six staff and found that all six had completed training in those key areas.
- The provider demonstrated some understanding of the individual learning needs of staff and provided protected time and training to meet them.

Coordinating patient care and information sharing

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

- Patients who used the service received coordinated and person-centred care. Staff referred to, and communicated effectively with other services where appropriate. For example, the provider worked closely with an external pathology laboratory to ensure blood testing results were processed in a safe and timely manner.
- Our review of care records confirmed that before providing treatment, doctors at the service ensured they had adequate knowledge of the patient's health, previous medical and medicines history.
- Patient information was shared routinely with patient consent, and the information needed to plan and deliver care and treatment was available to relevant staff in a timely and accessible way.
- All patients were asked for consent to share details of their consultation and treatment, with their GP, when they registered with the service. Clinicians routinely dictated letters to be typed and sent to the patient's GP, following consultation or treatment, where the patient had given their consent.
- There were effective arrangements for supporting patients to access care with other related services. For example, patients were provided with information to promote access to counselling and support networks.

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.

- Patients were provided with extensive information about procedures, including the benefits and risks of treatments provided. The service provided access to timely advice and support to patients, including out of hours support.
- In the event that patients presented with concerns or complications post treatment, appropriate support and advice was provided. Staff told us that patients would be promptly reviewed within the service if required.
- Where patients' needs could not be met by the service, staff told us they redirected them to the appropriate service for their needs

Consent to care and treatment

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

Good

Are services effective?

- Staff understood the requirements of legislation and guidance when considering consent and decision making.
- Staff supported patients to make decisions. Where appropriate, they assessed and recorded a patient's mental capacity to make a decision.
- The service monitored the process for seeking consent appropriately.

Good

Are services caring?

We rated caring as Good because:

Kindness, respect and compassion

Staff treated patients with kindness, respect and compassion.

- The service gave patients timely support and information in relation to their care and treatment.
- Staff understood patients' personal, cultural, social and religious needs. They displayed an understanding and non-judgmental attitude to patients.
- The service actively invited feedback on the quality of care patients received via a satisfaction survey sent out to patients following their treatment. Patients were also able to complete a survey whilst at the service, utilising an electronic hand-held device.
- The survey provided patients with the opportunity to provide feedback and make suggestions for improvements to services. The service collated this information in order to identify areas for improvement and feedback which required a direct response to the patient.
- The service's website also included links to encourage patients to provide reviews on Google, Facebook and the HFEA website.

Involvement in decisions about care and treatment

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

- We saw that the service provided comprehensive information about the service and treatments offered, on their website and within the centre. We noted that information on display within the patient waiting area included for example, the provider's complaints procedure and confidentiality statement.
- The service ensured that patients were provided with all the information they required to make decisions about their treatment prior to treatment commencing. The service provided comprehensive verbal and written pre and post-treatment advice and support to patients.
- Some information about pricing was available to patients on the service's website and within the service. Patients were provided with individual quotations for their treatment following their first consultation.
- Translation services were available for patients who did not have English as a first language. Staff within the service were able to speak several languages. There was a hearing loop in place and reception staff could support patients in its use.

Privacy and Dignity

The service respected patients' privacy and dignity.

- Staff recognised the importance of people's dignity and respect. Consultations and treatments took place behind closed doors and conversations could not be overheard.
- Patients were collected from the waiting area by the clinician and escorted into the consultation room.
- Chaperones were available should a patient choose to have one. There were signs on display within the service to encourage patients to request a chaperone. Staff who provided chaperoning services had received training to carry out the role.
- Reception staff were aware that if patients wanted to discuss sensitive issues or appeared distressed, they could offer them a private room to discuss their needs.

Good

Are services caring?

- Staff complied with the service's information governance arrangements. Processes ensured that all confidential electronic information was stored securely on computers. Staff working in the reception area operated a clear desk policy and hard copy documents were promptly locked away.

Good

Are services responsive to people's needs?

We rated responsive as Good because:

Responding to and meeting people's needs

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

- The provider understood the needs of their patients and arranged services in response to those needs. For example, some Saturday appointments were available to meet the treatment needs of individual patients. Appointments were available to patients at an alternative satellite location in order to promote ease of access to services.
- The facilities and premises were maintained to a high standard and were appropriate for the services and treatments delivered. Services were delivered over two floors. Patients with limited mobility were able to access the premises at street level.
- Reasonable adjustments had been made so that people in vulnerable circumstances could access and use services on an equal basis to others. For example, there was a hearing loop and translation support services were available.
- Patients were directed to NHS services if they required treatment for certain conditions and for urgent assistance when the service was closed.

Timely access to the service

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

- Appointments could be booked in person or by telephone. Patients usually had appointments within a short time from their request. Weekend appointments were available to accommodate required treatment scheduling.
- Waiting times, delays and cancellations were minimal and managed appropriately.
- Referrals to other services were undertaken in a timely way and were managed appropriately. For example, where patients required ongoing referral to secondary care services.

Listening and learning from concerns and complaints

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

- Information about how to make a complaint or raise concerns was available within the service. There was a patient charter and information about how to make a complaint on the provider's website.
- Staff treated patients who made complaints compassionately.
- The service was able to demonstrate how appropriate and timely actions were taken in response to a complaint. However, our review was limited, as complaints received related mainly to services and treatments which fell outside of CQC regulation.
- There was evidence that complaints had been discussed and the learning shared across the organisation. Complaints were discussed at regular team and operational meetings.

Requires Improvement

Are services well-led?

We rated well-led as Requires improvement because:

The was a lack of oversight for monitoring and storage of staff documentation in relation to staff recruitment. Some aspects of infection control had not been effectively monitored.

Leadership capacity and capability;

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

- Leaders demonstrated the capacity to implement systems and processes to support the delivery of high-quality care.
- Leaders had awareness and understanding of the issues and priorities relating to the quality and future of the service.
- Leaders within the service were visible and approachable. They worked closely with the team of staff and others and told us they prioritised compassionate and inclusive leadership.
- There was a staffing structure in place across the service and staff were aware of their individual roles and responsibilities. The provider had identified individual members of staff to assume lead roles in key areas. For example, centre management, quality management, and infection prevention and control.
- There were formal and informal lines of communication between staff working within the service. Staff spoke of team meetings they attended, and we saw records of those meetings.

Vision and strategy

- The provider had a vision and desire to provide a high-quality service that put caring at its heart, and which promoted good outcomes for patients.
- Staff we spoke with were consistent in their awareness and understanding of the vision, values and strategy of the service and their role in achieving them. Staff felt motivated to contribute to driving improvement within the service.

Culture

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

- Staff we spoke with told us they felt respected, supported and valued. They were proud to work for the service.
- The service focused on the needs of patients.
- Leaders and managers encouraged behaviour and performance consistent with the vision and values.
- The service was focused upon the needs of patients and ensuring the best possible outcomes.
- Staff at all levels were fully engaged in ensuring the promotion of optimum outcomes for patients.
- Staff were recognised for their achievements. We noted the provider had recently introduced a monthly staff recognition award.
- Staff told us they could raise concerns and suggestions for improvement and were encouraged to do so.
- The provider was aware of and had systems to ensure compliance with the requirements of the duty of candour.
- There were processes for providing staff with the development they needed. Staff employed by the service had been in post for less than six months so had not had an appraisal, however they had regular reviews of their performance in the form of one-to-one meetings with their manager.
- Clinical staff were supported to meet the requirements of professional revalidation where necessary.
- There was a strong emphasis on the well-being of all staff. We saw records which confirmed all staff had participated in one-to-one review meetings with their line manager.
- The service actively promoted equality and diversity. It identified and addressed the causes of any workforce inequality. Staff had received equality and diversity training. Staff felt they were treated equally.

Requires Improvement

Are services well-led?

- There was a culture of promoting positive relationships and prompt and effective communications between staff. Staff team meetings were held regularly. For example, staff participated in a weekly clinical, multi-disciplinary team meeting, in which care and treatment of individual patients was reviewed and discussed in order to promote optimum treatment outcomes and to share learning.
- Organisational communications were shared effectively across the team. The provider had developed a staff newsletter to promote information sharing across the team and other sites.
- The provider implemented an online platform in which they stored for example, organisational policies, records of meetings, clinical protocols and staff newsletters. The software package provided a secure place to store, organise, share, and access information from any device.

Governance arrangements

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

- Structures, processes and systems to support good governance and management were clearly set out and understood for some areas of the service.
- Staff were not always clear on staff members roles, for example staff were unclear who the safeguarding lead was, we asked three staff members and they each told us a different member of staff.
- Leaders held regular update meetings to discuss and review the service.
- There was an effective staff meeting structure and systems for cascading information within the organisation.
- The provider had appointed a quality manager who worked alongside the centre manager to implement governance processes and policy development.
- There were mainly appropriate policies, procedures and activities to ensure the safety of staff and patients. However, there were some instances where processes were not operating as intended and did not ensure safe care and treatment. For example, there was a lack of recruitment records including CV's/applications, signed contacts, proof of identity, references, DBS, medical indemnity, interview summary, and induction checklist that could not be found on the day of the inspection. Two staff members employed by the service had commenced work, prior to their DBS being issued and no risk assessment had been done whilst the staff members had started working at the service.
- There were incomplete records kept for staff immunisation.
- The provider utilised a corrective and preventive action process (CAPA) in order to identify and investigate risks and incidents within the service. However, some identified risks were not always included in action planning or followed up in a timely manner. For example, risks associated with the management of Legionella bacteria had not been addressed following a risk assessment undertaken in October 2022.
- There were some monitoring and auditing processes in place. However, these had not always identified when systems were not operating as intended or in line with current guidance. For example, infection prevention and control audits had not identified risks and shortfalls associated with Legionella management, staff immunisation requirements or the tracking system used for monitoring ultrasound cleaning probes, or the daily cleaning schedule had not been signed off since November 2022.
- Staff clearly understood their individual roles and responsibilities and were well supported by the centre manager and other leaders in fulfilling those roles.
- There were arrangements in line with data security standards for the availability, integrity and confidentiality of patient identifiable data, records and data management systems.
- The service submitted data or notifications to external organisations as required.
- We saw medical indemnity cover for two clinical staff; however the service could not find the cover for another clinical member of staff. When we raised this with the service, they explained that all staff were covered under a group policy. When we asked to see this the service showed us public and employer's liability insurance, not medical indemnity.

Requires Improvement

Are services well-led?

- The provider had business continuity processes in place.

Managing risks, issues and performance

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

- There were some governance processes to ensure leaders were able to identify, understand, monitor and address current and future risks including risks to patient safety.
- Leaders had oversight of safety alerts, incidents, and complaints. There was a system for recording and acting upon significant events. Staff understood their duty to raise concerns and report incidents and near misses. Leaders and managers supported them when they did so.
- Auditing of patient records was undertaken to review compliance with the provider's expected standards of clinical record keeping.
- Staff told us they regularly attended staff meetings. We saw documented evidence of staff meetings, where for example, updates, incidents and complaints had been discussed and outcomes from the meetings cascaded to staff.

Appropriate and accurate information

There was a lack of appropriate and accurate information available in some areas.

- Quality and operational information was used to monitor performance and drive improvement.
- The service used feedback from patients combined with performance information, to drive improvement.
- There was a lack of records to demonstrate that recruitment checks had been carried out in accordance with regulations for some staff. Staff immunisations were not monitored in line with current guidance.
- The monitoring and storage of staff documentation was not well managed and did not ensure leaders had clear oversight of their ongoing status.
- 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. Clear, accurate and contemporaneous patient records were kept. Treatment planning and treatment records were fully documented.
- Staff told us they had attended regular staff meetings. We saw documented evidence of staff meetings, where for example, updates, patient feedback and complaints had been discussed, and outcomes and learning from the meetings cascaded to staff.
- There were arrangements in line with data security standards for the availability, integrity and confidentiality of patient identifiable data, records and data management systems. Processes ensured that all confidential electronic information was stored securely on computers. All patient information kept as hard copies was stored in locked cupboards within a locked room. Staff demonstrated a good understanding of information governance processes.
- The provider ensured document management protocols were followed, which included version control, author and review dates.

Engagement with patients, the public, staff and external partners

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

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

Requires Improvement

Are services well-led?

- The service was transparent and open with stakeholders about the feedback received.

Continuous improvement and innovation

- The service made use of internal and external reviews of incidents and complaints. Learning was shared and used to make improvements.
- Leaders and managers encouraged staff to take time out to review individual and team objectives, processes and performance.
- The service had achieved International Organisation for Standardisation (ISO) 9001 accreditation for quality management. (ISO supports the development of standards to ensure the quality, safety and efficiency of products, services and systems.)

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 Surgical procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment The provider had not done all that was reasonably practicable to ensure care and treatment was provided in a safe way for service users. In particular: • To ensure tracking in relation to decontamination of transvaginal ultrasound probes per individual patient, to ensure an audit trail of decontamination for each intracavity examination. • To ensure action is taken to address and manage identified risks associated with Legionella bacteria. • To ensure oversight of the monitoring of cleaning in relation to cleaning equipment and schedules • To ensure required recruitment checks are carried out for all staff and documents stored effectively. • To ensure the monitoring of staff immunisations in line with current guidance. • To ensure all staff are aware of and understand who the safeguarding lead is. This was in breach of regulation 12(1)(2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Regulated activity	Regulation
Diagnostic and screening procedures Surgical procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance The provider was unable to demonstrate that systems and processes were implemented effectively to assess, monitor and improve the quality and safety of the services provided in the carrying on of the regulated activities.

This section is primarily information for the provider

Requirement notices

In particular:

- To adequately identify, assess and monitor infection prevention and control risks within the service.
- To implement effective monitoring and storage of staff documentation in relation to staff recruitment, and immunisation, to ensure leaders have a clear oversight of their ongoing status and associated risks.

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