Surrey Cardiovascular Limited - Huxley Road

Quality Report

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This report describes our judgement of the quality of care at this location. It is based on a combination of what we found when we inspected and a review of all information available to CQC including information given to us from patients, the public and other organisations

Overall summary

We carried out an announced comprehensive inspection on 1 March 2016 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 this service was not providing safe care in accordance with the relevant regulations.

Are services effective?

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

Are services caring?

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

Are services responsive?

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

Are services well-led?

We found this service was providing well-led care in accordance with the relevant regulations.

Background

The Surrey Cardiovascular Clinic (SCVC) is an independent clinic specialising in cardiology services related to the early diagnosis, investigation and treatment of patients with all forms of heart disease. It is a private outpatient clinic which provides advice for a range of problems, including chest pain, heart failure, high blood pressure and breathlessness. Patients can undergo a range of cardiovascular tests including stress testing and electrocardiograms. The service is consultant led and supported by a team of nurses and technicians.

The lead consultant is the registered manager. A registered manager is a person who is registered with the Care Quality Commission (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.

Summary of findings

The clinic is located in self-contained premises close to the Royal Surrey County Hospital. It has free parking and the buildings are accessible to disabled patients. Its facilities included three consulting rooms, four investigation/procedure rooms, reception and waiting area. Administration staff were based in a building nearby. The clinic had a service level agreement with a pathology laboratory.

The clinic was open Monday to Friday 8am to 5pm. Tuesday and Thursday's appointments were available until 8pm. There was no out of hour's provision or agreement with external stakeholders.

As part of our inspection, we asked for CQC comment cards to be completed by patients prior to our inspection. We received 55 comment cards, which were all positive about the standard of care received. Patients reported they had received an excellent service and staff were caring and helpful.

Our key findings were:

- There was an open and transparent approach to safety and an effective system in place for reporting and recording incidents.
- Staff had the skills, knowledge and experience to deliver effective care and treatment.
- The clinic had good facilities and was well equipped to treat patients and meet their needs.
- There were systems in place to check all equipment had been serviced regularly.
- Risks to patients were well managed. There were effective systems in place to reduce the risk and spread of infection.
- Staff were up to date with current guidelines and were led by a proactive management team.
- Staff assessed patient's needs and delivered care in line with current evidence based guidance.
- Patients said they were treated with compassion, dignity and respect and they were involved in their care and decisions about their treatment.
- Staff were kind, caring, competent and put patients at ease.
- Information about services and how to complain was available and easy to understand.
- There was a clear leadership structure and staff felt supported by management. The clinic proactively sought and acted on feedback from staff and patients.
- The provider was aware of and complied with the requirements of Duty of Candour.
- All staff had received training in the Mental Capacity Act 2005 and obtained consent prior to treatment. However, we found on one occasion this was not always done in line with legislation and national guidance but was done in the patients best interest.

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

- All staff must receive training in safeguarding children to a level that is appropriate for their role in line with nationally recognised guidance.
- Staff must have appropriate training in gaining consent from children which is relevant to the child's age and capacity to consent, including knowledge and understanding of 'Gillick competence'.

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**:

- The registered provider should ensure they assess, monitor and improve the quality of service by strengthening the programme of clinical audits to ensure these are completed with timelines for improvement and review are identified and implemented.
- The provider should ensure that all patients who have capacity understand and consent to their treatment, regardless of any physical illness which reduces their ability to verbalise their consent.

Summary of findings

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Medical care

Summary of this inspection

Background to Surrey Cardiovascular Limited - Huxley Road

The inspection was carried out on 1 March 2016. Our inspection team was led by a CQC Lead Inspector. The team included a cardiologist specialist advisor, a CQC inspection manager and three CQC inspectors.

Prior to the inspection we had asked for information from the provider regarding the service they provided. We informed other organisations, for example Healthwatch, we were inspecting the service. However we did not receive any information of concern from them.

During our visit we:

- Spoke with a range of staff including the registered manager, clinical staff, administration and reception staff.
- Reviewed the personal care and treatment records of patients.
- Reviewed comment cards where patients and members of the public shared their views and experiences of the services.

To get to the heart of patients' experiences of care and treatment, we always ask the following fives 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.

Summary of this inspection

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). Patients were at risk of harm because systems and processes were not in place or had weaknesses. For example, the safeguarding lead was not trained to level 3 for vulnerable children in line with national guidelines.

However, there were effective systems in place for the reporting, recording and learning from incidents. Staff were aware of and able to explain duty of candour. Procedures were in place to manage and respond to medical emergencies. The staffing levels were appropriate for the provision of care and treatment with a good skill mix across the service. We found the equipment and premises were visibly clean and well maintained with a planned programme of maintenance.

Are services effective?

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

The clinic provided evidence based care which was focussed on the needs of the patients. Consultations were carried out in line with best practice guidance such as the National Institute for Health and Care Excellence (NICE). Patients received a comprehensive assessment of their health needs which included their medical history. We saw examples of effective and collaborative team working. The staff were up to date with current guidance and received professional development appropriate to their role and learning needs. Staff who were registered with a professional body such as the Nursing and Midwifery Council (NMC) had opportunities for continuing professional development (CPD) and were meeting the requirements of their professional registration. All staff had received training in the Mental Capacity Act 2005 and obtained consent prior to treatment.

However, this was not always done in line with legislation and national guidance And protocols, training and guidance did not refer to Gillick competencies for young people

Are services caring?

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

Summary of this inspection

Feedback from patients through completed comment cards was positive about their experience at the clinic. Patients told us they were listened to, treated with respect and were involved in the discussion of their treatment options. This included the risks, benefits and costs. Information for patients about the service was easy to understand and was accessible. Patients said staff displayed empathy, friendliness and professionalism towards them. We observed the staff to be caring, committed to their work and maintain confidentiality.

Are services responsive?

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

The facilities at the clinic were comfortable and welcoming to patients. The service had made reasonable adjustments to accommodate patients with a disability or impaired mobility. Patients told us through comment cards the staff were responsive to their needs and supported patients who were anxious or nervous. The service handled complaints in an open and transparent way and apologised when things went wrong. The complaint procedure was provided in its patient information pack and available in the reception area.

Are services well-led?

We found that this service was providing well-led care in accordance with the relevant regulations.

There was a management structure in place and staff understood their responsibilities. The registered manager was approachable and the culture within the service was open and transparent. Staff were aware of the organisational ethos and philosophy and told us they felt well supported and were confident to raise concerns. There were effective clinical governance and risk management structures in place. The service assessed risks to patients and staff and audited areas of their practice as part of a system of continuous improvement and learning. The service sought the views of staff and patients. The registered manager ensured policies and procedures were in place to support the safe running of the service.

Medical care

Safe	
Effective	
Caring	
Responsive	
Well-led	

Are medical care services safe?

Reporting, learning and improvement from incidents

There was an effective system in place for the reporting and recording of incidents. The clinic carried out a thorough analysis of incidents; feedback and actions taken were documented.

We looked at seven incidents reported January 2015 to January 2016. All had been investigated and actions identified and implemented to ensure the safety of patients and staff. For example, an incident regarding the abnormally high recordings from a patient's 24 hour blood pressure monitoring, had resulted in the production of a patient information sheet. This explained to the patient what to expect during the monitoring and what actions to take in the event of discomfort.

Staff told us that action had been taken after a patient experienced a cardiac arrest in the exercise testing room. The layout of the equipment in the room had been organised to enable easier access for the emergency trolley.

Staff were able to describe the rationale and process of duty of candour, Regulation 20 of the Health and Social Care Act 2008. This relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of 'certain notifiable safety incidents' and provide reasonable support to that person. Service users and their families were told when they were affected by an event where something unexpected or unintended had happened. The clinic apologised and informed people of the actions they had taken.

Reliable safety systems and processes (including safeguarding)

The clinic did not have clearly defined and embedded systems, processes and practices in place to keep people safe and safeguarded from abuse, which included:

The responsibility of a safeguarding lead is to ensure providers have the right systems and process in place to make sure children and adults were protected from risk or actual abuse and neglect. National statutory guidelines 'Working together to safeguard children – a guide to interagency working to safeguard and promote the welfare of children' (2015) states safeguarding leads are to be trained to level 3 for vulnerable children as the lead takes the responsibility for the organisations safeguarding arrangements. However, the providers safeguarding lead was trained to level 2. This is considered a risk as children could accompany an adult who were visiting the clinic. Providers must have effective procedures and processes to prevent people using the service from being abused by staff or other people they may have contact with when using the services, including visitors.

The clinic accepted referrals for younger patients, 16 and 17 year olds, with suspected heart conditions. Patients under the age of 16 would need to undergo investigations at a hospital or clinic with staff and facilities for paediatric care.

Clinical and administrative staff were trained to level 2 safeguarding vulnerable adults. Medical staff were trained to level 2 safeguarding vulnerable adults and level 2 safeguarding vulnerable children. Staff we spoke with were able to demonstrate they understood their responsibilities.

Relevant legislation and local requirements and policies were accessible to all staff. The policies clearly outlined who to contact for further guidance if staff had concerns

about patients welfare. Staff were able to describe a documented reporting system for raising concerns such as safeguarding, whistleblowing and complaints. They told us they were confident to use it.

We reviewed personnel files and found recruitment checks had been undertaken prior to employment. Checks required included proof of identification, references, proof of qualifications, and registration with the appropriate professional body.

Patient's individual records were written and managed in a way to keep people safe. These included ensuring records were accurate, complete, eligible, up-to-date and shared with the referring clinician and the patients NHS GP. Records were both paper and electronic. We saw that paper records were stored in locked cupboards.

Medical emergencies

The clinic had procedures and equipment in place to respond to medical emergencies. The clinic had two receptionists who were designated first aiders. We saw they had achieved a First Aid at Work Certificate. Two administrative staff were also trained in 'emergency first aid at work' and we saw evidence of this. This ensured there was sufficient cover on the premises to cover sickness and annual leave.

The consulting and treatment rooms had a push button system to alert other healthcare staff to an emergency. We saw permanent staff were trained in basic life support (BLS) and the use of automatic external defibrillators (AED). An AED is a portable electronic devise that analyses life threatening irregularities of the heart and delivers an electric shock to attempt to restore a normal heart rhythm in an emergency situation.

The clinic had an emergency trolley and two AED's. The trolley and one AED were in the clinical room and the other AED was in the exercise room. The trolley contained emergency medicines and oxygen. The medicines were stored in locked drawers, sealed with tamperproof ties and recorded on the checklist. We saw the top of the emergency trolley was checked every working day and the locked cupboards monthly or sooner if used. The AED equipment was checked on the days there were clinics.

Other than administering emergency basic life support, the patient would then be transferred to hospital following a 999 call to the emergency services.

Staffing

There was adequate staffing to meet the demands of the service, with an integrated multi-disciplinary team focus on holistic care. The clinic employed three clinical staff, 1.4 Whole Time Equivalent (WTE) and 11 administrative staff (7.6 WTE). Technical support was provided by cardiac physiologists. The clinic had a service level agreement with another organisation which they contracted to provide 14 hours of technologist time per week. Bank nurses and physiologists were contracted to provide cover as required by the clinic.

Medical practitioners had practicing privileges. The granting of practising privileges is a well-established process within independent hospital healthcare sector whereby a medical practitioner is granted permission to work in a private hospital or clinic in independent private practice, or within the provision of community services. There should be evidence that the provider has complied with legal duty to ensure that the regulation 19 in respect of staffing and fit and proper persons employed are complied with. Where practising privileges are being granted, there should be evidence of a formal agreement in place. We were provided with the documentation of the formal agreements that set out the rules and conditions of employment for the medical practitioners working under practising privileges.

We were provided with documentation that informed us of the medical practitioner's qualification, General Medical Council (GMC) number and revalidation, appraisal date, indemnity and Disclosure and Baring Services (DBS) check. 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.

Monitoring health & safety and responding to risks

There were procedures in place for monitoring and managing risks to patients and staff safety. For example the administration building and pathology laboratory were separated from the clinic by a busy road. This was risk assessed. Staff were encouraged to wear high visibility vests and arm bands, when crossing between sites or taking blood specimens to the laboratory.

The transportation of specimens to the pathology laboratory must comply with The Carriage of Dangerous Goods Act 2011-UN3373, Packaging instruction P650. The packaging must be of good quality, strong enough to

withstand the shocks and loadings normally encountered during carriage and must meet specific requirements. Blood specimens were transported to the pathology laboratory in a clear plastic lidded container, with a hazardous materials sign on the lid. We were told the container was leak proof and any breakages could be seen.

The clinic met the Control of Substances Hazardous to Health 2001 (COSHH) regulations. There was a COSHH file, which identified the risks to patients, staff and visitors and the actions to be taken to reduce the risk. This also explained the first aid that would be required. The cleaner's cupboard had a separate COSHH folder and a COSHH poster displayed.

Appropriate indemnity arrangements were in place to cover potential liabilities that may arise.

Infection control

There was a designated lead for infection prevention and control (IPC) for the clinic. There were written policies for infection control including hand hygiene, sharps injury and use of personal protective equipment (PPE), such as gloves and aprons. These were readily accessible to staff.

Staff told us that an Infection Prevention and Control Nurse IPC nurse visited every year to assess the clinic. An audit report was not written but we saw an 'actions required' list that was drawn up because of the visit. However, there was not a documented process to complete the action within a required timeframe.

Staff were up to date with their yearly hand hygiene assessments. Hand hygiene was also part of the induction process for new staff. Correct hand washing technique and 'five moments' posters were on display. PPE was available in all treatment and consulting rooms in appropriate sizes for staff. Hand sanitising foam, soap and paper towels were available for use throughout the clinic. However, the nozzles of all the hand soap dispensers were found to not be clean. Best practice states that these should be clean and free of congealed product. The clinic had effective arrangements in place to meet the Health Technical Memorandum (HTM) 07-01 section 5.11 safe management of healthcare waste. The clinic had a service level agreement with a contractor registered for healthcare waste and disposal. There was appropriate outside storage space for clinical and sharps waste and these were stored in locked bins. We saw waste was correctly segregated within the treatment and consulting rooms and posters explaining this were displayed in all rooms. Bins were labelled for usage. Three bins out of 12 were not foot operated and we were told these had been ordered.

There were processes in place to meet HTM 04-01 guidelines for the control of legionella, a bacterium found in the environment which can contaminate the water supplies of the clinic. We saw there was a schedule for water chlorination and a daily schedule for the running of taps. A risk assessment had been completed and no low usage outlets had been found.

Premises and equipment

The clinic maintained appropriate standards of cleanliness and hygiene. The rooms in the clinic were tidy and uncluttered. Equipment in the consulting and treatment rooms were visibly clean. We saw cleaning protocols and a weekly room audit, which included the cleaning of equipment. Disinfectant wipes were available for use to clean equipment between patients.

There was a system in place to ensure equipment was maintained and regularly serviced. This included the boiler, gas safety checks, air conditioning and safety testing for electrical equipment.

There was a spill kit available in the phlebotomy room in the event of a body fluid spillage. The kit was in date and had clear instructions for use. PPE was included in the kit, mask and goggles were available.

Cleaning equipment was stored in a designated cupboard which was locked. There was a contract for cleaning and the schedule was available. The cleaners used a colour coding system that was based on the national guidance for colour coding to prevent the spread of infection. We were told the cleaning staff changed equipment between rooms. The contracted cleaning service undertook monthly cleaning audits and these were seen.

Safe and effective use of medicines

We looked at the systems in place for managing of medicines. We spoke with the clinical lead and the registered manager involved in the governance, administration and supply of medicines.

Medicines were stored appropriately in the clinic. A locked cabinet was used and the keys were held by a trained nurse when the clinic was open and placed in a safe when closed.

Medical care

When applicable, medicines were stored in a dedicated medicine fridge that was locked. We saw records showing daily checks of temperatures and these were within the required range as set by national guidelines.

There was a clear audit trail for the ordering, receipt and disposal of medicines. There were processes to ensure medicines were safe to administer and supply to patients. Controlled drugs were not used or stored in the clinic.

Prescription pads were stored securely and only authorised prescribers could use them. Patient Group Direction (PGDs) were not used in the clinic.

Are medical care services effective?

Assessment and treatment

Patients who used the service initially completed an online self-assessment document which requested medical history information and included patient consent. The online submission created an individual confidential portal for each patient where they could access their health assessment and results. The clinicians undertook face-to-face assessments created from evidence based on national guidance and standards.

The service had systems in place to keep all clinical staff up to date. Staff had access to best practice guidelines and used this information to deliver care and treatment that met patients' needs. The service monitored these guidelines were adhered to through routine audits of patient's records.

Clinical Audit

The clinic told us they had a programme of audits to monitor the quality of care and treatment provided and make any changes necessary as a result. We were told they had carried out audits in the last 12 months and these included: room audit, phlebotomy audit. Actions required were recorded and noted when completed. However the audits did not identify specific time lines for completion, implementation or review.

We saw an audit completed in February 2016 of patients records. The audit was a random selection and review of ten records over a four-week period. Its objective was to assess accurate record keeping relating to paper notes and identify where improvements should be made. We found the records were audited for quality of content and to ensure appropriate referrals and actions were taken. There saw no completed cycle of clinical audit.

Staff training and experience

Medical, clinical and administrative staff had the right qualifications, skills, knowledge and experience to do their job. Staff were supported to deliver effective care through opportunities to undertake training, learning and development and through meaningful and timely supervision and appraisal.

The clinic was able to demonstrate the training clinical and administrative staff had received in the previous 12 months. These included basic life support, fire training, gas safety, infection control, safeguarding vulnerable adults, manual handling and COSHH. Training was accessed either at the clinic, online training or attending courses at another local health provider.

We saw registered professionals were up to date with their Continuing Professional Development (CPD) and supported to meet the requirements of their professional registration.

Working with other services

The information needed to plan and deliver care and treatment was available to relevant staff in a timely and accessible way through the clinic's patient record system. This included care assessments, medical records, investigations and test results.

Staff worked together as a multidisciplinary team to meet the range of people's needs and to assess and plan ongoing care and treatment. The clinic only made referrals to other independent or private sector services.

The clinic had a service level agreement with a local pathology laboratory. This enabled the prompt obtaining of blood results which were required for consultations. The laboratory was regulated by the Clinical Pathology Accreditation (CPA) and was in the transition process to be regulated by United Kingdom Accreditation Service (UKAS).

Consent to care and treatment

Consent to care and treatment was not always in line with legislation and guidance. All staff had received training in the Mental Capacity Act (MCA) 2005. Staff told us they sought patients' consent to care and treatment. Where written consent was required for a specific procedure,

consent forms clearly detailed why a procedure needed to take place, what the procedure involved, any risks to the patient and where applicable any extra costs. We looked at five patient records. All were completed with appropriate assessments and plan of care but did not contain written consent. When we questioned the provider we were told consent was not required for non-invasive procedures.

Young persons aged 16 and above are usually presumed to be Gillick competent. The Gillick competence is a term used to decide whether a young person is able to consent to their own medical treatment, without the need for parental permission or knowledge. The clinic's policy did not refer to the gaining of consent for this age group or Gillick competence. Staff acknowledged that this was an area they needed further support and training in understanding this..

The clinic had a 'Valid and Informed Consent' policy stating which procedures would require verbal and written consent. It referred to guidance from the General Medical Council and Regulation 18 of the Health and Social Care Act 2008. Regarding a patient's capacity to consent the policy stated "in the event of a medical emergency when it is not possible to find out a patient's wishes they can be treated without their consent provided the treatment is immediately necessary to save their live or prevent serious deterioration". The MCA states "for consent to be valid, it must be voluntary and informed, and the person consenting must have the capacity to make the decision". Staff told us of an example where a stroke patient's capacity had been questioned and staff gained consent from the patient's spouse. This practice was not in accordance with legislation. However, it was undertaken in the patient's best interest.

Are medical care services caring?

Respect, dignity, compassion & empathy

We observed staff were courteous and very helpful to patients and treated patients with dignity and respect.

We saw curtains were provided in consulting rooms to maintain patients' privacy and dignity during examinations, investigations and treatments. Consultation room doors were closed during consultations and conversations taking place in these rooms could not be overheard.

Staff explained to us how they ensured information about patients using the service was kept confidential. The clinic had electronic records which were held securely. The day to day operation of the service used computerised systems and the clinic had an external backup for this system. Staff demonstrated to us their knowledge of data protection and how to maintain confidentiality.

The 55 patient CQC comment cards we received were positive about the service. Patients said the clinic offered an excellent service and staff were helpful, caring and treated them with dignity and respect. Comments included how professional staff were, patients felt listened to and supported. Examples included "exceptional, friendly, professional staff, simply the best", "I have received not only a high class of service, but have also felt the staff respect and genuinely care about their patients" and "all the staff at SCVC are extremely caring and helpful, nothing is ever too much trouble". There were positive comments about individual members of staff with many patients expressing how they would recommend the service to others.

We saw patients were dealt with in a kind and compassionate manner. We observed staff being polite, welcoming, professional and sensitive to the different needs of patients. Staff we spoke with were aware of the importance of protecting patient confidentiality and reassurance. They told us they could access an empty room away from the reception area if patients wished to discuss something with them in private or if they were anxious about anything. However there was not a formal procedure or process to signpost patients who had received bad news to support agencies.

Involvement in decisions about care and treatment

Staff told us patient's medical status was discussed with them in respect of decisions about the care and treatment they received. We saw these discussions were always documented. Staff told us they used a number of different methods including display charts, pictures and leaflets to demonstrate what different treatment options involved so that patients fully understood. We saw a range of information available in the clinic.

Patients comment cards told us they felt involved in decision making about the care and treatment they received. They told us they felt listened to and supported by staff and had sufficient time during consultations to make an informed decision about the choice of treatment.

Medical care

Comments included “staff very reassuring, I felt I was listened to and my concerns were addressed accordingly” and “clear explanation of procedures, tests, results and next steps”.

Are medical care services responsive?

Responding to and meeting patients’ needs

The main reception was decorated in neutral colours and had seating appropriate for patients whilst they waited for their appointment. Refreshments and reading materials were provided. The treatment and consultation areas were well designed and well equipped.

The clinic offered flexible opening hours Monday to Friday and appointments to meet the needs of their patients. The clinic offered four screening packages to suit the individual’s budget and requirements. The range of services was kept under review to meet demand. Staff reported the service scheduled enough time to assess and undertake patients care and treatment needs. Staff told us they did not feel under pressure to complete procedures and always had enough time available to prepare for each patient.

The clinic provided a wheelchair for patients who were unable to bring their own. The clinic also offered the facility of a member of staff to be a guide and assist from the car park if required.

Tackling inequity and promoting equality

The clinic offered appointments to anyone who requested one and had viable finance available. The clinic did not discriminate against any client group. We asked staff to explain how they communicated with patients who had different communication needs such as those who spoke another language. They could contact a telephone translation service. Staff told us they treated everybody equally and welcomed patients from many different backgrounds, cultures and religions.

The facilities at the clinic complied with the Disability Discrimination Act 2005; there was ramp access to the building. The clinic had an accessible toilet available for all patients attending the service.

Access to the service

Appointments were available at varied times while the clinic was open Monday to Friday. The appointments were dependent on the availability of the specialist clinicians. The length of the appointment was specific to the patient and their needs.

Out of hours, there was a telephone answering service for routine messages. Patients who needed to access care in an emergency or outside normal opening hours were directed to the NHS 111 service. We saw the website also included contact information, as did the ‘patient guide’ information given to patients.

The provider informed us they were researching an electronic system where patients could contact a consultant out of hours by telephone. This service would be available for a limited time after a procedure.

Concerns & complaints

The clinic had a complaints policy, which provided staff with information about handling formal and informal complaints from patients. Information for patients about how to make a complaint was available in the clinic waiting room and provided in the ‘patient guide’. This included contact details of other agencies to contact if a patient was not satisfied with the outcome of the clinic’s investigation into their complaint.

We looked at four complaints received in the last six months and found they were satisfactorily handled and dealt with in a timely way. The clinic demonstrated an open and transparent approach in dealing with complaints. Lessons were learnt from concerns and complaints and action was taken to as a result to improve the quality of care. Three complaints related to a misunderstanding of fees. We saw there was an effective system in place that ensured there was a clear response with learning disseminated to staff about the event.

Are medical care services well-led?

Governance arrangements

The governance arrangements of the service were evidence based and developed through a process of continual learning. The service had a number of policies and procedures in place to govern activity and these were

available to all staff. All the policies and procedures we saw had been reviewed and reflected current good practice guidance from sources such as the General Medical Council (GMC).

The practice manager had responsibility for the day-to-day running of the service. They had monthly meetings with the staff to discuss any issues and identify any actions needed. There was a clear leadership structure with named members of staff in lead roles. For example, a clinical lead oversaw all aspects of the clinical nurse role and liaised with the practice manager.

Leadership, openness and transparency

There was a clear leadership structure in place and staff felt supported by management. Staff told us the clinic held monthly meetings which were attended by permanent clinical and administrative staff. Due to the part time hours of other clinicians, not everyone attended these meetings routinely.

The registered and practice manager complied with the requirements of duty of candour. The clinic had systems in place for knowing about notifiable safety incidents. Service users and their families were told when they were affected by something that had gone wrong. The clinic apologised and informed people of the actions they had taken.

The culture of the clinic encouraged candour, openness and honesty. Staff told us there was an open culture within the clinic and they had the opportunity and confidence to raise any issues at team meetings. Staff said they felt respected, valued and supported. Staff were involved in discussions about how to run and develop the clinic.

Learning and improvement

The clinic was open to feedback and offered patients the opportunity to reflect on their experiences. The clinic encouraged learning from complaints and significant events.

Staff told us the clinic supported them to maintain their clinical professional development through training and mentoring. The management of the service was focused on achieving high standards of clinical excellence and provided supervision and support for staff. We found formal appraisals had been undertaken and were embedded within the culture of the clinic. Staff we spoke with told us the clinic was supportive of training and professional development, and we saw evidence to confirm this.

A programme of audits ensured the service monitored the quality of care and treatment provided and made any changes necessary as a result. For example, we found the patients records were audited for quality of content and to ensure appropriate referrals or actions were taken.

Provider seeks and acts on feedback from its patients, the public and staff

The clinic encouraged and valued feedback from patients, the public and staff. It proactively sought patients' feedback about the delivery of the service. The clinic also gathered feedback from staff through staff meetings, appraisals and discussion.

All patient feedback was read by the practice manager and clinical lead and bought to the attention of all staff including those with practising privileges. A report which outlined the results of patient surveys was provided for all staff to ensure they were aware of any issues that had been highlighted.

We looked a three patient satisfaction surveys that had 38 responses. The majority were complimentary towards the service experienced and were confident in the practitioner seen. One feedback contained negative comments regarding the cost of treatment and this was actioned by staff contacting the patient to explain its rationale.

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 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment How the regulation was not being met: Regulation 13(2) We found that the registered provider did not comply with current legislation and guidance with regard to the protection of children. The safeguarding lead was not trained to level 3 safeguarding children. Staff must receive safeguarding training that is relevant, and at a suitable level for their role. Training should be updated at appropriate intervals and should keep staff up to date and enable them to recognise different types of abuse and the ways they can report concerns. This includes the evidence of a certificate of completion to be kept with the personnel files. Policies and procedures did not adequately reflect how a child's capacity to consent would be assessed, to determine if they were Gillick competent. Staff had not received training in assessing Gillick competence.