Top Medical Clinic LLP

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Inspection report

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Date of inspection visit: 27 March 2019
Date of publication: 05/06/2019

Overall summary

We carried out an announced comprehensive inspection on 27 March 2019 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.

CQC inspected the service on 17 January 2018 and asked the provider to make improvements for breaches in regulations 12, 17 and 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We checked these areas as part of this comprehensive inspection and found most of the issues had been resolved.

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 general 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.

The practice manager has applied to be a registered manager. A registered manager is a person who is registered with the Care Quality Commission to manage

Summary of findings

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.

We received 15 Care Quality Commission comments cards from patients who used the service and spoke to four patients during the inspection; all were positive about the service experienced. Many patients reported that the service provided high quality care.

Our key findings were:

- The service had systems to manage risk so that safety incidents were less likely to happen. When incidents did happen, the practice learned from them and improved their processes. However, identification of incidents and significant events required improvement.
- The practice reviewed the effectiveness and appropriateness of the care it provided. However, it did not always ensure that care and treatment was delivered according to evidence-based guidelines.
- 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.
- There was a focus on learning and improvement at all levels of the organisation.

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

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

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

Dr Rosie Benneyworth BM BS BMedSci MRCGP

Chief Inspector of Primary Medical Services and Integrated Care

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 at 1B Church Road, Croydon CR0 1SG. The service website can be accessed through www.topmedicalclinic.com

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 seven reception and administrative staff. All of the 14 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 8am and 9pm Monday to Saturday and from 8am 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 provider is not registered to provide maternity and midwifery services; following the inspection the provider had applied to add this this regulated activity to their registration.

Our inspection team was led by a CQC lead inspector. The team included a GP specialist advisor and an interpreter.

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. We found staff did not have the appropriate level of safeguarding children training; the provider had not completed a health and safety risk assessment of the premises and did not have a business continuity plan. The day after the inspection the provider made changes and told us:

- Staff had now completed safeguarding training relevant to their role.
- They had developed a detailed business continuity plan for the service.
- They had completed a health and safety risk assessment of the premises.

Had we not inspected and identified the issues, the provider would not have known and made these changes.

Safety systems and processes

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

- The provider had appropriate safety policies, which were regularly reviewed and communicated to staff. Staff received safety information from the service as part of their induction and refresher training. The service had some systems to safeguard children and vulnerable adults from abuse. Policies were regularly reviewed and were accessible to all staff. They outlined who to go to for further guidance.
- The service had systems in place to assure that an adult accompanying a child had parental authority to consent to care and treatment.
- The service worked with other agencies to support patients and protect them from neglect and abuse. Staff took steps to protect patients from abuse, neglect, harassment, discrimination and breaches of their dignity and respect.
- The provider carried out staff checks at the time of recruitment and on an ongoing basis where appropriate. 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).
- Clinical staff did not receive safeguarding training appropriate to their role. After we raised this with the provider, staff completed appropriate training and the provider sent us evidence to support this. Staff we spoke with knew how to identify and report concerns. Staff who acted as chaperones were trained for the role and had received a DBS check.
- There was an effective system to manage infection prevention and control.
- The provider had completed a legionella risk assessment and had acted on the recommendations.
- 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.

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.
- There was an effective induction system for staff tailored to their role.
- Staff understood their responsibilities to manage emergencies and to recognise those in need of urgent medical attention. They knew how to identify and manage patients with severe infections, for example sepsis.
- The service had all the emergency medicines and equipment in line with recognised guidance.
- When there were changes to services or staff the service assessed and monitored the impact on safety.
- There were appropriate indemnity arrangements in place to cover all potential liabilities.

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.
- The service had systems for sharing information with staff and other agencies to enable them to deliver safe care and treatment. They had a policy in place for sharing information with other healthcare professionals.

Are services safe?

- Clinicians made appropriate and timely referrals in line with protocols. The provider informed they had introduced an improved system to manage referrals and we saw evidence to support this.
- We found that all records were written in English. The provider informed us that they provided Polish language notes to patients on their request.

Safe and appropriate use of medicines

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

- The systems and arrangements for managing medicines, emergency medicines and equipment minimised risks. The service kept prescription stationery securely and had introduced a new system to monitor its use.
- The service recently carried out an antimicrobial prescribing audit for four clinicians working at the service. The audit only included a review of 11 medical records; the results indicated that only six out of 11 patients were appropriately prescribed.
- The service did not ensure they followed local guidelines in the prescribing of antimicrobials. After we raised this with the provider they contacted the local clinical commissioning group and obtained local antimicrobial prescribing guidelines to use in the service and sent us evidence to show they had these.
- Staff prescribed, administered or supplied medicines to patients and gave advice on medicines in line with legal requirements and current national guidance.
- Processes were in place for checking medicines and staff kept accurate records of medicines. However, we found that batch numbers of medicines used for minor operations were not consistently recorded.
- There were effective protocols for verifying the identity of patients including children.

Track record on safety

- There were comprehensive risk assessments in relation to safety issues; with the exception of a comprehensive health and safety risk assessment of the premises. After we identified this and raised it with the provider, they completed a risk assessment the day following the inspection and sent us evidence to support this. The risk assessment had the details of risk and proposed actions recorded.

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. However, identification of incidents and significant events required improvement.
- There were adequate systems for reviewing and investigating when things went wrong.
- 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.

When there were unexpected or unintended safety incidents:

- The service gave affected people reasonable support, truthful information and a verbal and written apology
- 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.

Are services effective?

(for example, treatment is effective)

Our findings

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

Effective needs assessment, care and treatment

The provider did not have effective systems to keep clinicians up to date with current evidence-based practice. The clinicians assessed needs of patients; however, they did not always deliver care and treatment in line with current legislation, standards and guidance.

- Patients' needs were fully assessed.
- Clinicians had enough information to make or confirm a diagnosis
- 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. They had undertaken clinical audits; however, they had not undertaken any completed cycle clinical audits. For example, they had undertaken an independent review of referral letters just before the inspection. They looked at 14 referral letters drafted by two clinicians to ascertain if they contain all the necessary information. The review indicated that information including general condition, examination, current management and past medical history were missing on some letters. Following the audit, the reviewer recommended that doctors read guidance on content on referral letters and that good examples of referral letters are discussed in staff meetings and to perform a periodic review of referral letters. However, the results of this audit had not yet been discussed with the clinicians.

The service had also performed an independent review of clinical consultations to ascertain if these were compliant with clinical record keeping requirements. The review included 60 medical records from January to March 2019. The reviewer made a number of recommendations following this audit which were not yet discussed with the clinicians.

The patient management system used by the service sis not support linking patient records to pathology results and did not support in performing clinical audits as the system was non-searchable. The provider undertook the audits by manually looking at patient records.

The service had a program of regular records audits which they had undertaken; however, we had not seen any evidence of impact on patient outcomes:

- **Chronic diseases:** To ascertain if chronic diseases were highlighted in the patient management system and they had received medication and health reviews.
- **Allergies:** To ascertain if allergies were highlighted in the patient management system.
- **Referrals:** To ascertain if referrals are entered to the referral tracker, referral receipt confirmed, copy given to patients and their GP, and if referrals followed up on time.
- **Safeguarding children:** To ascertain if safeguarding checklists are completed when seeing paediatric patients and if safeguarding concerns are appropriately reported and documented.
- **Medical records audit:** Monthly audit of five records for each doctor by the clinical supervisor.
- **Laboratory results:** Monthly checks to ascertain if all pathology test results were sent to patients' and patients' GP.

Effective staffing

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

- All staff were appropriately qualified. The provider had an induction programme for all newly appointed staff.
- Relevant professionals (medical and nursing) were registered with the General Medical Council (GMC)/ Nursing and Midwifery Council and were up to date with revalidation
- The provider 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.
- Staff whose role included reviews of patients with long term conditions had received specific training and could demonstrate how they stayed up to date.
- The provider had only recently appointed an external clinical supervisor for the doctors working at the service who had one to one discussion with three doctors working at the service and we saw evidence to support this.

Coordinating patient care and information sharing

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

Are services effective?

(for example, treatment is effective)

- Patients received coordinated and person-centred care.
- Before providing treatment, doctors at the service ensured they had adequate knowledge of the patient's health, any relevant test results and their medicines history.
- All patients were asked for consent to share details of their consultation and any medicines prescribed with their registered GP on each occasion they used the service. The provider had a policy to cover where patients refused to share this information.
- The provider had risk assessed the treatments they offered. However, they had not identified medicines that were not suitable for prescribing if the patient did not give their consent to share information with their GP, or they were not registered with a GP. For example, medicines liable to abuse or misuse, and those for the treatment of long-term conditions such as asthma. Where patients agreed to share their information, we saw evidence of letters sent to their registered GP in line with GMC guidance.
- Patient information was shared appropriately (this included when patients moved to other professional services), and the information needed to plan and deliver care and treatment was available to relevant staff in a timely and accessible way. There were arrangements in place for following up on people who have been referred to other services.

Supporting patients to live healthier lives

- Where appropriate, staff gave people advice so they could self-care.
- Where patients needs could not be met by the service, staff 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.

- 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.

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.

- Feedback from patients was positive about the way staff treat people.
- Staff understood patients' personal, cultural, social and religious needs. They displayed an understanding and non-judgmental attitude to all patients.
- The service gave patients timely support and information.
- All of the 15 patient Care Quality Commission comments cards and the four patients we spoke to during the inspection were positive about the service experienced. This was in line with the feedback received by the service.

Involvement in decisions about care and treatment

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

- The service did not use interpretation services as 95% of the patients they saw were Polish; all staff were able to speak Polish.
- Information leaflets were available in easy read formats in English and Polish, to help patients be involved in decisions about their care.
- Distressed patients were offered an alternative waiting area in the first floor which was quieter than the general waiting area.
- The service website provided patients with information about the range of treatments available at the clinic. However, the service informed us that this needs to be updated.
- Patients told us through comment cards, that they felt listened to and supported by staff and had sufficient time during consultations to make an informed decision about the choice of treatment available to them.
- Staff communicated with people in a way that they could understand, for example, communication aids and easy read materials were available.

Privacy and Dignity

The service respected patients' privacy and dignity.

- Staff recognised the importance of people's dignity and respect.
- Staff knew that if patients wanted to discuss sensitive issues or appeared distressed they could offer them a private room to discuss their needs.

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

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 improved services in response to those needs.
- Access to the clinic was not suitable for people with limited mobility and those who used a wheelchair. The provider informed us patients with limited mobility are usually seen in the ground floor consulting room and patients were informed that the clinic had limited access when they book an appointment.
- 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 the NHS services. The provider 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 service within an appropriate timescale for their needs.

- Patients had timely access to initial assessment, test results, diagnosis and treatment.
- Waiting times, delays and cancellations were minimal and managed appropriately.
- Patients reported that the appointment system was easy to use.
- Referrals and transfers to other services were undertaken in a timely way. The referral letters we reviewed during the inspection confirmed this.

Listening and learning from concerns and complaints

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

- Information about how to make a complaint or raise concerns was available. Staff treated patients who made complaints compassionately.
- The service informed patients of any further action that may be available to them should they not be satisfied with the response to their complaint.
- The service had complaint policy and procedures in place. The service learned lessons from individual concerns, complaints and also from analysis of trends. It acted as a result to improve the quality of care.

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 service was managed by the practice manager supported by an external clinical supervisor and there was no local clinical lead. Each clinician worked separately and there was limited evidence of integrated care.
- Leaders were knowledgeable about issues and priorities relating to the quality and future of services.
- Leaders were visible and approachable.
- The provider did not have effective processes to develop leadership capacity and skills, including planning for the future leadership of the service.

Vision and strategy

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

- There was a clear vision and set of values. The service had a realistic strategy and supporting business plans to achieve priorities.
- Staff were aware of and understood the vision, values and strategy and their role in achieving them.

Culture

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

- Staff felt respected, supported and valued. They were proud to work for the service.
- The service focused on the needs of patients.
- 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 told us they were able to raise concerns and were encouraged to do so. They had confidence that these would be addressed.
- There were processes for providing all staff with the development they need. This included appraisal and career development conversations. All staff received regular annual appraisals in the last year. Staff were supported to meet the requirements of professional revalidation where necessary. Staff were considered valued members of the team. They were given protected time for professional time for professional development and evaluation of their clinical work. However, we found not all staff had completed safeguarding training to the required level. This was completed immediately after the inspection.
- There was a strong emphasis on the safety and well-being of all staff.
- The service actively promoted equality and diversity. It identified and addressed the causes of any workforce inequality. Staff felt they were treated equally.
- There were positive relationships between staff and teams.

Governance arrangements

There were roles and responsibilities and systems of accountability to support good governance and management. However, structures, processes and systems to support good governance and management required improvement.

- Staff were clear on their roles and accountabilities
- Leaders had policies, procedures and activities to ensure safety; however, there were some gaps for example, lack of business continuity plan. While some audits had been carried out we did not see any evidence of impact on patients from these audits.
- The service had monthly staff meetings; however, they did not have an effective system to share learning from complaints and significant events.

Managing risks, issues and performance

There were processes for managing risks, issues and performance.

- The service had processes to manage current and future performance. Performance of clinical staff could be demonstrated through audit of their consultations, prescribing and referral decisions. Leaders had oversight of safety alerts, incidents, and complaints.
- There was some evidence of quality improvement; however, they had not undertaken any completed cycle clinical audits to ascertain improvement.
- The provider had no business continuity plan in place. After we raised this issue with the provider they sent us a detailed business continuity plan the day following the inspection.
- The provider had completed a clinical governance assessment which covered areas including infection

Are services well-led?

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

control, safeguarding, staff, patient, public and environmental safety, evidence-based practice and research, prevention and public health, clinical records, patient privacy and confidentiality, staff involvement and development, patient information and involvement, fair and accessible care, clinical audit and peer review and quality assurance.

Appropriate and accurate information

The service acted on appropriate and accurate information.

- Quality and operational information was used to ensure and improve performance.
- The service submitted data or notifications to external organisations as required.
- There were arrangements in line with data security standards for the availability, integrity and confidentiality of patient identifiable data, records and data management systems.

Engagement with patients, the public, staff and external partners

The service involved patients and staff to develop high-quality sustainable services.

- The patients' and staff views and concerns were encouraged, heard and acted on to shape services and culture. For example, the provider collected feedback from patients after each consultation. The provider informed us they were in the process of introducing a new patient satisfaction survey and we saw evidence to support this.

Continuous improvement and innovation

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

- There was a focus on learning and improvement. Staff we spoke to indicated that they had seen many improvements in the last year. For example, more staff meetings, recruitment of new reception staff, improved learning from complaints, improved systems for data protection, checking the identity of patients and improved system to manage referrals.
- The patient management system used by the service is non-searchable and did not link patient records to pathology results; Hence, the service informed us they were in the process of implementing a new customised patient management system and were testing it for safety.

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
	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 fundamental standards of care. The provider did not ensure significant events and complaints are widely discussed to ensure learning is shared. There was no business continuity plan in place to deal with emergencies. There was no health and safety risk assessment of the premises. The provider did not undertake any completed cycle clinical audits to ascertain any improvement. The provider did not ensure batch numbers of medicines used for minor operations were consistently recorded to ensure safety. The provider did not ensure clinical staff were up to date with evidence-based guidance. The provider did not have effective quality improvement systems in place. For example, they had not undertaken any completed cycle clinical audits. The provider did not ensure staff complete training relevant to their role.