Fast Medica Ltd

FAST MEDICA LTD

Inspection report

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Overall summary

We carried out an announced comprehensive inspection on 19 December 2018 to ask the service the following key questions; Are services safe, effective, caring, responsive and well-led?

Our findings were:

Are services safe?

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

Are services effective?

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

Are services caring?

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

Are services responsive?

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

Are services well-led?

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

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the service was meeting the legal requirements and regulations associated with the Health and Social Care Act 2008.

Fast Medica Ltd is an independent clinic in the London Borough of Ealing and provides private primary medical services. The service offers services for adults and children. Most of the patients seen at the service are from the Polish speaking community. Medical consultations and diagnostic tests are provided by the clinic however no surgical procedures are carried out.

One of the directors 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.

Twenty eight people provided feedback about the service, which was positive about the care and treatment offered by the service. They were satisfied with the standard of care received and thought the doctor was approachable, committed and caring. They said the staff were helpful and treated them with dignity and respect.

Our key findings were:

Summary of findings

- There was a lack of good governance and limited evidence of quality improvement activity to review the effectiveness and appropriateness of the care provided. There was a lack of effective clinical leadership.
- The levels of risk found at this inspection was a direct result of the provider not ensuring appropriate systems had been implemented to effectively identify, manage and mitigate risk.
- Information needed to deliver safe care and treatment was not always available to the relevant staff in a timely manner.
- The service did not have reliable systems for appropriate and safe handling of medicines and ultrasound scans.
- The service was unable to provide evidence that the consultations of all clinicians were undertaken in line with accepted best practice in the UK or had a documented rationale for alternative treatment provided.
- Prescribing was not audited or reviewed to identify areas for quality improvement.
- There was insufficient quality monitoring of clinicians' performance.
- Patient identity was not always verified.
- Appropriate recruitment checks were not always undertaken prior to employment.
- Some policies and protocols did not include sufficient information.
- Appointments were available on a pre-bookable basis. The service provided only face to face consultations.
- Staff involved and treated patients with compassion, kindness, dignity and respect.
- Information about services and how to complain was available.
- The provider was aware of and complied with the requirements of the Duty of Candour.
- The provider demonstrated a willingness to work with CQC to improve the quality and effectiveness of the service.

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

- 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.

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

There were areas where the provider **should** make improvements:

- Review systems to verify a patient's identity on registering with the service.
- Review the policy for offering the baby scans when consent to share information with the woman's NHS GP is not given.
- Arrange an active signposting training for the non-clinical staff members.
- Review contents of the registration questionnaire regarding administration charges for sharing information with the NHS GP.
- Implement a system for the effective management of blank prescription pads.

Professor Steve Field CBE FRCP FFPH FRCGP

Chief Inspector of General Practice

FAST MEDICA LTD

Detailed findings

Background to this inspection

Fast Medica Limited provides a private, non-NHS service. Fast Medica Ltd started in March 2018 and has two directors who run the service. The service employs a number of self-employed doctors. All doctors are on the General Medical Council (GMC) register, and have indemnity insurance to cover their work.

The service is run by two directors, supported by a practice manager and a head receptionist.

Services are provided from: Fast Medica Ltd, 2nd Floor, Hanwell Health Centre, 20 Church Road

London, W7 1DR. We visited this location as part of the inspection on 19 December 2018.

Online services can be accessed from the practice website: www.fastmedica.co.uk.

The service offers services for adults and children.

The service offers general practice services and gynaecology services including scans for babies. On average they offer five general practitioner consultations per month, 105 gynaecological consultations and scans per month (a combination of scans for babies, non-pregnant women and other scans).

In addition, the service offers consultations with Cardiologist, Dermatologist, Sexual Health Practitioner, Respiratory Physician, Allergist, Diabetologist, Endocrinologist, Paediatrician, Urologist, Cryotherapy and Psychiatrist.

The service has core opening hours from 9am to 9pm Monday to Saturday and 9am to 3pm Sunday.

The service is registered with the Care Quality Commission to provide the regulated activities of diagnostic and screening procedures, treatment of disease, disorder and injury, and surgical procedures. This service is registered with CQC under the Health and Social Care Act 2008 in respect of the services it provides.

On 19 December 2018, our inspection team was led by a CQC Lead Inspector. The team included a GP specialist advisor.

Pre-inspection information was gathered and reviewed before the inspection. We spoke with the directors, the responsible officer, a practice manager and a head receptionist. We collected written feedback from a member of staff. We looked at records related to patient assessments and the provision of care and treatment. We also reviewed documentation related to the management of the service. We reviewed patient feedback received by the service.

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

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

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

Are services safe?

Our findings

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

Safety systems and processes

The service had some systems to keep people safe and safeguarded from abuse. However, improvements were required.

- The provider was renting space in shared premises and the host was responsible for managing the premises. The safety risk assessments were available. It 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 systems to safeguard children and vulnerable adults from abuse. Policies were available and were accessible to all staff. They outlined clearly who to go to for further guidance.
- The service treated children and had a system in place to ensure that children were protected.
- The service had processes in place to ensure that all children under the age of 16 years old attended the appointment with parent or guardian who had parental responsibility for them and they were accompanied at all times during consultation and treatment. The service offered consultations on a one to one basis to patients aged 16-18 unless they requested to be accompanied by a chaperone. The service had a documented policy in place which required evidence of parental responsibility to be provided before a child could be seen by the doctor.
- All staff had received child safeguarding training relevant to their role in line with intercollegiate guidance for all staff working in healthcare settings, with the exception of a doctor, who had not received level three child safeguarding training. However, they had received level two child safeguarding training and treated children at the service. The provider informed us after the inspection that the doctor had completed level three child safeguarding training on 4 January 2019. All staff had received adult safeguarding training relevant to their role.
- The practice manager was the safeguarding lead and had received level three child safeguarding training.
- Staff understood their responsibilities to protect patients from abuse, neglect, harassment, discrimination and breaches of their dignity and respect.
- A notice in the waiting room advised patients that chaperones were available if required. Not all staff who could act as chaperones were trained for their role. However, the provider informed us after the inspection that all staff who could act as chaperones had received relevant training on 21 December 2018.
- 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).
- The service carried out staff checks, including checks of professional registration where relevant, on recruitment and on an ongoing basis. However, the three staff files we reviewed showed that appropriate recruitment checks had not been always undertaken prior to employment as documents to evidence satisfactory conduct in previous employment, in the form of references, and health checks (satisfactory information about any physical or mental health conditions) were not available on the day of the inspection. After the inspection, the provider developed a new version of health checks declaration statement and shared with us.
- There was an effective system to manage infection prevention and control. We observed that appropriate standards of cleanliness and hygiene were followed. They had carried out hand hygiene audits. However, the provider had not carried out an infection control audit. The provider informed us after the inspection that they had carried out an infection control audit on 22 December 2018.
- There were systems for safely managing healthcare waste.
- The provider ensured that facilities and equipment were safe and that equipment was maintained according to manufacturers' instructions.
- On registering with the service a patient identity was not always verified. The service had a system to ask for a photographic identity during the registration process. However, the staff we spoke with informed us that they would be flexible if identity documents were not available and patients were able to register with the

service by verbally providing a date of birth and address. They were able to pay by the bank account, debit or credit card and cash. Patients could choose to provide their debit or credit card details during the registration process.
- The provider had a formal documented business continuity plan in place.

Risks to patients

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

- 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. The provider was unable to demonstrate that an active signposting training had been provided to the non-clinical staff members to enable them to identify and manage patients with acutely unwell or deteriorating condition, for example sepsis. After the inspection, the provider informed us they booked an in-house signposting training.
- The service did not have a paediatric pulse oximeter which could be required to enable assessment of a child patient with presumed sepsis. After the inspection, the provider informed us they bought a paediatric pulse oximeter.
- When there were changes to services or staff the service assessed and monitored the impact on safety.
- There were appropriate indemnity arrangements in place.

Information to deliver safe care and treatment

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

- Individual care records were maintained, but the care records we saw showed that in most cases limited information was recorded in the individual patient's notes. For example, we saw a record, where there was no clinical rationale recorded in the patient's notes for the decision to carry out a scan and blood tests. There was no documented evidence of any action plan or follow up required in the patient's notes.
- Consultation notes were documented in the English language, but most of the scan results were documented in the Polish language or mixed notes were documented in both languages. There was a risk that the information needed to deliver safe care and treatment was not available to the relevant staff (including NHS GP or external consultants) in an accessible way in a timely manner due to the language barrier.
- The service had systems for sharing information with the NHS GP (for patients who do consent to share information with their GP) to enable them to deliver safe care and treatment. The registered manager informed us they did not charge an administration fee for sharing this information. However, we noted the registration questionnaire included the information that 'report to the patient's GP was not included in the cost of the visit'.
- The service informed us they had a policy not to make any external referrals and the patients were referred back to their NHS GP for further treatment.
- Patient records and consultation notes were stored securely using an electronic record system. Staff used their login details to log into the operating system, which was a secure programme. The doctors had access to the patient's previous records held by the service. Any paper records were scanned and stored securely.
- The service had a system in place to retain medical records in line with Department of Health & Social Care (DHSC) guidance in the event that they cease trading.
- The service was registered with the Information Commissioner's Office.

Safe and appropriate use of medicines

The service did not have reliable systems for appropriate and safe handling of medicines.

- The service did not carry out regular medicines audits to ensure prescribing was in line with best practice guidelines for safe prescribing. The service was unable to provide any prescribing data on the day of the inspection.
- The service informed us they did not prescribe or store any controlled drugs. However, the service had failed to ensure the correct information was included in the medicines policy which included 'controlled drugs may only be administered by a treating medical practitioner and must be witnessed'.
- On the day of the inspection, the provider was unable to provide the information whether the doctors were prescribing any high risk medicines which required

regular monitoring. Processes were not in place for checking and monitoring whether medicines were prescribed in line with legal requirements and current national guidance.

- The service had a documented antibiotic prescribing protocol to support good antimicrobial stewardship in line with local and national guidance. However, the provider was unable to provide the documentary evidence to demonstrate whether the doctors were following this antibiotic prescribing protocol.
- The systems and arrangements for managing stored medicines, including vaccines, emergency medicines and equipment minimised risks. Processes were in place for checking medicines and staff kept accurate records of medicines.
- The service kept prescription stationery securely but did not monitor its use. The provider had printed the letterhead prescription pads with a company name, which included the serial numbers and introduced a prescription security protocol which required to record the serial numbers and monitor its use. However, the provider was not following their own protocol as these were not recorded and tracked through the service at all times. These paper prescriptions were prescribed and signed by the doctor. All paper prescriptions were scanned and saved online along with the patient consultation notes.
- All medicines were prescribed based on clinical need on an acute basis. The provider informed us they were not responsible for monitoring the care and treatment of patients with a long term condition, with the exception of patients receiving treatment from the psychiatrist.
- The service did not have a documented repeat prescribing policy. However, the provider informed us that repeat prescriptions were rarely issued for up to two months. Patients were advised to attend a follow up appointment with the service, without which the doctors would not prescribe further medicines. After the inspection, the provider developed a repeat prescribing policy and shared with us.

Track record on safety

The service had a good safety record in some areas. However, improvements were required.

- There were comprehensive risk assessments in relation to safety issues.
- The service had up to date fire risk assessment in place and the host was carrying out regular fire safety checks. However, there was no documented fire evacuation plan specific to the service. The provider did not carry out a risk assessment to identify how staff could support patients with mobility problems to vacate the premises.
- The service had up to date legionella risk assessment in place and regular water temperature checks had been carried out. (Legionella is a term for a particular bacterium which can contaminate water systems in buildings).
- The service was renting space in shared premises and they did not have any formal monitoring system in place to ensure that regular safety checks had been undertaken by the host who was responsible for managing the premises. This arrangement would have helped the provider to understand risks and give a clear, accurate and current picture to ensure safety improvements.
- All clinical equipment was checked and calibrated to ensure clinical equipment was safe to use and was in good working order.
- We noted that the safety of electrical portable equipment was assessed at the premises to ensure they were safe to use.

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 we spoke with demonstrated their understanding to raise concerns and report incidents and near misses.
- The service had an awareness of the need to review and investigate when things went wrong and there was a system for staff to inform the practice manager of any incidents. There was a structure for staff meetings in place. The service learned and took action to improve safety in the service. For example, the service had reviewed their staff retention policy after the clinical staff member left the service without notice.
- The provider was aware of and complied with the requirements of the Duty of Candour. The provider encouraged a culture of openness and honesty.

When there were unexpected or unintended safety incidents:

Are services safe?

- The service gave affected people reasonable support, truthful information and a verbal and written apology. They kept records of written correspondence.
- The service had signed up to receive patient and medicine safety alerts. They provided examples of alerts they had received but there were no examples of alerts being acted on as none had been relevant since the service started in March 2018.

Are services effective?

(for example, treatment is effective)

Our findings

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

Effective needs assessment, care and treatment

The registered manager told us their clinicians were expected to work within current national guidelines.

- The service was unable to provide evidence that the work of all its clinicians was undertaken in line with relevant national UK guidelines, or had a documented rationale for alternative treatment provided when it had not been prescribed in accordance with these guidelines.
- We saw an example of treatment and prescribing undertaken where national guidelines were not always followed and there was no documented rationale for alternative treatments provided. For example, the doctor we spoke with informed us they were following the World Health Organization (WHO) guidelines. We saw an example where medicine was prescribed to treat issues related to the women's health which was not in line with accepted best practice in the UK or had a documented rationale for alternative treatment provided.
- All patients completed a registration questionnaire at their first visit which included information about their past medical history, personal details, date of birth and NHS GP details (plus consent to update NHS GP of all consultations details). This questionnaire was available in both the English and the Polish languages. This questionnaire was scanned and uploaded into the attachments section of the clinical record system.
- The outcomes of each assessment were not always clearly recorded and presented with explanations to make their meaning clear, which included a discussion on the treatment options. For example, we saw an example where a thyroid scan and blood tests were carried out. However, the clinical notes had not included appropriate information regarding the initial assessment (to explain why the scan and blood tests were carried out) and no clear information was documented regarding any follow up actions required.
- We saw no evidence of discrimination when making care and treatment decisions.

An ultrasound scan service was offered onsite which included scans for babies carried out by the gynaecologist. In addition, the scans were also carried out by urologist and endocrinologist consultants to help diagnose the causes of pain, swelling and infection in the body's internal organs. (An ultrasound scan is a procedure that used high-frequency sound waves to create an image of the inside of the body).

- The scans were offered for clinical diagnostic purposes only after the consultation with the doctors. The ultrasound examination was not performed as a result of an external referral.
- All doctors who conduct the scan were appropriately trained to operate the equipment and analyse the scan results. The provider informed us all the doctors were following the British Medical Ultrasound Society (BMUS) guidelines.
- The provider had a protocol for ultrasound operators, however, it did not include sufficient information relating to the effective management and handling of ultrasound scans to ensure the delivery of safe and effective care. The provider had not carried out a medical notes audit to check the quality of clinical records, assessments and record keeping of patients' involvement in making decisions about their care and treatment, which also included the ultrasound scans and appropriate onward referrals as required. The provider had not carried out any quality improvement activity to ensure BMUS guidelines were followed correctly. After the inspection, the provider provided evidence that they had subsequently undertaken a medical notes audit.
- The baby scans were offered in addition to the NHS maternity pathway. All women were advised to attend their NHS scans as part of their maternity pathway. All women who undertake these scans were given verbal information about the potential risks to the unborn child from additional use of ultrasound during the pregnancy so they could make an informed decision before proceeding with the scan. The woman's consent to care and treatment was always obtained and documented. The service shared information with the woman's NHS GPs with their consent. However, the service was required to review the policy for offering the baby scans when consent to share information with the woman's NHS GP was not given. The provider had not

Are services effective?

(for example, treatment is effective)

carried out a formal documented risk assessment to consider how they would manage the risk (when consent to share information was not given) if a significant abnormality was detected.

Monitoring care and treatment

The service was not actively involved in quality improvement activity.

- The provider had not carried out any clinical audits to ensure effective monitoring and assessment of the quality of the service.
- There was limited evidence of quality improvement activity to review the effectiveness and appropriateness of the care provided. For example, the provider had carried out a consent form audit of random forms to check the accuracy and record keeping of patients' details and the treatment agreed, and to ensure all consent forms were legible, signed and dated by the patients and the doctors.
- There were no prescribing audits to monitor the individual prescribing decisions, for example, to monitor their antibiotic prescribing, but individual patients on prescribed medicines were monitored to identify the appropriateness of their medicines. The doctors advised patients what to do if their condition got worse and where to seek further help and support.
- There was no evidence to support the provider undertaking a systematic review of prescribing patterns against best practice standards and did not have a process in place for identifying improvements.
- We found the service was following up on pathology results and had an effective monitoring system in place to ensure that all abnormal results were managed in a timely manner and saved in the patient's records.

Effective staffing

Staff had the skills, knowledge and experience to carry out their roles. However, some improvements were required.

- The service was run by two directors. One of the directors was a CQC registered manager. The directors were supported by a practice manager and a head receptionist to deal with telephone, email and face to face queries and book appointments.
- The doctors were registered with the General Medical Council (GMC) the medical professionals' regulatory body with a license to practice.
- The service had kept the evidence of doctors' professional qualification in their staff files.
- The doctors had a current responsible officer. (All doctors working in the United Kingdom are required to have a responsible officer in place and required to follow a process of appraisal and revalidation to ensure their fitness to practice). The doctors were following the required appraisal and revalidation processes. All the doctors had received a formal internal appraisal within the last nine months.
- The provider understood the learning needs of staff and had an induction programme for all newly appointed staff. Up to date records of skills, qualifications and training were maintained. Staff were encouraged and given opportunities to develop.
- Most staff had received training relevant to their role that included: safeguarding children and adults, infection control, basic life support, health and safety, equality and diversity and fire safety training. We noted a doctor had not received level three child safeguarding training and not all staff who could act as chaperones were trained for their role.
- The provider did not have a clear approach for supporting and managing clinical staff to assess if their performance was satisfactory or variable.

Coordinating patient care and information sharing

- Patients received person-centred care. The provider informed us if a patient needed further examination they were directed back to their NHS GP or regular physician. They had a policy not to make any external referrals. If the provider could not deal with the patient's request, this was explained to the patient and a record kept of the decision. After the inspection, the provider informed us they developed a referral policy for physicians.
- When a patient contacted the service, they were asked if the details of their consultation could be shared with their NHS GP. If the patient did not agree to the service sharing information with their GP, then in case of an emergency the provider discussed this again with the patient to seek their consent. However, the provider informed us they would not refuse the treatment, maintaining that they were supportive of the patient's right to refuse consent to share their information with the patient's GP.
- The provider had not risk assessed the treatments they offered. They had not identified medicines that were not

Are services effective?

(for example, treatment is effective)

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 which required regular monitoring.

- The information needed to plan and deliver care and treatment was not always available to relevant staff in a timely and accessible way.
- All patients were asked to share details of any medicines prescribed with their registered GP on each occasion they used the service. The provider did not have clear and effective arrangements for following up on people who have been referred back to their NHS GP. For example, patient information was shared by email, post or a letter was given to the patient by hand and advised to share this information with their NHS GP. The provider did not attempt to contact the GP practice and confirmation of receipt was not received. There was a risk that the information needed to deliver safe care and treatment could not be made available to the NHS GP in a timely manner and had the potential to expose patients to the risk of harm.
- Information shared by email was password protected in order to ensure data security.

Supporting patients to live healthier lives

Staff were consistent and proactive in helping 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 doctors understood and sought patients' consent to care and treatment in line with legislation and guidance. If a patient's mental capacity to consent to care or treatment was unclear we were told the doctor would assess the patient's capacity and record the outcome of the assessment.
- Staff demonstrated a clear understanding of the Gillick competency test. (These are used to help assess whether a child under the age of 16 has the maturity to make their own decisions and to understand the implications of those decisions).
- The service had a consent policy in place and the doctors had received training on consent.
- We were told that any treatment including fees was fully explained to the patient prior to the procedure and that people then made informed decisions about their care.
- There was information on the service's website with regards to how the service worked and what costs applied. The website had details on how the patient could contact them with any enquiries.

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.

- The staff we spoke with was aware of their responsibility to respect people's diversity and human rights.
- Staff understood patients' personal, cultural, social and religious needs.
- We obtained the views of patients who used the service. We received 27 patient Care Quality Commission (CQC) comment cards. We also received one online feedback via the CQC website. Feedback from patients was positive about the way staff treat people. Patients said the staff was helpful, caring and treated them with dignity and respect. They told us they were satisfied with the care provided by the provider and said their dignity and privacy was respected.
- We saw that staff treated patients respectfully and politely over the telephone.

Involvement in decisions about care and treatment

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

- The service gave patients clear information to help them make informed choices including details of the scope of services offered and information on fees.
- 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. Feedback suggested that patients felt diagnosis and treatment options were explained clearly to them.
- 95% of the patients seen at the service were from the Polish community. We found that interpretation services were available for patients who did not have Polish or English as a first language. However, the provider informed us that the patients would be told in advance that they would be paying additional charges for interpretation services. Patients were also told about the multi-lingual staff who might be able to support them.
- Staff communicated with people in a way that they could understand, for example, easy read materials were available.
- The service provided a hearing induction loop for those patients who were hard of hearing.

Privacy and Dignity

The service respected patients' privacy and dignity.

- Staff recognised the importance of people's dignity and respect.
- The service complied with the Data Protection Act 1998.
- The service had a confidentiality policy in place and systems were in place to ensure that all patient information was stored and kept confidential. Staff were mindful and adherent to the provider's confidentiality policy when discussing patients' treatments.
- The service had arrangements in place to provide a chaperone to patients who needed one during consultations.
- 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.

- Patient's individual needs and preferences were central to the planning and delivery of tailored services. Services were flexible, provided choice and ensured continuity of care, for example, late evening and weekend appointments were available for patients who were unable to attend the service during normal working hours.
- The provider offered services for adults and children. The service ensured that all patients were seen face to face for their consultation.
- The provider offered consultations to anyone who requested and paid the appropriate fee, and did not discriminate against anyone.
- The facilities and premises were appropriate for the services delivered. The premises was accessible for patients with mobility issues. The services were offered on the second floor. There was a lift and ramp available in the premises. The service had carried out an Access Audit.
- There was a patients' leaflet which included arrangements for dealing with complaints, information regarding access to the service, consultation and treatment fees, terms and conditions, and cancellation policy.
- The service website was well designed, clear and simple to use featuring regularly updated information. The service website included a translation facility.

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.
- The appointment system was easy to use. Appointments were available on a pre-bookable basis. The service only offered face to face consultations.
- Consultations were available between 9am to 9pm Monday to Saturday and 9am to 3pm Sunday. The provider was flexible to accommodate consultations if required for working patients who could not attend during normal opening hours.
- Patients could access the service in a timely way by making their appointment over the telephone, in person or online.
- This service was not an emergency service. Patients who had a medical emergency were advised to ask for immediate medical help via 999 or if more appropriate to contact their own GP or NHS 111.
- The patient feedback we received confirmed they had flexibility and choice to arrange appointments in line with other commitments.

Listening and learning from concerns and complaints

The service had a system in place for handling complaints and concerns.

- The service had a complaints policy and there were procedures in place for handling complaints. The policy contained appropriate timescales for dealing with the complaint. There was a designated responsible person to handle all complaints.
- The complaints policy included information of the complainant's right to escalate the complaint to the Centre for Effective Dispute Resolution (CEDR), the General Medical Council (GMC), and the Care Quality Commission (CQC) if dissatisfied with the response.
- Information about how to make a complaint or raise concerns was available. Staff treated patients who made complaints compassionately.
- We looked at two complaints received in the last nine months and found that complaints had been addressed in a professional manner and patients received a timely response. There was evidence that the service had provided an apology when required. However, complaint responses did not always include information of the complainant's right to escalate the complaint if dissatisfied with the response.

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

- Leaders had capacity and they aspired to deliver high-quality, sustainable care. However, there was a lack of effective clinical leadership.
- The registered manager (a non-clinical person) was the clinical governance lead and relied on the doctor's responsible officer to provide advice and mentoring to carry out this lead responsibility.
- The levels of risk found at this inspection was a direct result of the provider not ensuring appropriate systems had been implemented to effectively identify, manage and mitigate risk.
- Leaders understood the challenges and were trying to address them. However, they had faced staff recruitment challenges.
- On the day of the inspection, the provider told us they were in the process of recruiting a clinician who would be able to offer clinical leadership. However, the provider informed us three days after the inspection that one of the doctors (also the director) had agreed to perform duties as a clinical lead from 4 January 2019.
- Leaders at all levels were visible and approachable.

Vision and strategy

- The provider had a vision. However, the provider's vision to deliver high quality care and promote good outcomes for patients was not always supported by effective governance processes.
- The service was lacking a credible strategy to deliver high quality care, sustainable care. They did not have a formal documented business plan to include improvements to the service such as improving the way treatment was given and in line with current national guidelines.
- The provider had not monitored progress to identify and mitigate risks within the service.

Culture

- Staff felt respected, supported and valued. They were proud to work for the service.
- Openness, honesty and transparency were demonstrated when responding to incidents and complaints. The provider was aware of and had systems to ensure compliance with the requirements of the duty of candour.
- Staff 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. Staff were supported to meet the requirements of professional revalidation where necessary. Clinical staff were considered valued members of the team.
- There was a strong emphasis on the safety and well-being of all staff.
- The service actively promoted equality and diversity. Staff had received equality and diversity training. Staff felt they were treated equally.
- There were positive relationships between staff and teams.

Governance arrangements

There was a lack of good governance and improvements were required. The number of concerns we identified during the inspection demonstrated this. For example:

- Service specific policies were available and saved online in the cloud-based server. However, some policies and protocols did not include sufficient information including medicines management and handling of ultrasound scans. Most of the policies did not include the name of the author and they were not dated so it was not clear when they were written or when they had been reviewed.
- There were no systems or processes in place to ensure safe prescribing guidelines were followed. They did not have a documented repeat prescribing policy.
- There were ineffective processes to identify a failure to maintain securely an accurate, complete and contemporaneous record in respect of each service user. This includes a record of the care and treatment provided to the service user and of decisions taken in relation to the care and treatment provided.
- We found there was a lack of documented prescribing rationale when national guidelines were not followed.
- The service was unable to provide documentary evidence of any clinical audit demonstrating improved

Are services well-led?

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

outcomes for patients. An infection control audit was not in place to monitor infection control standards. There was no medicine or prescribing audit to monitor the quality of prescribing.

Managing risks, issues and performance

There were some processes in place for managing risks, issues and performance. However, improvements were required.

- There were some arrangements for identifying, recording and managing risks, issues and implementing mitigating actions. However, monitoring of specific areas required improvement, such as the management of medical records, recruitment checks and availability of a paediatric pulse oximeter were not always managed appropriately.
- The service did not have reliable systems for appropriate and safe handling of medicines to ensure safe prescribing.
- We noted the service was unable to monitor and review clinical activity effectively. This did not enable them to understand risks and give a clear, accurate and current picture that led to safety improvements.
- There was insufficient quality monitoring of clinicians' performance including the handling of ultrasound scans. Individual prescribing and diagnostic decisions were not monitored or reviewed by the service to assure themselves that treatment was given appropriately. There was no evidence of regular clinical supervision, mentorship or support. The provider could not demonstrate they had appropriate processes in place to assess the doctor's competency for the work they were undertaking. However, the doctors had received an internal appraisal within the last nine months.
- There was no peer review system in place.
- The service held regular staff team meetings.
- The service had developed a Medical Advisory Committee (MAC) and both the directors and the responsible officer were included in the MAC. They had decided to meet twice a year to review the performance of all practitioners with practising privileges.
- Clinical audit had not been carried out. There was no evidence of action to change services to improve quality.
- They did not have any formal monitoring system in place to ensure that regular safety checks had been undertaken by the host who was responsible for managing the premises.
- Service leaders had oversight of safety alerts, incidents, and complaints.
- The provider had plans in place and had trained staff for major incidents.

Appropriate and accurate information

- Quality and operational information was not always used to ensure and improve performance. Performance information was combined with the views of patients.
- Care and treatment records were securely kept but included limited information. The information needed to deliver safe care and treatment was not available to the relevant staff in an accessible way in a timely manner due to the language barrier.
- There were robust 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 encouraged and valued feedback from patients and staff.

- The service had gathered feedback from patients through feedback and in-house patient surveys. The service had carried out patients survey from March 2018 to October 2018. This was highly positive about the quality of service patients received.
- There were examples of compliments received by the service. We saw a number of positive comments documented on the online review websites at the time of our inspection.
- The service had initiated an online networking tool to communicate quickly with staff members. This networking platform was used to share information, staffing matters and monitor the resources.
- Staff meetings were held regularly which provided an opportunity for staff to engage with the service.

Continuous improvement and innovation

- There was a limited focus on continuous improvement and significant improvements were required.

Are services well-led?

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

- Staff were involved in discussions about how to run and develop the service.
- The staff we spoke with informed us that they could raise concerns and discuss areas of improvement with the directors as and when required. The staff were encouraged to identify opportunities to improve the service delivered.

This section is primarily information for the provider

Enforcement actions

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 **How the regulation was not being met:** We found the registered person did not have suitable arrangements in place for assessing and managing risks in order to protect the welfare and safety of service users and others who may be at risk from the carrying on of the regulated activity. In particular: The service did not have reliable systems for appropriate and safe handling of medicines. For example: • The service did not carry out regular medicines audit or prescribing audits. • They were unable to provide the information whether the doctors were prescribing any high risk medicines which required regular monitoring. • There was no monitoring system in place to assure whether the doctors were following the antibiotic prescribing protocol in place. • The service did not have a documented repeat prescribing policy. • The service informed us they did not prescribe or store any controlled drugs. However, the provider had failed to ensure the correct information was included in the medicines policy. This was in breach of regulation 12 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

This section is primarily information for the provider

Enforcement actions

Regulation 17 HSCA 2008 (Regulated Activities) Regulations 2014 Good Governance

How the regulation was not being met:

The registered person did not have effective governance, assurance and auditing processes to enable the registered person to assess, monitor and mitigate the risks relating to the health, safety and welfare of service users and others who may be at risk. In particular:

- There was a lack of good governance and limited evidence of quality improvement activity.
- There was a lack of effective clinical leadership.
- The levels of risk found at this inspection was a direct result of the provider not ensuring appropriate systems had been implemented to effectively identify, manage and mitigate risk.
- Information needed to deliver safe care and treatment was not always available to the relevant staff in a timely manner.
- There was limited information available in the consultation notes.
- Most of the scan results were documented in the Polish language or mixed notes were documented in both English and Polish languages.
- The service did not have reliable systems for appropriate and safe handling of ultrasound scans.
- The service was unable to provide evidence that the consultations of all clinicians were undertaken in line with accepted best practice in the UK or had a documented rationale for alternative treatment provided.
- There was insufficient quality monitoring of clinicians' performance.
- Some policies and protocols did not include sufficient information.
- They had not always undertaken appropriate recruitment checks prior to employment.
- There was no documented fire evacuation plan specific to the service. The provider did not carry out a risk assessment to identify how staff could support patients with mobility problems to vacate the premises.
- The service did not have any formal monitoring system in place to ensure that regular safety checks had been undertaken by the host who was responsible for managing the premises.

This section is primarily information for the provider

Enforcement actions

- The provider did not have clear and effective arrangements for following up on people who have been referred back to their NHS GP.

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