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Sample report, generated 2026-05-19

Verivius Mock Inspection Report, Worked Example

Provider: Northgate Day Surgery (fictional) **Location ID:** 1-22334455 (fictional) **CQC service type:** Acute services with overnight beds, NHS: No (private only) **Regulated activities:** Surgical procedures; Treatment of disease, disorder or injury **Inspection dates:** Platform review 11-15 May 2026; on-site fieldwork 18-19 May 2026; draft report 5 June 2026; final report 12 June 2026 **Consultant:** Janet Hardy (fictional; ex-CQC inspector, 14 years' inspection experience; nursing background, OPD theatre specialism) **Engagement reference:** MI-2026-001 **Pack version:** Verivius Mock Inspection v1, methodology dated 2026-05-19

> This is a worked example. All names, dates, locations, findings, and record IDs are fictional. The document illustrates the structure and depth of a finished Verivius Mock Inspection report so a prospect can see the shape of the deliverable before they buy. Do not present any of its content as a real engagement.
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1. Executive summary

Northgate Day Surgery is a single-location independent provider performing day-case cataract and minor general-surgery procedures. The provider has been registered with CQC since 2019 and holds a "Good" overall rating from its last inspection in February 2023. This engagement assessed the provider against the CQC Single Assessment Framework as published on cqc.org.uk on 1 April 2026.

Overall provisional rating: Requires improvement.

Two of the five CQC key questions are provisionally rated Requires improvement (Safe; Well-led). Both ratings are driven by specific, named process gaps rather than systemic failure. The provider has many real strengths, and the consultant judges that, with the action plan in Section 9 completed on schedule, Northgate could be ready for a real CQC inspection at the Good rating within 4-6 months.

Top three risks identified:

1. **Duty of Candour is being applied late or not at all** on incidents that meet the moderate-harm threshold. Four open incidents from the last 12 months have no recorded DoC assessment. This is the single highest-impact finding from this engagement and the headline action.

2. **Fit and proper persons evidence is out of date** for one of the three surgeons (DBS check last refreshed September 2022; the provider's own policy requires 3-yearly refresh).
3. **Whistleblowing / Freedom to Speak Up evidence is weak.** The policy exists and a Freedom to Speak Up Guardian is nominated, but there is no documented evidence of staff being made aware of the route, and no FtSU activity has been recorded since the role was created.

Top three strengths identified:

1. **Service-user feedback is consistently strong** (98% positive in the last quarter; 24-month trend stable).
2. **Complaints handling is exemplary.** All 7 complaints in the last 12 months acknowledged within 3 working days; substantive responses within the provider's 20-working-day target; 2 partially-upheld cases produced improvement actions, both completed on schedule.
3. **Monthly governance cycle is well-implemented.** Since the 2023 inspection the registered manager has run a monthly oversight meeting with documented minutes, decision log, and action follow-up. This is a material step up from the previous inspection finding.

Provisional ratings per key question:

Key question	Provisional rating	Direction of travel since 2023
Safe	Requires improvement	Static (DoC issue carries forward)
Effective	Good	Static
Caring	Good	Static
Responsive	Good	Improved (complaints handling)
Well-led	Requires improvement	Improved overall, but two new gaps prevent Good
Overall	**Requires improvement**	Static (the DoC gap drives the headline)

Headline recommended action: Implement a structured Duty of Candour assessment trigger on all moderate-harm-and-above incidents using the existing Verivius DoC sub-lifecycle, and backfill the assessment on the four open incidents from the last 12 months. With this single change completed (target: 30 June 2026), the Safe rating is provisionally Good; with the Well-led actions in Section 9 completed in parallel, the overall provisional rating returns to Good.

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2. Methodology and scope

2.1 Framework applied

This engagement applied the CQC Single Assessment Framework as published on cqc.org.uk on 1 April 2026, covering:

- Five key questions: Safe, Effective, Caring, Responsive, Well-led.
- Six evidence categories: People's experiences; Feedback from staff and leaders; Feedback from partners; Observation; Processes; Outcomes.
- The 23 Quality Statements that operationalise the key questions for the relevant service type.

Where this methodology and the live framework diverge as of the date of the inspector's reading, the live framework wins. The consultant noted no material divergence at the time of this engagement.

2.2 What was reviewed

Platform review (11-15 May 2026, ~3.5 working days of consultant time):

The consultant was granted Viewer access to the provider's Verivius tenant on 11 May 2026 and reviewed:

- **Incidents register:** 27 incidents covering the last 24 months. Cited record IDs INC-2024-0091 through INC-2026-0017.
- **Complaints register:** 12 complaints covering the last 12 months. Cited record IDs COM-2025-0001 through COM-2026-0003.
- **Safeguarding register:** 4 safeguarding concerns covering the last 24 months. Cited record IDs SFG-2024-0011 through SFG-2026-0001.
- **Notifications register:** 8 outbound notifications covering the last 24 months. Cited record IDs NOT-2024-0005 through NOT-2026-0002.
- **Safety alerts register:** 19 alerts covering the last 12 months, with 17 actioned and 2 marked not-applicable.
- **Improvement actions register:** 41 actions covering the last 12 months, of which 38 are closed (93%) and 3 are in progress.
- **Document register:** 142 documents including 18 policies, 24 audits, 12 governance committee minutes packs, 36 training records, 52 operational SOPs and standards.
- **People register:** 14 staff records.
- **Mandatory monthly governance reports:** 11 monthly reports from June 2025 to April 2026 (the provider's monthly cycle).

The platform review applied the consultant's own structured note-taking against the 23 Quality Statements; the consultant logged 53 candidate findings during this phase, of which 24 carried forward to the final report after triangulation in fieldwork.

Fieldwork (18-19 May 2026, on-site, 2 working days of consultant time):

The consultant attended the location for 2 working days. Activities:

- Tour of the clinical area, theatres, decontamination area, drug storage, patient waiting and recovery areas.
- Eight structured conversations: registered manager (60 min); nominated individual (60 min); one of the three surgeons (45 min); two of the four operating-department practitioners (30 min each); the lead nurse (45 min); the lead pharmacist (45 min); a healthcare assistant (30 min). Conversations were private. Each interviewee was assured that their words would be reported anonymously in the report.
- Patient pathway tracing: two cataract patients followed end-to-end from arrival to discharge. Both consented to the consultant's presence; no clinical care was delayed by the observation.
- Document spot-checks: 14 specific documents pulled at random from the document register and physically inspected against the platform record.
- Drug storage and CD register physical inspection: present in the inspector's company; lead pharmacist available; reconciliation walked through for the audit window.
- Sterile services traceability walk-through: 3 instrument tray batch numbers traced from the autoclave log through the theatre log into the patient record.

Report drafting (20 May to 5 June 2026, ~3 working days of consultant time):

Synthesis of platform review and fieldwork notes into this report.

2.3 Scope clarifications

This engagement assessed all the regulated activities at the location, with intensified focus on:

- Safe care and treatment (HSCRA Reg 12), particularly the medicines management and Duty of Candour dimensions.
- Good governance (HSCRA Reg 17), particularly the monthly oversight cycle and the board / independent oversight question.
- Fit and proper persons employed (HSCRA Reg 19), particularly the credentialing currency.

The scope did not include:

- A clinical-outcomes audit (this is not within the consultant's professional remit; the provider's own audit cycle generates this evidence, and the consultant reviewed the audit cycle's currency but not its substantive findings).
- A premises safety / Fire Risk Assessment audit (the consultant noted FRA documentation in the register; the substantive fire safety assessment is the Responsible Person's duty).
- A financial / commercial assessment (out of scope of the Mock Inspection product).

2.4 Method limitations and consultant disclosures

The consultant disclosed at engagement start: no prior professional relationship with Northgate Day Surgery or its staff; no personal connection to the company's directors. The consultant's previous CQC inspection experience covers approximately 240 inspections across NHS and independent acute providers, including 60+ day-case surgery providers.

This report is the consultant's professional judgement against the live CQC framework. It is not endorsed, certified, or approved by CQC. Real CQC inspectors may reach different conclusions on the same evidence.

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3. Service profile

Northgate Day Surgery is a 6-suite day-case theatre operating from purpose-built premises in Northgate, Greater Manchester. The premises were custom-built in 2018-2019; the provider has been operational since November 2019 and CQC-registered since the same date.

Activity volumes (last 12 months):

- Approximately 1,200 procedures per year.
- Cataract surgeries: approximately 800 (66% of volume).
- Minor general-surgery cases: approximately 400 (34% of volume; principally hernia repair, varicose vein procedures, minor skin lesion excision).
- Day-case rate: 100% (no overnight stays; transfer-out arrangement with the local NHS trust for any patient requiring escalation).

Staffing (14 total):

- 3 consultant surgeons (2 ophthalmic, 1 general surgery). All hold substantive NHS consultant contracts elsewhere; Northgate is a private-practice secondary site.
- 4 operating-department practitioners (band 6 equivalent).
- 2 registered nurses (1 senior, 1 junior).
- 3 healthcare assistants.
- 2 administrative staff (one of whom is the practice manager / governance lead, reporting to the registered manager).

The registered manager is also one of the three surgeons (Mr Patel, the senior ophthalmic consultant, anonymised). The nominated individual is Mr Patel's spouse, who serves as the provider company's director but does not work clinically.

Patient demographic: approximately 70% NHS-contracted overflow patients (under the Independent Sector Treatment Centre arrangement with the regional ICB) and 30% private-pay. Predominantly aged 60-85 (the cataract population).

Premises: ground-floor purpose-built unit on a small business park; 6 theatre suites; pre-operative consultation rooms; recovery bay with 8 trolleys; decontamination room with autoclave; controlled-drugs storage; staff areas; patient waiting and reception.

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4. Safe, provisional rating: Requires improvement

Reasoning: Northgate has a generally strong safety culture and clinical outcomes are within expected ranges. The incident learning rate is materially above sector benchmark. However, four specific process gaps prevent a Good rating, of which the Duty of Candour application gap is the most serious.

Finding S1, Duty of Candour application is inconsistent (critical risk)

The incidents register shows 27 incidents recorded over the last 24 months. Of these, 7 are tagged with moderate harm or above (per the provider's own harm-level scale, which aligns to the CQC harm taxonomy). The Verivius Duty of Candour sub-lifecycle has been triggered on 3 of these 7; the other 4 have no recorded DoC assessment.

Of the 4 unassessed incidents:

- INC-2025-0042: post-operative pain reported by patient at 36-hour follow-up, eventually managed by GP. Moderate harm. No DoC assessment.
- INC-2025-0051: corneal abrasion identified during recovery (instrument contact, not patient-action). Moderate harm. No DoC assessment.
- INC-2026-0003: medication administration error (incorrect dose of post-operative analgesia by a factor of 2). Moderate harm. No DoC assessment.
- INC-2026-0007: patient identification near-miss escalated by ODP before the procedure started. No physical harm but the near-miss itself was reportable to the patient under the provider's own DoC policy (which applies a threshold below the statutory line, as a positive safety practice).

The provider's policy on Duty of Candour, dated October 2023, is well-documented and aligns with HSCRA Regulation 20. The gap is in operational application, not policy. The registered manager confirmed in conversation that the DoC sub-lifecycle is "always intended to be used" but acknowledged that on busy weeks the trigger is missed.

Evidence: Incidents INC-2025-0042, INC-2025-0051, INC-2026-0003, INC-2026-0007. Duty of Candour Policy v3.2, document register entry DOC-POL-DUTY-CANDOUR-V3.2. Registered manager interview, 18 May 2026.

Statutory anchor: HSCRA Reg 20(2) requires the registered person to "act in an open and transparent way with relevant persons in relation to care and treatment provided" and (Reg 20(3)) "as soon as reasonably practicable after becoming aware that a notifiable safety

incident has occurred", notify the relevant person of the incident in accordance with this regulation. The "as soon as reasonably practicable" language is statutory; specific timeframes ("10 working days" in some industry guidance) are operational defaults, not statutory.

Severity: Critical risk.

Finding S2, Controlled-drugs reconciliation has weekly gaps

The documents register holds a controlled-drugs register (paper-based; the provider keeps the original at the controlled-drugs cupboard and a scanned weekly copy in the document register). Reconciliation entries are missing for the weeks of 8 March, 22 March, and 12 April 2026.

The lead pharmacist confirmed in conversation that the missing weeks correspond to her annual leave; no backup arrangement was in place. On the consultant's request, the lead pharmacist walked through the controlled-drugs stock balance on 19 May 2026. The stock balance matched the most recent reconciled entry (5 May 2026); no discrepancy is evident from the available records.

The Misuse of Drugs Regulations 2001 (SI 2001/3998) Regulation 19 requires the responsible person to keep a controlled-drugs register meeting specified content requirements. The MD(SC)R 1973 imposes safe-custody requirements. Neither regulation mandates a specific reconciliation frequency, but the absence of any reconciliation across the 6-week audit window indicates that the provider's own SOP (weekly reconciliation per the medicines management policy) was not followed.

Evidence: Controlled-drugs register, March-April 2026 (paper original inspected). Medicines Management Policy v2.1, document register entry DOC-POL-MEDICINES-V2.1. Lead pharmacist interview, 19 May 2026.

Statutory anchor: Misuse of Drugs Regulations 2001 (SI 2001/3998) Reg 19; HSCRA Reg 12 (Safe care and treatment); the provider's own Medicines Management Policy.

Severity: Gap (no harm evident; process discipline missing).

Finding S3, WHO Surgical Safety Checklist completeness has minor gaps

The theatre log records WHO Surgical Safety Checklist completion for every procedure. Patient pathway tracing on 18-19 May 2026 confirmed checklist application in real-time for two cataract procedures observed. However, document spot-check of 30 randomly-selected procedures from the last 90 days showed that the "pre-procedure team briefing" component of the Checklist was marked as complete-without-comments for 27 of 30 procedures (90%) but the corresponding briefing notes were absent for 8 of those 27 (30% of the marked-complete subset).

In conversation, the lead nurse explained that the team briefing is conducted but is sometimes verbal-only, with the formal note completed at end of list. The consultant's view is that this is

operationally defensible but the documentation gap creates evidential vulnerability.

Evidence: Theatre log, March-May 2026. WHO Surgical Safety Checklist SOP v1.4, document register entry DOC-SOP-WHO-SSC-V1.4. Lead nurse interview, 19 May 2026.

Severity: Minor gap.

Finding S4, Drug fridge temperature monitoring has 3 missing daily log entries

Daily temperature monitoring of the controlled-drug fridge and the room-temperature medicines fridge is the provider's SOP. The temperature log for the last 90 days shows 87 of 90 daily entries (97% completion). The 3 missing entries cluster around the May Bank Holiday weekend (28-30 April and 1 May 2026).

No temperature excursion is evident on the surrounding entries.

Evidence: Fridge temperature log, March-May 2026.

Severity: Minor gap.

Finding S5, Sterile services traceability is strong

The consultant traced three instrument tray batch numbers from the autoclave log through the theatre log into the patient record. All three resolved cleanly; the patient record cited the specific tray batch number consumed. This is materially above the typical day-case surgery provider's traceability.

Evidence: Autoclave log, theatre log, patient records (anonymised), 11-15 May platform review.

Severity: Strength.

Finding S6, Strong incident learning culture

The incidents register shows that learning summaries are written on every closed incident (27 of 27, 100%) and improvement actions are completed at 93% within the original target date. This is materially above the typical day-case surgery provider's pattern (sector benchmark approximately 70-80%). The consultant noted that the learning summaries are substantive (averaging 200-400 words) and reference both clinical and operational dimensions.

Evidence: Incidents register, all 27 entries, last 24 months.

Severity: Strength.

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5. Effective, provisional rating: Good

Reasoning: Clinical outcomes are within expected ranges. The audit cycle is mostly current. Refresher training cadence has minor gaps but no systemic issue. The NICE guidance review currency is satisfactory.

Finding E1, Clinical outcomes within expected ranges

The provider's own quarterly clinical outcomes audit (cataract: visual acuity at 4-week post-op; general surgery: re-attendance / complication rates at 30 days) shows outcomes within or above national benchmarks for the last 8 quarters reviewed. The audit was conducted by the provider's own audit team (the practice manager + one of the surgeons), not externally peer-reviewed; this is normal for a provider of this size and is methodologically defensible but worth noting.

Evidence: Quarterly clinical outcomes audits Q3 2024 - Q1 2026, document register entries DOC-AUD-CLINICAL-2024Q3 through DOC-AUD-CLINICAL-2026Q1.

Severity: Strength.

Finding E2, Refresher training cadence has 2 individual gaps

The training records register shows that 11 of 14 staff are current on all their mandatory annual training. The 3 individuals with gaps are:

- One ODP (anonymised) whose annual safeguarding refresher is overdue by 6 weeks.
- One ODP (anonymised) whose annual basic life support refresher is overdue by 4 weeks.
- One healthcare assistant whose moving and handling refresher is overdue by 3 weeks.

In each case the staff member confirmed in conversation that they are booked for the next available session (June 2026) and the practice manager confirmed the schedule.

Evidence: Training records register, individual records (anonymised). Practice manager interview, 19 May 2026.

Severity: Minor gap (operationally being closed within the consultant's review period).

Finding E3, Audit cycle is mostly current

The provider's audit schedule (defined in the Governance Policy) lists 5 quarterly audits across clinical outcomes, infection prevention and control, medicines management, complaints handling, and patient experience. In the period under review (Q3 2024 - Q1 2026, 7 quarters), 32 of 35 expected audits are documented (91%). The 3 missing audits are:

- Q2 2025 IPC audit (rescheduled; the lead nurse confirmed and provided the rescheduled minutes from Q3 2025 that included the deferred content).
- Q4 2025 patient experience audit (the practice manager confirmed this was deferred for staffing reasons; deferred work appears in the Q1 2026 audit).

- Q1 2026 complaints handling audit (in progress at the time of inspection; due 30 June 2026).

Evidence: Audit register, document register entries DOC-AUD-* covering the period. Governance Policy v4.0, document register entry DOC-POL-GOV-V4.0.

Severity: Minor gap (the deferred audits have appeared in subsequent quarters' work).

Finding E4, NICE guidance review currency is satisfactory

The provider's quarterly NICE guidance review log shows that all relevant NICE guidance updates published in the last 12 months have been reviewed against the provider's local protocols. Two updates (NG214 cataracts in adults, NG140 perioperative care in adults) had no protocol changes required; one (NG28 type 2 diabetes in adults, relevant for the provider's peri-operative diabetes-screening protocol) triggered a minor protocol amendment that was documented and circulated.

Evidence: NICE guidance review log, document register entry DOC-AUD-NICE-2026Q1.

Severity: Strength.

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6. Caring, provisional rating: Good

Reasoning: Patient feedback is consistently strong. Consent documentation completeness is high. Dignity practice on the ward was observed positively. No findings to weight the rating downwards.

Finding C1, Patient feedback consistently strong

The patient experience audits (quarterly; last conducted Q1 2026) report Net Promoter Score of 76 and patient-reported positive sentiment at 98% for the last quarter. The trend over the last 24 months is stable (Net Promoter Score range 73-81). Free-text comments cited in the audits emphasise the calm waiting area, staff friendliness, and clear pre-operative communication. There is no recurring theme in the negative-sentiment minority that warrants action.

Evidence: Patient experience audits Q3 2024 - Q1 2026, document register entries DOC-AUD-PATEXP-2024Q3 through DOC-AUD-PATEXP-2026Q1.

Severity: Strength.

Finding C2, Consent documentation completeness is high

Pathway tracing of two cataract patients during fieldwork confirmed that pre-operative consent was taken, recorded in the patient record, and that the patient was given a written

copy. Document spot-check of 20 randomly-selected consents from the last 90 days showed 19 of 20 (95%) with all required fields completed; the one outlier had the witness signature missing but was otherwise complete.

The consent forms reflect the post-Montgomery (Supreme Court 2015) requirement to inform patients of material risks. The consultant noted that the form template was updated to a post-Montgomery version in October 2023 and has been consistently applied since.

Evidence: Consent forms (anonymised) from the last 90 days. Consent SOP v2.0, document register entry DOC-SOP-CONSENT-V2.0.

Severity: Strength.

Finding C3, Dignity practice observed positively

Fieldwork observation of the recovery area and the pre-operative waiting area found no concerns. Curtains were drawn during examinations; staff knocked before entering the recovery bay's privacy curtain area; patient names were used (after verifying with the patient that they preferred first names over surnames). The consultant's professional judgement: the dignity practice is operationally embedded.

Evidence: Fieldwork observation, 18-19 May 2026.

Severity: Strength.

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7. Responsive, provisional rating: Good

Reasoning: Complaints handling is exemplary. Reasonable adjustments are anticipated and provided. Patient flow is well-managed. Cancellation rate is low and root-causes are documented.

Finding R1, Complaints handling is exemplary

Of the 12 complaints received in the last 12 months, all 12 were acknowledged in writing within 3 working days (the provider's policy target is 3 days, which exceeds the HSCRA Reg 16 "without delay" expectation). Substantive responses were issued within the provider's 20-working-day target on 11 of 12 (the 12th took 23 working days; the complaint contained a clinical-outcomes element that required a consultant peer review).

Two complaints were partially upheld:

- COM-2025-0007: patient was not adequately briefed about expected post-operative discomfort; the apology was issued and the pre-operative information sheet was updated. The improvement action IMP-2025-0089 was closed within 3 weeks.

- COM-2025-0014: appointment was rescheduled at short notice; the apology included a goodwill gesture and the booking SOP was amended. The improvement action IMP-2026-0005 was closed within 4 weeks.

Evidence: Complaints register, all 12 entries, last 12 months. Linked improvement actions IMP-2025-0089, IMP-2026-0005. Complaints Policy v3.0, document register entry DOC-POL-COMPLAINTS-V3.0.

Severity: Strength.

Finding R2, Reasonable adjustments are anticipated and provided

The accessibility log documents the provider's anticipatory programme under the Equality Act 2010 Section 20:

- Easy-read pre-operative information sheet available on request (used 8 times in the last 12 months).
- Hearing-loop in the consultation room and reception (tested monthly; last test 6 May 2026, working).
- BSL interpreter on-call arrangement with a named agency (used twice in the last 12 months).
- Accessible toilet with low-level grab rails and a fold-down changing platform.
- Step-free entry; lift not required (ground-floor unit).

The provider's Equality and Reasonable Adjustments Policy is current (reviewed October 2025).

Evidence: Accessibility log, document register entry DOC-LOG-ACCESS-2025-2026. Equality and Reasonable Adjustments Policy v2.0, document register entry DOC-POL-EQUALITY-V2.0.

Severity: Strength.

Finding R3, Patient flow is well-managed

Pathway tracing on 18-19 May 2026 found patient waiting times averaging 12 minutes from arrival to consultation, against a 20-minute provider target. Cataract list throughput is steady. No bottleneck observed in the recovery area; recovery dwell time aligned with the post-operative protocol.

Evidence: Fieldwork observation; theatre log, 18-19 May 2026.

Severity: Strength.

Finding R4, Cancellation rate is low and documented

The provider's cancellation rate for the last 12 months is 2.3% (27 cancellations across approximately 1,200 procedures). Root cause is documented for each. The most common

reasons are patient-side (illness on the day, transport issues) at 17 of 27 (63%); provider-side cancellations (equipment failure, staff absence) account for 6 of 27 (22%); and rescheduling for clinical reasons (e.g., pre-procedure assessment flagging a need for further investigation) accounts for 4 of 27 (15%).

Evidence: Cancellation log, last 12 months.

Severity: Strength.

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8. Well-led, provisional rating: Requires improvement

Reasoning: A strong monthly governance cycle and an engaged registered manager are offset by three specific governance-and-credentialing gaps: training records for new staff (W1), fit and proper persons evidence currency (W3), and weak Freedom to Speak Up activity (W4). The provider also lacks meaningful independent oversight (W5), although this is a common pattern in single-location ISC providers and is not in itself a regulatory finding; it is noted as a structural observation.

Finding W1, Staff training records are incomplete for two new ODPs

Two operating-department practitioners (anonymised) onboarded in February 2026 have no recorded completion of the mandatory induction safeguarding module or the controlled-drugs administration competency assessment. The People register holds their basic record; the Documents register has no training certificates attached for either individual.

In conversation, the practice manager confirmed that the inductions did occur (the verbal and demonstration components) but that the certificate-attachment-to-record step was missed. Both individuals are booked to redo the safeguarding module and CD competency in June 2026 to create a documented record.

Evidence: People register, two individuals (anonymised). Document register, search for staff training certificates February-May 2026. Practice manager interview, 19 May 2026.

Statutory anchor: HSCRA Reg 18 (Staffing) requires the registered person to ensure persons employed receive such training as is necessary to enable them to carry out the duties they are employed to perform. The evidence requirement under Reg 17(2) (good governance) means the training record must be documented, not only that the training occurred.

Severity: Risk.

Finding W2, Monthly oversight cycle is exemplary

Since the 2023 inspection the registered manager has implemented a monthly oversight meeting with documented minutes filed in the Documents register. The cycle covers: review of all incidents and complaints; CD reconciliation status; training currency; audit cycle status;

safety alerts received and actioned. The Verivius monthly oversight report is reviewed at every meeting; the consultant verified that 11 of 11 monthly reports in the period under review were both generated AND reviewed AND minuted (the latter being the gap most often found in similar providers).

This is a material improvement over the 2023 inspection finding (the 2023 report noted that monthly oversight was conducted but not minuted).

Evidence: Monthly governance meeting minutes June 2025 - April 2026, document register entries DOC-MIN-MONTHLY-2025-06 through DOC-MIN-MONTHLY-2026-04. Verivius monthly oversight reports same period.

Severity: Strength.

Finding W3, Fit and proper persons evidence is out of date for one surgeon

The People register entries for the three surgeons include their professional registration numbers, dates of substantive employment, and dates of DBS check. The provider's own Fit and Proper Persons Policy requires DBS check refresh every 3 years.

Two of the three surgeons have current DBS checks (refreshed in 2024 and 2025 respectively). The third (Surgeon C, anonymised) has a DBS check dated September 2022; the refresh is now overdue by approximately 8 months.

In conversation, the registered manager acknowledged the gap and stated that a DBS check refresh was initiated on 14 May 2026 (4 days before fieldwork) and that the certificate is expected by mid-June. The consultant verified the DBS application reference in the People register entry.

Evidence: People register, three surgeon entries (anonymised). Fit and Proper Persons Policy v1.3, document register entry DOC-POL-FPP-V1.3. Registered manager interview, 18 May 2026.

Statutory anchor: HSCRA Regulation 19 (Fit and proper persons employed) requires the registered person to be satisfied that persons employed have such qualifications, competence, skills and experience as are necessary for the work to be performed and are physically and mentally fit (subsection 2(b)). DBS check currency is part of the operational discharge of this duty; the 3-year refresh cycle is the provider's own policy, not a statutory deadline.

Severity: Risk (mitigated by the refresh in progress).

Finding W4, Freedom to Speak Up evidence is weak

The Freedom to Speak Up Policy v1.1 (dated August 2024) exists in the document register. A Freedom to Speak Up Guardian has been nominated (the practice manager, doubling the role). However:

- There is no documented evidence that staff have been told about the route. Staff induction records do not include FtSU briefing.
- The Guardian has not reported any FtSU activity since the role was created in August 2024 (a 21-month period). It is possible that no staff member has felt the need to use the route, but the absence of any activity AND the absence of documented awareness-raising together suggest the route is not visible to staff.

Two of the four staff members the consultant spoke to (the two ODPs, anonymised) said in conversation that they did not know who the FtSU Guardian was. One (the lead nurse) named the Guardian correctly. The healthcare assistant said the term was unfamiliar.

Evidence: Freedom to Speak Up Policy v1.1, document register entry DOC-POL-FTSU-V1.1. Staff interviews 18-19 May 2026 (anonymised). No FtSU activity log present in the document register.

Statutory anchor: No single statutory section; the Public Interest Disclosure Act 1998 protects whistleblowers; HSCRA Regulation 17(2)(e) requires the registered person to "investigate, and where necessary take action in respect of, any complaint, observation or feedback made or received from service users and other persons in respect of the carrying on of the regulated activity".

Severity: Risk.

Finding W5, No independent governance oversight (structural observation)

The registered manager (Mr Patel, anonymised) is also one of the three surgeons and a 33% shareholder in the provider company. The nominated individual (Mr Patel's spouse) holds the other 67% but does not work clinically and does not participate in clinical governance meetings.

The monthly governance meeting is therefore convened, chaired, and minuted by the same person whose practice is being reviewed at the meeting. The complaints handling and DoC pathways report into the registered manager; there is no independent route for issues to escalate outside the management line.

This is a common structural pattern in single-location ISC providers and is not in itself a regulatory finding. The consultant flags it because:

- The DoC application gap in S1 may be partly a function of this structure (the manager who would be expected to chase DoC application is the manager whose own practice may be DoC-relevant).
- The provider may wish to consider a periodic external clinical-governance peer review or an independent non-executive role on the governance committee as the company grows.

Evidence: Companies House records (public); Governance Policy v4.0; monthly meeting minutes.

Severity: Structural observation (not a regulatory finding).

Finding W6, IPC governance is mostly current but environmental audit is overdue

The Infection Prevention and Control Policy is current (reviewed October 2025). Hand hygiene audits are monthly and the last 12 months show >95% compliance, with the lowest single-month figure at 92%. Antimicrobial stewardship is minimal at this provider (antimicrobial prescribing is limited to peri-operative prophylaxis on a small subset of cases, and the provider's pharmacist confirmed adherence to the protocol).

The environmental audit (which should be quarterly per the policy) was last conducted in Q3 2025 and the Q4 2025 and Q1 2026 audits have not been completed. The lead nurse confirmed that the audit is scheduled for early June 2026.

Evidence: IPC Policy v2.2, document register entry DOC-POL-IPC-V2.2. Hand hygiene audits, monthly for last 12 months. Environmental audit log; lead nurse interview, 19 May 2026.

Severity: Minor gap.

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9. Action plan

The action plan groups by priority. Each action carries a target completion date; the provider is encouraged to convert each into an improvement-actions register entry on the platform with a named owner, target date, and finding reference.

High priority

#	Action	Owner	Due	Source finding
IMP-2026-0044	Backfill Duty of Candour assessment on the four moderate-harm-and-above open incidents from the last 12 months (INC-2025-0042, INC-2025-0051, INC-2026-0003, INC-2026-0007). Each backfill recorded on the Verivius DoC sub-lifecycle with verbatim Reg 20 reference.	Registered manager	2026-06-30	S1
IMP-2026-0045	Implement the Verivius DoC sub-lifecycle as the default workflow on every moderate-harm-and-above incident going forward. Configure the tenant such that closing an incident at moderate-harm-and-above without a DoC assessment requires an explicit "DoC not required, reason" entry.	Registered manager	2026-06-15	S1

#	Action	Owner	Due	Source finding
IMP-2026-0046	Complete the DBS check refresh for Surgeon C and attach the certificate to the People register entry.	Practice manager	2026-06-30	W3
IMP-2026-0047	Complete induction safeguarding training and CD administration competency for the two ODPs onboarded in February 2026. Attach training certificates to each People register entry.	Practice manager	2026-06-30	W1

Medium priority

#	Action	Owner	Due	Source finding
IMP-2026-0048	Establish a backup controlled-drugs reconciliation procedure for weeks when the lead pharmacist is absent. Designate a deputy reconciler in the SOP.	Lead pharmacist	2026-07-31	S2
IMP-2026-0049	Add a "team briefing notes" field to the theatre log such that the WHO Surgical Safety Checklist's pre-procedure briefing component captures the substantive notes at the time of marking. Apply prospectively from 1 July 2026.	Lead nurse	2026-07-01	S3
IMP-2026-0050	Reinstate the daily drug fridge temperature monitoring on Bank Holiday weekends through a published roster or an automatic monitoring device.	Lead pharmacist	2026-08-31	S4
IMP-2026-0051	Conduct the overdue annual refresher training for the three named staff (two ODPs + one HCA) by 30 June 2026. Document in their People register entries.	Practice manager	2026-06-30	E2
IMP-2026-0052	Complete the Q1 2026 complaints handling audit and bring the audit cycle current.	Practice manager	2026-06-30	E3
IMP-2026-0053	Conduct the overdue Q4 2025 and Q1 2026 environmental IPC audits (combined catch-up audit acceptable per the policy).	Lead nurse	2026-06-30	W6

#	Action	Owner	Due	Source finding
IMP-2026-0054	Issue a tenant-wide Freedom to Speak Up briefing to all 14 staff. Document the briefing in each person's training record. Add an annual FtSU briefing into the induction and refresher cadence.	Freedom to Speak Up Guardian	2026-07-31	W4
IMP-2026-0055	Establish an FtSU activity log in the document register, even where the log reads "no activity in this period" for quarters where no concerns are raised, so the route's existence is visible in the audit trail.	Freedom to Speak Up Guardian	2026-07-31	W4

Lower priority / structural

#	Action	Owner	Due	Source finding
IMP-2026-0056	Attach training certificates to staff records as part of onboarding going forward. Add a step to the onboarding checklist.	Practice manager	Ongoing	W1
IMP-2026-0057	Consider a periodic external clinical-governance peer review or an independent non-executive role on the governance committee. Defer to nominated individual / shareholder decision; surface in the next quarterly governance review.	Nominated individual	Q3 2026	W5 (structural observation)
IMP-2026-0058	Confirm the audit-cycle calendar with all named owners at the start of each quarter, surfacing any deferral risks one quarter ahead.	Practice manager	Ongoing	E3

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10. Re-inspection readiness statement

In the consultant's judgement, Northgate Day Surgery would be ready for a real CQC inspection at the Good rating by **October 2026**, provided:

- The four high-priority actions (IMP-2026-0044, 0045, 0046, 0047) are completed by their target dates of 30 June 2026.
- The Freedom to Speak Up programme (IMP-2026-0054, 0055) is in place by 31 July 2026, with documented evidence of staff briefings.
- The controlled-drugs reconciliation backup procedure (IMP-2026-0048) is documented and operational by 31 July 2026.
- The medium-priority actions are demonstrably progressing through to closure on schedule.

The consultant emphasises that this is a professional judgement against the live CQC framework. A real CQC inspection may reach different conclusions; the readiness statement is the consultant's view of the work needed to make the rating defensible, not a guarantee of the rating CQC will reach.

A 3-month follow-up check is booked for 12 September 2026, included in the engagement fee. The follow-up will assess action-plan completion and any new issues since the report.

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11. Comparison to last CQC inspection (February 2023)

The 2023 CQC inspection rated Northgate Day Surgery Good overall (Good across all five key questions). The current consultant assessment is Requires improvement overall.

The change is driven by:

- **DoC application has not improved since 2023.** The 2023 report noted "occasional inconsistency" in DoC application; the 2026 review finds the inconsistency has worsened (4 unassessed moderate-harm incidents in the last 12 months versus 1 in the 2023 audit window).
- **Two new gaps have emerged.** The Freedom to Speak Up programme weakness (W4) was not previously a finding because the FtSU role was created post-2023. The Surgeon C DBS check currency (W3) is a function of timing; the 2023 inspection caught the prior 3-yearly refresh as current.

Things that have improved since 2023:

- Monthly governance cycle (was conducted-but-not-minuted; now exemplary).
- Complaints handling pathway (was reactive; now exemplary).
- Patient experience audit cycle (was annual; now quarterly).

Things that have stayed the same:

- Clinical outcomes (stable, within expected ranges).
- Caring (stable, with strong patient feedback).

The 2026 ratings drop is therefore not a deterioration in the substantive quality of care, but in two specific governance / credentialing dimensions that the 2023 inspection either did not surface or that have arisen since.

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12. Sources and traceability appendix

Records cited in the body of this report:

Incidents: INC-2024-0091 through INC-2026-0017 (27 records). Specifically cited: INC-2025-0042, INC-2025-0051, INC-2026-0003, INC-2026-0007.

Complaints: COM-2025-0001 through COM-2026-0003 (12 records). Specifically cited: COM-2025-0007, COM-2025-0014.

Safeguarding concerns: SFG-2024-0011 through SFG-2026-0001 (4 records). None individually cited; the absence of safeguarding concerns is itself noted.

Notifications: NOT-2024-0005 through NOT-2026-0002 (8 records). None individually cited.

Safety alerts: 19 records over the last 12 months; 17 actioned, 2 marked not-applicable. Aggregate citation only.

Improvement actions: Existing actions referenced in the body (IMP-2025-0089, IMP-2026-0005). Action plan actions to be created at IMP-2026-0044 through IMP-2026-0058.

Documents cited:

- Duty of Candour Policy v3.2 (DOC-POL-DUTY-CANDOUR-V3.2).
- Medicines Management Policy v2.1 (DOC-POL-MEDICINES-V2.1).
- Complaints Policy v3.0 (DOC-POL-COMPLAINTS-V3.0).
- Governance Policy v4.0 (DOC-POL-GOV-V4.0).
- WHO Surgical Safety Checklist SOP v1.4 (DOC-SOP-WHO-SSC-V1.4).
- Consent SOP v2.0 (DOC-SOP-CONSENT-V2.0).
- Fit and Proper Persons Policy v1.3 (DOC-POL-FPP-V1.3).
- Freedom to Speak Up Policy v1.1 (DOC-POL-FTSU-V1.1).
- Equality and Reasonable Adjustments Policy v2.0 (DOC-POL-EQUALITY-V2.0).
- IPC Policy v2.2 (DOC-POL-IPC-V2.2).
- Monthly governance meeting minutes (DOC-MIN-MONTHLY-2025-06 through DOC-MIN-MONTHLY-2026-04).
- Quarterly clinical outcomes audits Q3 2024 - Q1 2026 (DOC-AUD-CLINICAL-*).
- Quarterly patient experience audits Q3 2024 - Q1 2026 (DOC-AUD-PATEXP-*).

- NICE guidance review log Q1 2026 (DOC-AUD-NICE-2026Q1).
- Accessibility log 2025-2026 (DOC-LOG-ACCESS-2025-2026).

Fieldwork participants (anonymised):

- Registered manager (Mr Patel pseudonym; senior ophthalmic surgeon).
- Nominated individual (spouse of registered manager; non-clinical director).
- Surgeon B (ophthalmic).
- Surgeon C (general).
- Lead nurse.
- Lead pharmacist.
- Two operating-department practitioners.
- One healthcare assistant.

Total fieldwork conversation time: approximately 6.5 hours across the two days.

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13. Disclaimers and process narrative

Verivius Mock Inspection disclaimers

A Verivius Mock Inspection is not endorsed, certified, or approved by the Care Quality Commission. Provisional ratings stated in this report are the consultant's professional judgement against the live CQC Single Assessment Framework. Real CQC inspectors may reach different conclusions on the same evidence.

This report is the customer's confidential document. Verivius retains a copy for record-keeping in line with its Records Management Policy. The consultant retains professional notes in accordance with their own professional records retention practice.

The methodology used in this engagement mirrors the CQC Single Assessment Framework as published on cqc.org.uk on 1 April 2026. Where this methodology and the live framework diverge after that date, the live framework wins.

Process narrative

- The customer received this report on 5 June 2026 as a draft.
- The customer has a 5-working-day factual-correction window from receipt to flag factual errors in writing. Factual errors are: a date was misstated, a record was misread, a person's role was wrongly described. The factual-correction window is not for rating disputes; rating disputes are handled under clause 2.5 of the engagement letter (arbitration).

- The customer flagged 2 factual corrections during the window (date of last training-record entry for one ODP; spelling of the lead pharmacist's surname). Both corrections were verified and the report updated.
- The final report was issued on 12 June 2026.
- The 3-month follow-up check is booked for 12 September 2026 and is included in the engagement fee.

Consultant statement

I confirm that this report is my professional judgement against the live CQC Single Assessment Framework and that the findings reported are based on the evidence cited. I have no prior or current professional relationship with Northgate Day Surgery or its staff that would affect the objectivity of my assessment.

Janet Hardy (fictional) Ex-CQC inspector, 14 years' inspection experience 12 June 2026
