

Cooper Health at Cardio Direct Limited

112 Harley Street

Inspection report

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Overall summary

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

Our findings were:

Are services safe?

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

Are services effective?

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

Are services caring?

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

Are services responsive?

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

Are services well-led?

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

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

CQC have not inspected this service before. This service was registered by CQC on 7 June 2018. New services are assessed to check they are likely to be safe, effective, caring, responsive and well-led.

The provider, 112 Harley Street, also known as Cooper Health Limited, is registered with the CQC as an organisation providing an independent doctors consulting service to private patients from consulting rooms at 112 Harley Street, London W1G 6HJ. The provider is registered to provide the regulated activities of treatment of disease, disorder or injury and diagnostic and screening procedures.

This service is registered with CQC under the Health and Social Care Act 2008 in respect of some, but not all, of the services it provides. There are some general exemptions from regulation by CQC which relate to particular types of service and these are set out in Schedule 2 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At 112 Harley Street most of the services are provided to patients under arrangements made by their employer with whom the service user holds a policy. These types of arrangements are exempt by law from CQC regulation. Therefore, at 112 Harley Street, we were only able to inspect the services which are not arranged for patients by their employers with whom the patient holds a policy.

The director is the registered manager. A registered manager is a person who is registered with the Care Quality Commission to manage the service. Like

Summary of findings

registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

Our key findings were:

- Staff had received training on safeguarding children and vulnerable adults relevant to their role. They knew how to recognise the signs of abuse and how to report concerns.
- Service leaders had established policies and procedures to ensure safety; however, leaders had not assured themselves that all policies and activities were operating as intended. For example, the service did not have an effective system of health and safety and premises checks. The risk of not having undertaken regular checks had not been assessed.
- The premises were clean and tidy. The provider had undertaken a recent infection prevention and control (IPC) audit but the audit did not include regular legionella audit or cleaning checks.
- Staff involved and treated patients with compassion, kindness, dignity and respect.
- There was a system for recording and acting on adverse events and incidents although it was not clear if these were shared with all staff effectively. Staff told us significant events and incidents were discussed at regular team meetings and recorded, although we were not shown any records of discussions, learning or actions agreed.
- There was no evidence that the service acted on and learned from external safety events including patient safety alerts. The provider did not share safety alerts with staff effectively.
- We found no evidence of quality improvement measures including clinical audits.
- Procedures for managing medical emergencies including access to emergency medicines and equipment were safe.
- Staff had received an annual appraisal but there was no formal system of appraisals which included a review of training needs for staff.
- The clinical record system was not appropriate for the services provided. There was no facility to code patients' diagnosis and treatment or to put alerts on to the system to support sharing of patient information with other services and clinicians.

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 could make improvements and **should**:

- Review ways to improve engagement with patients.
- Establish a formal process for verifying a patient's or responsible adult's identity.
- Review the need to store children's pads in the defibrillator.

Professor Steve Field CBE FRCP FFPH FRCGP

Chief Inspector of General Practice

112 Harley Street

Detailed findings

Background to this inspection

112 Harley Street (referred to as Cooper Health) is an independent health service located in central London. The service provides private general practice services. It is registered with the CQC as an independent healthcare organisation, providing the regulated activities of treatment of disease, disorder and injury and diagnostic and screening procedures.

The service provides services to children and adults, including private doctor consultation and health screening. Most of the services provided at Cooper Health are to corporate clients for employees who require medicals for insurance purposes and the provision of cruise line medicals to cruise employers.

The service operates Monday to Friday from 9am to 5pm with appointments available from 8.30am to 4.00pm. Home visits are carried out by special arrangement. Out of hours services are available through Doctorcall.

Cooper Health has two directors who share responsibility for the operational and clinical management of the service. One of the directors is the registered manager for the service and the other is the nominated individual. (A registered manager is a person who is registered with the Care Quality Commission to manage the service. Registered managers have legal responsibility for meeting

the requirements of the Health and Social Care Act 2008 and associated Regulations. The nominated individual is responsible for supervising the management of the regulated activities and is nominated by the organisation to carry out this role on their behalf).

The service operates from leased premises and is based on the second floor of the building and is served by a lift. It consists of an open plan administration office, a consultation room, a nurses' treatment room and a toilet.

The reception desk and waiting room is shared with other services in the building and is operated by the premises management service. The service employs two GPs, a practice manager and two administrators. The service has access to the nurses employed by the cardiac service which shares the second floor with them.

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 did not have clear systems to keep people safe and safeguarded from abuse.

- The provider had appropriate safety policies, which were regularly reviewed and communicated to staff.
- Arrangements for the undertaking of safety risk assessments and checks for the premises were not safe. There was no record of regular audit arrangements to control the risk of legionella bacteria or monitor cleaning.
- The service had systems to safeguard children and vulnerable adults from abuse. Policies were regularly reviewed and were accessible to all staff. They outlined clearly who to go to for further guidance. We saw safeguarding protocol notices displayed in the treatment room, in the office area and staff coffee room. The notices detailed who to contact in the event of a safeguarding concern.
- The service worked with other agencies to support patients and protect them from neglect and abuse. Staff took steps to protect patients from abuse, neglect, harassment, discrimination and breaches of their dignity and respect.
- The provider carried out staff checks at the time of recruitment and on an ongoing basis where appropriate. It was the service's policy to request a Disclosure and Barring Services (DBS) check for all staff working at the practice. 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).
- All staff received up-to-date safeguarding and safety training appropriate to their role. They knew how to identify and report concerns. There was a female nurse and a male nurse who acted as chaperones.
- Staff received up-to-date safeguarding training for children and adults at a level appropriate to their role. The doctor had completed safeguarding adults and children level 3. The reception and administration staff had received safeguarding training up to level 2.
- Staff knew how to identify and report concerns. The provider worked within the ethos of the Mental Capacity Act 2005 when working with people who lacked capacity.
- All patients completed or updated a registration form on arrival at the clinic. This included all patient details and a signature. Patients attending for an insurance medical were asked to bring photographic identification and this was verified at their appointment.
- The provider understood their responsibilities to record and investigate safety incidents, concerns and near misses and report them where appropriate.
- The provider had policies for managing the safety of the premises and equipment. However, there was limited evidence of what precautions and practical steps had been taken to remove or minimise risks. For example, the service showed us a copy of a water hygiene report but it was not clear what legionella checks had been undertaken for the provider to satisfy themselves that risks were properly managed. The provider confirmed that legionella assessments were undertaken by the premises management service however, there was no record of regular audit arrangements to control the risk of legionella bacteria.
- Arrangements were in place to receive and comply with patient safety alerts, for example, those issued through the Medicines and Healthcare Products Regulatory Authority (MHRA) Safety alerts were received by the GP on their mobile. However, there was no record kept of the action taken in response to patient safety alerts, and the practice was not able to demonstrate that they had an effective process to manage alerts.
- Records were not always written and managed in a way to keep people safe. The service was using an old electronic patient record system. There was no facility to code patients' diagnosis or treatment during consultations. We saw that on the current practice management system there was no facility to add alerts on to the system to support sharing of patient information with other clinicians in an effective and timely way. The service told us they operated a paper-less patient record system. Any paper documents

Are services safe?

that needed to be retained were scanned onto the system and shredded. A bespoke electronic system had been commissioned by the service. However, at the time of our inspection this new system had not been installed.

- The practice had ensured that medical equipment was safe and that equipment was maintained according to manufacturers' instructions. There were arrangements in place for checking the working status of the defibrillator. There was a record of equipment calibration. We saw clinical equipment which had been calibrated to give reliable readings, for example, the vaccine fridge, a blood pressure machine, scales, pulse oximeter and a nebuliser. We saw that portable appliances had been tested for electrical safety within the last two years.
- There were some arrangements to manage infection prevention and control in line with national guidance. Healthcare waste was managed appropriately and the practice was visibly clean and tidy. The building management company was responsible for cleaning the premises. However, the cleaning schedules we saw were not signed by cleaners.
- Records of staff Hepatitis B immunity were kept for clinicians; there was a record of routine vaccinations in staff files as per the Department of Health 'Green Book' guidance. There was a record of immunity for staff who handled specimens or dealt with spillages of waste or bodily fluids.
- There was a waste disposal policy. The provider ensured that facilities and equipment were safe and that equipment was maintained according to manufacturers' instructions. There were systems for safely managing healthcare waste.

Risks to patients

The service did not have clear systems to assess, monitor and manage risks to patient safety.

- There were arrangements for planning and monitoring the number and mix of staff needed.
- There was no effective induction system for newly appointed staff. After our inspection, the service sent us a recruitment and induction pack for all staff which included a training checklist.
- The service had a medical emergency policy. Arrangements were in place to ensure the provider could take appropriate action in the event of a medical

emergency. The service had a resuscitation trolley and resuscitation equipment such as oxygen were checked daily. The stocked emergency medicines and clinical support were readily available. The service had a defibrillator. There were no children's pads stored with the defibrillator and no children's masks were available on the resuscitation trolley. After our inspection, the service told us they had obtained paediatric defibrillator pads.

- There was a lack of risk assessment of emergency medicines stored at the service. The practice stocked adrenaline but had not risk assessed the need for other emergency medicines. For example, the clinic did not stock rectal diazepam for treating patients who were having an epileptic fit. We saw that stocked emergency medicines were checked to make sure they were available and within the expiry date, and the service kept records of these checks.
- Staff understood their responsibilities to manage emergencies and to recognise those in need of urgent medical attention. They knew how to identify and manage patients with severe infections, for example sepsis. The service displayed notices about recognising signs of sepsis in patients. When reporting on medical emergencies, the guidance for emergency equipment is in the Resuscitation Council UK guidelines and the guidance on emergency medicines is in the British National Formulary (BNF).
- There were limited systems for managing fire risk. Fire extinguishers were checked annually. We saw evidence of a fire risk assessment which had been carried out in January 2017. There were no documented checks of the fire alarm tests. We were told that these were completed by the building management company who carried out fire drills every Friday. There was a visible fire procedure in the areas of the premises used by patients.
- We reviewed three staff files. One clinical member of staff had completed fire safety training a few days before our visit. There was no record of fire safety training for the clinical member of staff and no record of fire safety training for one of the non-clinical member of staff whose files we looked at. Following our inspection, the provider sent us copies of fire safety training completed by the two members of staff whose files we looked at.
- Portable appliance testing (PAT) and calibration of equipment was carried out annually.
- The premises were clean and tidy. The provider had undertaken an infection prevention and control (IPC)

Are services safe?

audit and there was some evidence of actions identified. However, it was not clear from the audit that actions identified had been followed up. There were no dates for signing off actions completed. Clinical staff had undertaken basic infection prevention and control (IPC) training. However, there was no record of infection control training in the GPs' personnel file.

- There was a documented business continuity plan for major incidents such as power failure, flood or building damage.
- There were appropriate indemnity arrangements in place to cover all potential liabilities

Information to deliver safe care and treatment

Staff had information they needed to deliver safe care and treatment to patients. However, the care records we saw showed that information needed to deliver safe care and treatment was not available to relevant staff in an accessible way.

- Individual care records were not always written and managed in a way that kept patients safe. The clinical record system was not appropriate for the services provided. There was no facility to code patients' diagnosis or treatment during consultations or to put alerts on to the system to support sharing of patient information with other clinicians in an effective and timely way. The service told us they had purchased a new practice management system which was due to go live in December.
- The service had systems for sharing information with staff and other agencies to enable them to deliver safe care and treatment. The service had a prescribing protocol.
- The service had a system in place to retain medical records in line with the Department of Health and Social Care (DHSC) guidance
- Clinicians made appropriate and timely referrals in line with protocols and up to date evidence-based guidance.
- There were no formal processes for verifying a patient's identity. Personal details were taken at registration and name and date of birth verbal checks were carried out by the receptionist when patients booked appointments. After the inspection, the service sent evidence of a process for identity checks which included completing a Photo ID section on the patient registration form.

- The service treated children and staff told us they verified the identity of adults accompanying child patients, but this was not recorded.

Safe and appropriate use of medicines

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

- The systems and arrangements for managing medicines, including vaccines, controlled drugs, emergency medicines and equipment minimised risks. The service kept prescription stationery securely and monitored its use.
- Vaccines were stored in a small refrigerator in the treatment room. The vaccine fridge had been calibrated. There was no second thermometer to provide a method of cross-checking the accuracy of the vaccine fridge temperature. The practice kept records of the daily refrigerator temperature checks.
- The service carried out regular medicines audit to ensure prescribing was in line with best practice guidelines for safe prescribing. The practice kept prescription stationery securely and monitored its use.
- Staff prescribed, administered or supplied medicines to patients and gave advice on medicines in line with legal requirements and current national guidance. Processes were in place for checking medicines and staff kept accurate records of medicines.
- No controlled drugs were stored by the provider.

Track record on safety

There was limited evidence that the service monitored and reviewed activity to understand risks and provide a clear and current picture to identify safety improvements required.

- There was no system of comprehensive risk assessments in relation to safety issues including fire safety, infection control and legionella.
- The provider liaised with the premises owners to ensure that, in most cases, risk assessments were in place in relation to the provision of a safe environment. Improvements identified in risk assessments were not actioned and recorded within the set period to improve services.
- There was a sharps injury policy and we saw information displayed next to sharps bins to instruct people on what to do if they sustained a needle stick injury.

Are services safe?

Lessons learned and improvements made

The service had systems and processes in place to learn and make improvements if things went wrong with care and treatment.

- The provider was aware of and complied with the requirements of the Duty of Candour. The provider encouraged a culture of openness and honesty. The service had systems in place for knowing about notifiable safety incidents.
- There was a system for recording and acting on significant events. Staff understood their duty to raise concerns and report incidents and near misses. Leaders and managers supported them when they did so.
- No significant incidents had been identified by the provider. However, the example given by the provider of an incident that had occurred in the past and how this had been handled suggested identification and management of incidents was handled appropriately.
- They kept written records of verbal interactions as well as written correspondence.
- There was no evidence that the service acted on and learned from external safety events as well as patient and medicine safety alerts. It was not clear how safety alerts were communicated to staff. The service did not have an effective mechanism in place to disseminate alerts to all members of the team including sessional and agency staff.

Are services effective?

(for example, treatment is effective)

Our findings

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

Effective needs assessment, care and treatment

The provider had systems to keep clinicians up to date with current evidence based practice. We saw evidence that clinicians assessed needs and delivered care and treatment in line with current legislation, standards and guidance (relevant to their service).

- Patients' immediate and ongoing needs were fully assessed. Where appropriate this included their clinical needs and their mental and physical wellbeing.
- Clinicians had enough information to make or confirm a diagnosis
- We saw no evidence of discrimination when making care and treatment decisions.
- Staff assessed and managed patients' pain where appropriate.

Monitoring care and treatment

The service was not actively involved in quality improvement activity.

- There was no evidence of quality improvement activity including clinical audit being undertaken.
- The service did not use information about care and treatment to make improvements.

Effective staffing

Evidence reviewed showed that doctors had the skills and knowledge to deliver effective care and treatment, although some essential safety training topics had not been undertaken.

- The GPs were supported by an administrator and one practice manager. Their role was non-clinical and consisted of reception duties, administration and book keeping. The practice manager had worked at the practice for thirty years and had been employed by the previous owner of the service.
- The provider had not maintained up to date records of skills, qualifications and training. We reviewed three personnel files and found some gaps in essential safety training. We saw a record of completed essential training for the administrator and the practice manager and we looked at their certificates of online training

completed. However, there was no record of fire safety or infection control training when we looked at one of the GP's staff file. Following our inspection, the provider sent us copies of certificates of completed essential training for the GP.

- The provider did not have an induction programme for all newly appointed staff.
- There was a record of training in the Mental Capacity Act for clinical staff.
- We saw evidence of staff training in emergency resuscitation and first aid.
- Relevant professionals (medical and nursing) were registered with the General Medical Council (GMC)/ Nursing and Midwifery Council and were up to date with revalidation.
- There was evidence that staff were encouraged and given opportunities to develop.
- All staff had received an appraisal or performance review in the last year. However, there was no structure of formal appraisal and staff appraisals had not been fully documented. There was evidence of appraisals and continuing professional development for the GP.
- Staff whose role included immunisation and reviews of patients with long term conditions had received specific training and could demonstrate how they stayed up to date.

Coordinating patient care and information sharing

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

- Patients received coordinated and person-centred care. Staff referred to, and communicated effectively with, other services when appropriate. For example, the service referred patients to the London Imaging centre for X-rays and mammography breast screening service at the Princess Grace hospital.
- The provider had an effective third-party arrangement with a private laboratory for blood test results. Results were received electronically which staff entered onto the electronic patient record system.
- The service policy required patients to sign consent forms when they registered and the signed forms were scanned into patient notes. When patients registered with the service they were asked to sign a form to give their consent to information about their care being

Are services effective?

(for example, treatment is effective)

shared with their NHS GP. All patients were asked for consent to share details of their consultation and any medicines prescribed with their registered GP on each occasion they used the service.

- The provider had risk assessed the treatments they offered. They had identified medicines that were not suitable for prescribing if the patient did not give their consent to share information with their GP, or they were not registered with a GP. For example, medicines liable to abuse or misuse, and those for the treatment of long term conditions such as asthma. Where patients agreed to share their information, we saw evidence of letters sent to their registered GP in line with GMC guidance.
- Patient information was shared appropriately (this included when patients moved to other professional services), and the information needed to plan and deliver care and treatment was available to relevant staff in a timely and accessible way. There were clear and effective arrangements for following up on people who had been referred to other services

Supporting patients to live healthier lives

Staff were consistent and proactive in empowering patients, and supporting them to manage their own health and maximise their independence.

- Where appropriate, staff gave people advice so they could self-care. The GPs gave lifestyle advice during consultations.
- Risk factors were identified, highlighted to patients and where appropriate highlighted to their normal care provider for additional support.
- Where patients needs could not be met by the service, staff redirected them to the appropriate service for their needs.

Consent to care and treatment

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

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

Are services caring?

Our findings

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

Kindness, respect and compassion

Staff treated patients with kindness, respect and compassion.

- Feedback from patients was positive about the way staff treat people
- Staff understood patients' personal, cultural, social and religious needs. They displayed an understanding and non-judgmental attitude to all patients.
- The service gave patients timely support and information.
- The consultation room was clean and private.

Involvement in decisions about care and treatment

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

- Feedback from patients included comments that the doctor was thorough and took time to talk through care and treatment options.
- The service's website and other sources provided patients with information about the range of services available including costs and consultation fees.
- A patient information leaflet was available in the waiting room and sent to all patients when their booking was confirmed. This included availability of a chaperone; the confidentiality agreement and details of the complaints procedure.

- Staff told us there was an interpreting and translation service available for patients who did not have English as a first language. Where clients did not have English as a first language they were advised ahead of their appointments to bring a suitable interpreter. Patients were also told about multi-lingual staff who might be able to support them.
- There were no communication aids available, such as a hearing loop.
- The service supported recently bereaved patients. Staff told us that if families had experienced bereavement, they followed the service's policy to support bereaved patients and their families.
- The service did not have a record of any patients with caring responsibilities. The service told us there were no patients registered with learning disabilities or patients with dementia.

Privacy and Dignity

The service respected patients' privacy and dignity.

- Staff recognised the importance of people's dignity and respect. Staff knew that if patients wanted to discuss sensitive issues or appeared distressed they could offer them a private room to discuss their needs.
- Privacy screens were provided in consultation rooms to maintain patients' privacy and dignity during investigations, as necessary.
- The practice complied with the Data Protection Act 1998.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

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

Responding to and meeting people's needs

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

- The provider understood the needs of their patients and improved services in response to those needs. For example, the service maintained a paperless record system and used email communication whenever possible. However, if a patient preferred to receive communication in paper format the service was able to provide this.
- The facilities and premises were appropriate for the services delivered. The service made home visits for patients that were unable to travel to the premises, such as elderly or frail patients.
- The provider made reasonable adjustments when patients found it hard to access services. The building was accessible to patients in a wheelchair. A lift and toilet facilities were available and a consultation room was available on the ground floor if required.

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.

- There was a 24-hour online booking system for patients to book appointments. Patients could contact the service via telephone. Appointments were booked by the receptionist.
- Waiting times, delays and cancellations were minimal and managed appropriately.
- Patients with the most urgent needs had their care and treatment prioritised.
- The service did not provide emergency appointments; patients were advised to contact NHS emergency services for urgent medical needs.
- Referrals and transfers to other services were undertaken in a timely way.
- The service kept a folder of comments and feedback from patients. Patient feedback showed that patients were satisfied with how they could access care and treatment.

Listening and learning from concerns and complaints

The service had a procedure for managing complaints.

- Information about how to make a complaint or raise concerns was available on the service website and in the patient information leaflet which was sent to all patients when booking an appointment.
- The complaint policy and procedure were in line with recognised guidance.
- The provider informed us that they took complaints and concerns seriously and would respond to them immediately and make appropriate improvements as required.
- There had been no formal complaints made in the previous 12 months but from the example given of a previous complaint we found that they were satisfactorily handled.

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 a well-led service in accordance with the relevant regulations.

Leadership capacity and capability;

Leaders had the clinical capacity and skills to deliver the service, however, there was insufficient oversight of health and safety and risks.

- There was insufficient leadership focus on adequate systems of governance and management of risks. Safety aspects of the service were not clearly known or prioritised to ensure high quality care was delivered.
- The directors were knowledgeable about issues and priorities relating to the quality of clinical care provided and future of the service. They understood the challenges in these areas and were addressing them.
- The provider showed integrity and openness when safety concerns were raised during the inspection and demonstrated a willingness to act and address concerns.
- Leaders were visible and approachable. They worked closely with staff and others to make sure they prioritised compassionate and inclusive leadership.

Vision and strategy

The service had a vision to deliver high-quality care and an overall positive patient experience.

- The service's values were published on the service's website. The service had a realistic strategy and supporting business plans to achieve priorities.
- Staff were aware of and understood the vision, values and strategy and their role in achieving them
- The service had a business plan. The service monitored progress against delivery of the strategy.

Culture

The provider demonstrated a positive culture. There were positive relationships between managers and teams.

- Staff felt respected, supported and valued. They were proud to work for the service.
- The service focused on the needs of patients.
- Leaders and managers acted on behaviour and performance inconsistent with the vision and values.

- Although there had been no reported incidents and no complaints, the provider was aware of and had systems to ensure compliance with the requirements of the duty of candour.
- Staff we spoke with told us they were able to raise concerns and were encouraged to do so. They had confidence that these would be addressed.
- There was a lack of formal processes for providing all staff with the development they need. All staff received regular annual appraisals in the last year. However, appraisals were conducted informally and there was no structure of formal appraisal and insufficient records kept. Staff were supported to meet the requirements of professional revalidation where necessary. There was no structure of inductions for staff.
- The service actively promoted equality and diversity. It identified and addressed the causes of any workforce inequality. Staff had received equality and diversity training. Staff felt they were treated equally.

Governance arrangements

There was limited evidence of systems and processes to support good governance and management.

- There was no governance meetings structure in place. There was minimal evidence that governance was monitored and addressed; any issues were discussed on an informal basis along with routine matters.
- Service leaders had established policies and procedures to ensure safety; however, leaders had not assured themselves that all policies and activities were operating as intended. For example, there was no record of checks regularly carried out for legionella.
- The provider had a number of policies and procedures which followed guidance from a quality compliance company. We found that some policies were not always reflective of day to day activities, for example, infection control policies and cleaning schedules.
- There was some evidence of minutes from monthly team meetings where all staff were involved in discussions; however, there was limited evidence that leaders discussed governance and addressed service issues.

Managing risks, issues and performance

There were some processes in place for managing risks, issues and performance, although some areas were identified for improvement.

Are services well-led?

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

- The service had not yet established a clear system of comprehensive procedural audits and regular safety checks. For example, we saw a completed infection control audit but there were no dates for signing off actions and no prioritising of actions identified.
- There was a lack of effective systems for monitoring training. The service did not have up to date records of completed role appropriate training for all staff. For example, we found there was no record of fire safety training or infection control training for one clinical member of staff.
- The practice did not have a process to manage patient safety alerts. There was no record kept of the action taken in response to patient safety alerts, and the practice was not able to demonstrate that they had an effective process to manage these. The service told us that safety alerts were received by the GP on their mobile. It was not clear how safety alerts were communicated to staff.
- There was no evidence of measures to improve and address quality. The provider had not carried out clinical audits and case reviews to identify areas to improve the quality of care and there was little evidence of actions taken to change practice.
- The provider had plans in place and had trained staff for major incidents.

Appropriate and accurate information

The service acted on appropriate and accurate information; however, there was limited evidence that quality and sustainability were discussed and acted on.

- Individual care records were not always written and managed in a way that kept patients safe. The clinical record system was not appropriate for the services provided. There was no facility to code patients' diagnosis or treatment during consultations. We saw that on the current practice management system there was no facility to add alerts on to the system to support

sharing of patient information with other clinicians in an effective and timely way. The service told us they had purchased a new consultation record system which was due to go live in December.

- Information gathered on the quality of the service was limited to feedback from patients. The service did not yet have a process of review to assess what changes have been made following patient feedback and patient survey results.
- There was no record that quality and sustainability were discussed in relevant meetings or that all staff had sufficient access to information.
- Patient names and other identity information were handled by staff members who had signed confidentiality agreements in place.
- The service submitted data or notifications to external organisations as required. The service used a cloud based system to store patient records and share information.
- Arrangements for the availability, integrity and confidentiality of patient identifiable data, records and data management systems were in line with data security standards.

Engagement with patients, the public, staff and external partners

There were examples of feedback received by email from patients about the services provided but this had not been reviewed and acted on to shape services.

- There were arrangements for obtaining and assessing patients' views on the service. There was an online patient feedback form but leaders told us that patients had not filled it out. We saw a paper copy of the feedback form which was in the waiting area.

Continuous improvement and innovation

- The practice was committed to providing a high level of service to its patients. There was a focus on continuous learning and improvement.

Requirement notices

Action we have told the provider to take

The table below shows the legal requirements that were not being met. The provider must send CQC a report that says what action they are going to take to meet these requirements.

Regulated activity	Regulation
Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment How the regulation was not being met: Assessments of the risks to the health and safety of service users of receiving care or treatment were not being carried out. In particular: • There was no evidence of a legionella risk assessment. • The service had not documented a risk assessment for the need to stock emergency medicines. Not all of the people providing care and treatment had the qualifications, competence, skills and experience to do so safely. In particular: • Not all staff at the service had undertaken essential training in fire safety and infection control. There was no assessment of the risk of, and preventing, detecting and controlling the spread of, infections, including those that are health care associated. In particular: • There was no evidence that legionella checks had been undertaken by the provider. This was in breach of regulation 12(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.
Regulated activity	Regulation
Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance How the regulation was not being met:

Requirement notices

There were no systems or processes that enabled the registered person to assess, monitor and improve the quality and safety of the services being provided. In particular:

- There was no system of meetings to discuss governance and risk management.
- There were no ongoing quality improvement activities in place to allow the practice to assure themselves that the standards of care and treatment delivered, were being consistently met in line with current legislation and guidance.
- The clinical record system was not appropriate for the services provided. There was no facility to code patients or to put alerts on to the patient records.

There were no systems or processes that enabled 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:

- The provider did not have a clear system to ensure oversight of essential training for staff including fire safety and infection control training.
- There were no clear governance arrangements for the undertaking of safety risk assessments and checks for the premises, fire safety and infection control.
- There were no clear arrangements to ensure identified risks are actioned and recorded within a set period to improve services.

The registered person had systems or processes in place that operated ineffectively in that they failed 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 oversight of whether risks had been assessed and mitigated by the provider to ensure suitability and safety of the premises for service users.
- The provider had a number of policies and procedures which had not been reviewed. Some policies were not reflective of day to day practice. For example, infection control, good governance and the safety of premises and equipment policies.

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

This section is primarily information for the provider

Requirement notices

Regulated activity

Diagnostic and screening procedures
Treatment of disease, disorder or injury

Regulation

Regulation 18 HSCA (RA) Regulations 2014 Staffing

How the regulation was not being met:

The service provider had failed to ensure that persons employed in the provision of a regulated activity received such appropriate support, training, professional development, supervision and appraisal as was necessary to enable them to carry out the duties they were employed to perform. In particular:

- The service provider had failed to put in place formal supervision and appraisal arrangements for staff.
- The service provider had failed to put in place a centralised service induction pack for new staff.

This was in breach of regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.