

Dr Ann Yvonne Coxon

Dr Ann Coxon

Inspection report

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Overall summary

We carried out an announced comprehensive inspection on 7 November 2017 to answer the following key questions:

Are services:

- **Safe**
- **Effective**
- **Caring**
- **Responsive**
- **Well-led**

Our findings were:

Are services safe?

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

Are services effective?

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

Background

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.

The provider, Dr Ann Coxon, is registered with the CQC as an individual providing general medical services to private patients from consulting rooms at 101 Harley Street, London W1G 6AH. The provider is registered to provide the regulated activities of treatment of disease, disorder or injury and diagnostic and screening procedures. All patients are seen privately and referrals are made to private specialist consultants where required.

At this inspection we found:

- The practice had clear systems to manage risk and provide safe care and treatment.
- The premises were clean and tidy. The provider had not undertaken an infection control audit in the past 12 months but had made arrangements for this to be undertaken the following month by the theatre nurse based in the building. The provider had not undertaken recent infection prevention and control

Summary of findings

(IPC) training relevant to their role. However, IPC advice and support was available from the theatre nursing staff based in the building. An audit of antimicrobial prescribing had not been undertaken.

- Patient records were maintained in hard copy format only. Electronic patient records were not kept. Individual records were written and managed in a way to keep people safe. This included ensuring people's records were accurate, complete, eligible, up to date and stored appropriately. However, records pending action were not always kept in a locked cabinet although the room was locked when not occupied.
- The provider ensured that care and treatment was delivered according to evidence based guidelines. The provider routinely reviewed the effectiveness and appropriateness of the care provided to ensure it was in line with current research and best practice guidance. However, formal audits were not undertaken.

- Patients were treated with compassion, kindness, dignity and respect.
- The provider understood the needs of their patients and tailored services in response to those needs.
- There was a strong focus on continuous learning and improvement.

The areas where the provider **should** make improvements are:

- The provider should review their process for undertaking formal clinical audit.
- The provider should review their procedures for infection prevention and control to ensure training is updated in line with the requirements of their role and regular IPC audits are undertaken.
- The provider should review the process for storing records pending action.

Professor Steve Field CBE FRCP FFPH FRCGP Chief Inspector of General Practice

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?

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

However, we found areas where improvements should be made relating to the safe provision of treatment.

- The provider should review their infection prevention and control (IPC) procedures to ensure training is updated in line with the requirements of their role; that regular IPC audits are undertaken and that antimicrobial audits are undertaken as required.
- The provider should review their process for storing records pending action.
- Patient records were stored appropriately. However, records pending action were not always kept in a locked cabinet although the room was locked when not occupied.

Are services effective?

We found that this service was providing effective care in accordance with the relevant regulations. However, we found areas where improvements should be made relating to the effective provision of treatment.

- The provider should review their current arrangements for a programme of clinical audit.

Are services caring?

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

Are services responsive to people's needs?

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 providing well-led care in accordance with the relevant regulations.

Dr Ann Coxon

Detailed findings

Background to this inspection

The provider, Dr Ann Coxon, is registered with the CQC as an individual providing general medical services to private patients, from consulting rooms at 101 Harley Street, London W1G 6AH. The provider is registered to provide the regulated activities of treatment of disease, disorder or injury and diagnostic and screening procedures.

The provider has been in private practice for the past 35 years and has been based in the current accommodation for nine years. The current rooms occupied by the provider consist of the administration office and two consulting rooms (one room is rented to another service provider). The practice is based on the top floor of the building. The main reception desk and patient waiting room are on the ground floor and are shared with other services based in the building. The reception service is provided by the building's management service.

The service is provided by Dr Coxon, a doctor of internal medicine and neurology who is a member of the Independent Doctors Federation. The service is available to adults and children over one year old.

Approximately 50 patients are seen by the provider each week. This is mainly patients on return visits (approximately 40 per week) and new patients (approximately 10 per week). Appointments are generally of one hour duration for new patients and 30 minutes for return visits.

All patients are seen privately and referrals are made to private specialist consultants where required. If a patient is registered with an NHS GP, a summary treatment report is sent to the GP if requested by the patient.

Administrative support is provided by a Personal Assistant (PA) who is also responsible for accounts and reception duties.

Appointments are available between 8.30am and 6pm Monday to Friday with evening and Saturday appointments by arrangement.

Patients are able to contact the doctor by telephone (including text messaging) or email, at any time. Outside of core hours a shared arrangement with a colleague (a doctor of general medicine also based in Harley Street) is in place to ensure 24 hour telephone contact is available to patients.

Why we carried out this inspection

We carried out an announced, comprehensive inspection at Dr Coxon, 101 Harley Street, London W1G 6AH on 7 November 2017 under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. The inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008 and to look at the overall quality of the service under the Care Act 2014.

Our inspection was carried out by a CQC Lead Inspector and a GP Specialist Adviser.

How we carried out this inspection

During the inspection we:

- Spoke with the provider and staff member.
- Reviewed a sample of the personal care or treatment records of patients.
- Looked at information the provider used to deliver care and treatment plans.

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?

Detailed findings

- Is it well-led?

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

Are services safe?

Our findings

Safety systems and processes

- The provider understood their responsibilities to record and investigate safety incidents, concerns and near misses and report them where appropriate.
- 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) and these were reviewed and acted upon promptly where appropriate.
- Arrangements were in place to ensure the provider could take appropriate action in the event of a medical emergency. Resuscitation equipment and support was readily available from the service based in the basement of the building. We received confirmation from the service provider regarding this arrangement including details of the emergency medicines stocked and their monitoring regime for equipment checking. The provider also had medicines available in the consulting room for use in an emergency.
- There were arrangements in place to safeguard adults and children that reflected relevant legislation and requirements and the provider could demonstrate they worked within the legal framework for the care and treatment of children and young people.
- The provider received up-to-date safeguarding training for children and adults at a level appropriate to their role. They 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.
- Staff knew how to identify report and respond to concerns, such as safeguarding, whistleblowing and complaints and felt confident to do so.
- Annual basic life support (BLS) and management of anaphylaxis training was undertaken by the provider only. The Personal Assistant (PA) did not attend BLS training as the provider felt they had adequate support available from clinical personnel in the building.
- Patient records were maintained in hard copy format only. Electronic patient records were not kept.
- Individual records were written and managed in a way to keep people safe. This included ensuring

patient records were accurate, complete, legible, up to date and stored appropriately. However, records pending action were not always kept in a locked cabinet although the room was locked when not occupied.

- Arrangements were in place for a chaperone to be available if requested. The PA had undergone chaperone training and had received a DBS check.
- Fire evacuation drills were carried out regularly in the building.
- The premises were cleaned daily and carpets were steam cleaned every two months. A cleaning schedule was in place.
- All equipment used was for single use only, except for the mouthpieces used for the peak-flow meter. These were sterilised using an appropriate cold sterilisation solution. The provider informed us they were trying to obtain disposable mouthpieces to fit the equipment.

Risks to patients

- Risks to safety from service developments and disruption were assessed and arrangements to respond to emergencies were considered and planned for.
- Appropriate indemnity arrangements were in place to cover potential liabilities that may arise.
- Staff were able to identify and respond appropriately to signs of deteriorating health and medical emergencies and examples were given regarding how this had been managed in previous incidents.
- Equipment was calibrated annually and portable appliance testing (PAT) was carried out annually.
- The premises were clean and tidy. The provider had not undertaken an infection control audit in the past 12 months but had made arrangements for this to be undertaken the following month by the theatre nurse based in the building. The provider had not undertaken recent infection prevention and control (IPC) training relevant to their role. However, IPC advice and support was available from the theatre nursing staff based in the building.

Information to deliver safe care and treatment

- Individual care records were written and managed in a way that kept patients safe. The patient records we saw showed that information needed to deliver safe care and treatment was recorded and stored in an accessible way.

Are services safe?

- The provider had systems for sharing information with other agencies to enable them to deliver safe care and treatment.
- Referral letters included all of the necessary information and the provider would usually accompany patients to their first appointment following a referral to a specialist consultant.
- Patients received a summary of their medical history and treatment on completion of an episode of care and patients receiving ongoing care received an annual summary of their care and treatment.

Safe and appropriate use of medicines

- There were arrangements in place for the proper and safe management of medicines.
- There were appropriate documented arrangements for managing medicines that included obtaining, recording, storing, prescribing, dispensing and administration.
- Medicines on the premises were stored securely, in line with legal requirements and manufacturers' instructions.
- Medicines, such as vaccines which required cold storage, were stored appropriately including the daily recording of minimum and maximum fridge temperatures. Small stocks of the flu vaccine were kept and all other vaccines were ordered on a named patient basis.
- No controlled drugs were stored by the provider.
- The provider had reliable systems for appropriate and safe handling of medicines. Private prescriptions were issued on letter-headed paper which was stored appropriately. A photocopy of all prescriptions were kept in the patient's records. If a prescription for controlled drugs was required this was issued on an FP10PCD form as appropriate.
- The provider prescribed and administered medicines to patients and gave advice on medicines in line with current requirements and national guidance.
- The provider had not audited antimicrobial prescribing as they were the only prescriber. They informed us they were aware of, and adhered to, the current guidance on good antimicrobial stewardship. Patient records we reviewed supported this.

- Patients' health was monitored to ensure medicines were being used safely and were followed up appropriately. At the time of the inspection the provider had no formalised system in place to monitor patients on high-risk medicines as the majority of patients receiving these medicines obtained their prescriptions from the specialist consultant responsible for managing and monitoring their treatment and the provider had personal knowledge of patients requiring monitoring. However, following the inspection the provider informed us they had now also formalised this procedure by maintaining a written reminder to identify when blood test monitoring was required for patients on high risk medicines.
- When medicines were administered on the premises, a clear and accurate contemporaneous record was kept.
- The provider informed us that patients were given clear information on medicines they were prescribed including how and when to take the medicine, the purpose of the medicine and possible side effects. A written summary of treatment was also provided to the patient.

Track record on safety

- The provider monitored and reviewed activity in order to understand risks and provide a clear and current picture to identify safety improvements required.
- The provider liaised with the premises owners to ensure that, where appropriate, risk assessments were in place in relation to safety issues.

Lessons learned and improvements made

- The provider was aware of the need to review and investigate when things went wrong. No significant incidents had been identified by the provider in the previous 12 months. However, examples given by the provider of incidents that had occurred in the past and how these had been handled suggested identification and management of incidents was handled appropriately.
- There was a system for receiving and acting on safety alerts. The provider learned from external safety events as well as patient and medicine safety alerts and took action as appropriate.

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment, care and treatment

- The provider, who was the sole clinician, had systems in place to ensure they were kept up to date with current evidence-based practice. They did not access guidelines from the National Institute for Health and Care Excellence (NICE) but used medical research journals to ensure they were aware of relevant and current evidence based guidance and standards.
- Patients' needs were fully assessed. This included their clinical needs and their mental and physical wellbeing.
- We saw no evidence of discrimination when making care and treatment decisions.
- Patients were informed of what to do if their condition worsened and where to seek further help and support. Patients were given the mobile number of the provider to use when required.
- For patients with complex needs, the provider worked with other health and care professionals to ensure a coordinated package of care was delivered.

Monitoring care and treatment

The provider routinely reviewed the effectiveness and appropriateness of the care provided to ensure it was in line with current guidelines. However, formal audits were not undertaken.

Effective staffing

There was one member of staff employed by the provider. They were employed as a Personal Assistant (PA) responsible for secretarial and reception duties and accounts. They had the skills, knowledge and experience to carry out their role. They had worked with the provider since 1982 and felt able to discuss issues and raise concerns if required.

Arrangements were in place for the doctor sharing out of hours cover (based opposite the service location) to provide a service to patients if required when the provider

was on annual leave. Communication with the provider was maintained by mobile phone during such periods of absence. The PA would continue to provide a reception service during the period of provider absence to ensure patient enquiries and requests for appointments were managed appropriately.

Coordinating patient care and information sharing

- Patients received coordinated and person-centred care. This included when they were referred to other services. Following referrals to other Consultants a comprehensive written summary was provided and where appropriate the provider attended the first appointment with the patient to ensure sharing of information was accurate and that all relevant medical history and details of current treatment were accurately provided to the Consultant.
- Where appropriate, the provider ensured that end of life care and treatment of patients who were vulnerable because of their circumstances was delivered in a coordinated way which took into account the needs of individual patients.

Supporting patients to live healthier lives

- The provider identified patients who may be in need of extra support and directed them to relevant services. This included patients in the last 12 months of their lives and patients at risk of developing a long-term condition.
- The provider encouraged and supported patients to become involved in monitoring and managing their health and discussed suggested care or treatment options with patients and their carers as necessary.

Consent to care and treatment

- The provider understood the requirements of, and obtained, consent to care and treatment in line with legislation and guidance.
- The provider informed us that, where appropriate, a patient's mental capacity to make a decision was assessed and recorded.

Are services caring?

Our findings

Kindness, respect and compassion

- Staff understood patients' personal, cultural, social and religious needs.
- The provider gave patients timely support and information.
- Support was given to families following bereavement.
- Arrangements were in place for a chaperone to be available if requested.

Involvement in decisions about care and treatment

- The provider involved patients in decisions about their care and treatment.

- They helped arrange interpreting services for patients who did not have English as a first language.
- Patients and their carers were assisted in finding further information and access other services as appropriate.

Privacy and Dignity

- The provider respected and promoted patients' privacy, dignity and respect.
- A screen was provided in the consulting room to maintain patients' privacy and dignity during examinations, investigations and treatments.
- The provider complied with the Data Protection Act 1998. Patient records were stored in locked cabinets. Rooms were locked when not occupied.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

- The provider understood the needs of their patients and tailored services in response to those needs. For example, evening and weekend appointments and appointments in the patient's home were available if requested.
- The provider improved services where necessary.
- The facilities and premises were appropriate for the services delivered.
- 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 accessible to patients in a wheelchair were available and a consultation room was available on the ground floor if required.
- Care and treatment for patients with multiple long-term conditions and patients approaching the end of life was coordinated with other services.
- The provider had a good understanding of how to support patients with mental health needs and those patients living with dementia.

Timely access to the service

- Patients were able to access care and treatment within an acceptable timescale for their needs with timely access to initial assessment, test results, diagnosis and treatment.
- All patients were given the mobile number of the clinician for immediate access.
- Patients were seen in the evening and on Saturdays if required.
- Home visits were carried out if this was required by the patient.
- Patients could contact the clinician by email or telephone (including text).
- Patients with the most urgent needs had their care and treatment prioritised.
- The appointment system was easy to use.

Listening and learning from concerns and complaints

- 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 two years.
- The complaint policy and procedures were in line with recognised guidance.

Are services well-led?

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

Our findings

Leadership capacity and capability;

The provider had the capacity, experience and skills to deliver and address risks to the provision of quality, sustainable care.

- They were knowledgeable about issues and priorities relating to the quality of services. They understood the challenges they faced and were able to address them.
- They worked closely with their staff to ensure they prioritised compassionate and inclusive leadership.

Vision and strategy

The provider had a clear vision and strategy to deliver high quality care and promote good outcomes for patients. Staff were aware of and understood the vision, values and strategy and their role in achieving them.

Culture

- The provider encouraged a culture of high-quality sustainable care.
- Staff told us they felt respected, supported and valued and that the needs of patients was the main focus of the service. They were proud to work for the provider.
- The provider was aware of the need for openness, honesty and transparency when responding to incidents and complaints.
- Staff told us they were able to raise concerns and were encouraged to do so. They had confidence that these would be addressed.
- The member of staff did not have a formally recorded appraisal as they felt this was unnecessary. They had daily discussions with the provider and felt they were able to address development needs and obtain advice and support at any time.
- The relationship between the provider and the staff member was positive and longstanding.

Governance arrangements

- Structures, processes and systems to support good governance were clearly set out, understood and effective.
- Staff were clear of their roles and accountabilities including in respect of safeguarding and infection prevention and control.

- There were established policies and procedures in place to ensure safety and to assure the provider that they were operating as intended.

Managing risks, issues and performance

- There were clear and effective processes for managing risks, issues and performance.
- There was an effective, process to identify, understand, monitor and address current and future risks including risks to patient safety.
- The provider managed all patient safety alerts, incidents, and complaints.
- Formal clinical audit had not been undertaken. However, the provider informed us that they continuously reviewed their own clinical practice in line with new guidance and guidelines.
- The provider had plans in place for major incidents and disruptions to their service.

Appropriate and accurate information

- Quality and sustainability were addressed by the provider and arrangements considered and implemented to meet the needs of the service.
- Information used to deliver quality care was considered and any identified weaknesses addressed.
- The provider did not use information technology systems to monitor and improve the quality of care as patient records were not kept electronically.
- There were arrangements in place that were in line with data security standards for the availability, integrity and confidentiality of patient identifiable data, records and data management systems.

Engagement with patients, the public, staff and external partners

The provider involved patients, staff and external partners to support high-quality sustainable services.

- Patients and staff were actively encouraged to provide their views and concerns.
- An annual patient survey was undertaken. Patients had not identified any changes required through the survey but the provider informed us patient comments were reviewed and appropriate changes would be made where required.

Continuous improvement and innovation

Are services well-led?

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

There were systems and processes for learning and continuous improvement.

- There was a focus on continuous learning and improvement.
- The provider made use of internal and external feedback and used this to make improvements.
- The provider worked with their staff member to review individual and service objectives, processes and performance.