Privategp.com Ltd (Private General Practice Services)

Inspection report

Beech House No. 3 Knighton Grange Road
Stoneygate
Leicester
LE2 2LF
Tel: 01162700373
www.privategp.com

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This report describes our judgement of the quality of care at this service. It is based on a combination of what we found when we inspected, information from our ongoing monitoring of data about services and information given to us from the provider, patients, the public and other organisations.

Ratings

Overall rating for this location	Requires Improvement
Are services safe?	Inadequate
Are services effective?	Requires Improvement
Are services caring?	Good
Are services responsive to people's needs?	Good
Are services well-led?	Requires Improvement

Overall summary

This service is rated as Requires improvement overall. (The service was rated as inadequate at our previous inspection in October 2021)

The key questions are rated as:

Are services safe? – Inadequate

Are services effective? – Requires improvement

Are services caring? – Good

Are services responsive? – Good

Are services well-led? – Requires improvement

We carried out an announced comprehensive inspection at PrivateGP.com Ltd on 22 June 2022. This was to review the improvements that had been made since the provider was placed in special measures following our inspection in October 2021.

The Care Quality Commission (CQC) inspected the provider in October 2021, and the service was rated as inadequate in the key questions of safe, effective and well-led and therefore received an overall inadequate rating. Three warning notices and a requirement notice were issued. We returned to the provider in November and December 2021 to review compliance with the three warning notices and we found that the service was mostly compliant with these, however some workstreams were ongoing and we therefore issued two further requirement notices. In addition, we placed conditions on the provider's CQC registration to ensure that standards of record keeping were improved. We asked the provider to make improvements regarding the breaches in regulations, and to comply with the conditions that were imposed. We checked these areas as part of this comprehensive inspection in June 2022 and found that whilst significant improvements had been made, there were still some issues which needed further attention to achieve regulatory compliance. Previous inspection report can be found on our website at www.cqc.org.uk.

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. Therefore, at PrivateGP.com Ltd, we were only able to inspect the services which fall under the scope of CQC registration and the regulated activities.

The lead GP, who is also the Chief Executive Officer (CEO) and Medical Director, is the registered manager. A registered manager is a person who is registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated regulations about how the service is run.

Our key findings were:

- We found that there had been significant improvements to ensure compliance with our regulations since the previous inspection. However, some areas required further attention and work was ongoing to ensure that continued and sustainable improvements were achieved.

Overall summary

- We found concerns relating to the provision of safe care and treatment. This included the lack of a robust approach to safeguarding vulnerable patients; the need to ensure patient records were fully accurate and that key information was readily available; letters in patient records received from other health care professionals that had been filed without follow up actions being completed; and the need to embed a process to ensure that all significant events were identified and used as a learning experience to improve the service.
- We found concerns relating to the provision of effective services. This included the need to develop a more established programme of quality improvement and clinical audit to demonstrate the efficacy of patient outcomes.
- We found that the service was caring and compassionate with patients and we observed a range of positive comments received from patients.
- We found that the service was responsive and flexible to patients' needs.
- We found that the service did not have sufficient governance or assurance processes in place. This had improved since our previous inspection, but some issues required more attention, including a more comprehensive oversight of the work undertaken by contracted professionals, and strengthening of systems to support good governance such as learning from complaints and significant events.

The areas where the provider **must** make improvements as they are in breach of regulations are:

- 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.

(Please see the specific details on action required at the end of this report).

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

- Only supply unlicensed medicines against valid special clinical needs of an individual patient where there is no suitable licensed medicine available.
- The infection control lead should undertake additional training to support their role.

This service was placed in special measures in November 2021. Insufficient improvements have been made such that there remains a rating of inadequate for providing safe services. Therefore we are taking action in line with our enforcement procedures to begin the process of preventing the provider from operating the service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. The service will be kept under review and if needed could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within six months, and if there is not enough improvement we will move to close the service by adopting our proposal to vary the provider's registration to remove this location or cancel the provider's registration.

Dr Rosie Benneyworth BM BS BMedSci MRCGP
Chief Inspector of Primary Medical Services and Integrated Care

Our inspection team

Our inspection team was led by a CQC lead inspector, supported by a GP specialist adviser. Remote medicines advice was provided by a CQC pharmacist specialist.

Background to Privategp.com Ltd (Private General Practice Services)

PrivateGP.com Ltd is registered with the CQC to provide services from Beech House, 3 Knighton Grange Road, Stoneygate, Leicester. LE2 2LF. The service has a website at www.privategp.com

PrivateGP.com Ltd provides an alternative means for patients to receive medical consultation, examination, diagnosis and treatment by general practitioners and medical and clinical specialists. It is an independent provider which offers private GP consultations and a wide range of specialist services including functional medicine, sexual health, immunisations and vaccinations, bioidentical hormone replacement therapy, nutritional medicine including intravenous vitamin therapy, mental health services, occupational health assessments, and aesthetic procedures.

The service is delivered from a private residence. There is a reception and administrative office on the ground floor, with consulting rooms on the first floor. There is limited parking on site but street parking is available on the road outside the practice.

The service is registered to provide the regulated activities of diagnostic and screening procedures, family planning, maternity and midwifery services, treatment of disease, disorder or injury, and services in slimming clinics.

The service is available to any person and does not require a clinical referral. Whilst most patients will be from the Leicestershire area, the service sees people from other parts of the country.

The service is led by a GP, who is the medical director and the Chief Executive Officer. An additional GP works for the service for one session a week, and another GP undertakes occupational health assessments for the service, although at the time of the inspection, this had only happened once. Every day management is provided by an operations manager, with a support team of three administrative/reception staff. A general adult psychiatrist provides some limited input for patients offsite on a contractual basis.

The opening hours are 8.30am – 5pm from Monday to Thursday, and 8.30am – 4.30pm on a Friday. Patients can access face-to-face, telephone and online consultations. Home visits can be arranged when this is deemed necessary, but this occur rarely.

How we inspected this service

Throughout the pandemic CQC has continued to regulate and respond to risk. However, taking into account the circumstances arising as a result of the pandemic, and in order to reduce risk, we have conducted our inspections differently.

This inspection was carried out in line with all data protection and information governance requirements.

This included:

- Conducting interviews using video conferencing.
- Requesting evidence from the provider to be submitted electronically.
- A site visit which included a review of patients' notes and adherence to infection control standards.

To get to the heart of patients' experiences of care and treatment, we 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?

Inadequate

Are services safe?

We rated safe as Inadequate because:

- Patients with safeguarding concerns were not being effectively reviewed, and not being discussed as a team, or with outside agencies.
- The provider was not always ensuring that patient records provided key information in summary notes, and not all entries were clear with regards to who had undertaken specific tasks.
- We saw examples of letters that had been received from other health care professionals that had been filed without appropriate follow up actions being completed.
- The provider was not identifying significant events or near misses to maximise learning opportunities and subsequent improvements.

Safety systems and processes

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

- The service had developed some systems to safeguard children and vulnerable persons from abuse. However, we found that safeguarding registers were not up to date, for example, not all patients with a safeguarding alert were listed on the registers. The provider told us they were in the process of collating a child safeguarding register.
- We saw that the reviews of safeguarding patients were infrequent and limited. We were informed that safeguarding patients would be discussed at the service's governance meeting although there was no evidence to support this. The provider was also considering introducing a specific safeguarding meeting to review those patients on their safeguarding registers. The reviews of safeguarding patients were being undertaken by the lead GP, and did not involve other members of the team, or include any liaison with external providers (such as the patient's registered NHS GP), or other agencies. Following our inspection, the provider was able to give an unverified example of multi-agency working following a safeguarding concern.
- A clinician was able to describe a recent consultation that had identified some safeguarding concerns, although this patient had not been discussed at the governance meeting or added to the safeguarding register.
- There were comprehensive policies available for child and adult safeguarding which were accessible to staff, and they outlined clearly who to go to for further guidance. However, training requirements had not been updated in line with Intercollegiate guidance as highlighted at our previous inspection, although we observed that non-clinical staff had completed the appropriate level two training required. When we raised this, the provider took immediate action to update the policy to include the correct training requirements.
- At our previous inspection in 2021, we observed that recruitment checks were often incomplete. At this inspection in June 2022, we saw the provider now ensured that all necessary recruitment checks were completed and maintained on file as evidence. In addition, the service was now undertaking a similar process for their contracted clinicians to ensure they could provide evidence including professional registration, up to date training and appraisal, and ID checks. This was then updated via an annual renewal of Practising Privileges with a signed declaration from the contractor.
- Disclosure and Barring Service (DBS) checks were undertaken on appointment (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). DBS clearance was also checked for contracted professionals.

Infection Prevention and Control

- At our previous inspection, we found several significant concerns relating to infection prevention and control standards. At this inspection in June 2022, we found that significant improvements had been achieved to ensure compliance to infection control standards. The operations manager was the designated infection control lead,

although they had not undertaken any additional training to support this role; however, they told us that this would be organised. Practice infection control policies were much improved since the previous inspection. Consumable equipment was all found to be in date and we observed effective systems were in place to monitor expiry dates of all consumables within the practice.

- Since the inspection in 2021, the service had organised for a comprehensive infection prevention and control audit lead by an appropriate infection control lead based at the local acute hospital Trust. This led to the development of an action plan which the service had completed. They had introduced internal infection prevention and control audits to monitor adherence to the standards. In addition, the operations manager met regularly with the cleaning contractor and they also undertook site inspections to ensure ongoing compliance with standards.
- Carpeted clinical and consulting areas had been replaced with vinyl floorings, rooms had been decluttered, and equipment was clean and well organised. Clinical waste was being managed appropriately, and we saw that waste consignment notes were now available for inspection. We observed a clean and well maintained environment appropriate to deliver patient care at our inspection in June 2022. There were some limitations to achieving full compliance to infection control standards due to the service being provided from a residential property, but the provider told us they had decided to actively seek alternative accommodation.
- We observed that cleaning schedules were being documented, although some monthly checks had not always been signed off.
- Hand washing training had been completed by all staff and a supporting audit had been completed.
- The premises had been risk assessed for Legionella, and we saw that a programme of water testing was in place and records were kept to verify this.
- We did not see full evidence of the lead GP's immunisation status.

Health & Safety

- The provider ensured that equipment was safe, and that it was maintained according to manufacturers' instructions. We saw evidence that all medical equipment had been calibrated in the last 12 months and all electrical equipment had been subject to portable appliance testing (PAT). PAT is the term used to describe the examination of electrical appliances and equipment to ensure they are safe to use.
- The provider carried out environmental and safety risk assessments, including fire and health and safety checks. We raised concerns at our previous inspection in October 2021 about the fire risk assessment, but in June 2022, we saw that the provider had organised an external fire risk assessment which had been completed in January 2022 by a competent person. This had resulted in a comprehensive action plan. We saw the provider had worked to address the actions identified. There were some limitations due to the property being residential, but these would be addressed in the long-term by the proposed re-location to a new premise. There had been a recent fire drill on site, and staff had completed fire training.
- Appropriate signage was in place to indicate where oxygen cylinders were stored. We saw that there was access to oxygen in all three clinical rooms and we observed that the tanks were full.

Risks to patients

There were mostly effective systems to assess, monitor and manage risks to patient safety.

- There were arrangements for planning and monitoring the number and mix of staff needed.
- There was an effective induction system tailored to the staff member's role.
- The service did not use agency staff to cover clinical sessions.
- Staff understood their responsibilities to manage emergencies and to recognise those in need of urgent medical attention. Staff knew how to identify and manage patients with severe infections, for example sepsis. Not all staff had completed training in sepsis at the time of the inspection.

Inadequate

Are services safe?

- There were suitable medicines and equipment to deal with medical emergencies which were stored appropriately and checked regularly. There was only one defibrillator pad for adults and one for children. The provider told us they would order a second one of each following our inspection as a safety measure to ensure that if a pad was used, there would be immediate access to another.
- There was not a failsafe system in place to check that all cervical smears sent to pathology for analysis, had results reported back to the service. We saw that there were some processes but these required strengthening to ensure the system was fully effective. Following our inspection, the service provided us with information that they had introduced a log to track smear results and also other specimens sent for analysis. Administrative staff would review the spreadsheet on a daily basis to check actions which may be pertinent for them, for example, sending reminders to patients to make an appointment to see the doctor, or when to have a repeat test.
- There were appropriate indemnity arrangements in place.

Information to deliver safe care and treatment

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

- At our previous inspection in 2021, we found that individual care records were not written and managed in a way that kept patients safe. We applied conditions to the service's registration with the CQC to ensure that an externally appointed doctor undertook monthly audits of patient records to monitor that improvements were made. At this inspection in 2022, we saw that the standards of patient documentation had significantly improved. This included care plans and the use of comprehensive consent forms.
- However, we found that information being recorded on the summary screen was limited. This meant that any clinician looking at the record would not have access to key information without having to trawl through individual entries in the record, meaning that some information may be missed. Details of the patient's NHS GP were not clearly identified on the IT system. Summaries of prescribed medicines did not always reflect the actual medicines currently being prescribed. For example, we saw that a patient had been posted a prescription for an unlicensed medicine but this was not showing on the medicines page of the clinical record. In addition, we found that entries were often listed to a non-clinician, but when we reviewed the audit trail on the system we saw that these had been completed appropriately by a clinician, however the provider needed to review how the entries were inputted to make this clearer. Entries were also noted to have been inputted using incorrect codes for example, a non-clinician was listed against entries for a controlled medicines review and a care plan.
- We saw examples of letters that had been received from other health care professionals that had been filed without appropriate follow up actions being completed.
- Since our previous inspection, the service had implemented clear systems for sharing information with the patients' registered GP. This would be potentially important, for example, for GPs to be aware of any unlicensed medicines that were prescribed, and may influence their own clinical decision making.
- The service had a system in place to retain medical records in line with Department of Health and Social Care (DHSC) guidance in the event that they cease trading.
- Clinicians made appropriate and timely referrals in line with protocols and up to date evidence-based guidance.

Safe and appropriate use of medicines

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

- The systems and arrangements for managing medicines, including vaccines, emergency medicines and equipment minimised risks. We found emergency medicines to be in date; controlled drugs were well managed and stored in a cupboard which was secured to a wall; and vaccines fridges were well maintained and monitored daily.

Inadequate

Are services safe?

- Patient Group Directions (medicines which can be given without a prescription for specific groups of people) were not being used when we visited in June 2022, as there was no longer a nurse in post. The PGDs had been updated since our previous inspection and we were informed that these would be reviewed again in advance of any future appointment of a nurse. We saw evidence in patient notes that Patient Specific Directions (PSDs) had been used effectively in the recent past before the nurse had left. A PSD is a written instruction, signed by a prescriber for medicines to be supplied and/or administered to a named patient after the prescriber has assessed the patient on an individual basis.
- The service kept prescription stationery securely and monitored its use.
- At our previous inspection, the provider was prescribing cannabis for pain relief. We identified some concerns relating to the governance arrangements for this service. However, the provider had discontinued this service when we inspected in June 2022, and there were no plans to recommence this in the immediate future.
- The provider no longer held any controlled drugs for emergency use on site. All controlled drug prescriptions were secured and logged when used, and we saw this procedure had been introduced in May 2022.
- We observed that the procedure for dispensing medicines within the service had improved with two signatures now being recorded for all medicines dispensed as a safety check.
- At our previous inspection, we had concerns that vitamin B12 injections were being posted out to patients for self-administration and we were not assured of the level of training and oversight provided to patients. When we inspected in June 2022, this procedure had ceased, and the service was only available to patients who attended the premises.
- The provider adhered to General Medical Council (GMC) guidance to share information about the treatment and prescribing provided by the service with the patient's GP.
- We had previously raised concerns about the oversight of clinicians working on a contractual basis for the service and found that this issue had not been effectively addressed. For example, we saw a clinician had issued two prescriptions for controlled medicines for 28 tablets firstly on 10 May and then again on 31 May 2022. There was no justification recorded for this. The provider was unaware and was unable to say how they monitored this.
- The service provided Bioidentical Hormone Replacement Therapy. Some of the medicines this service prescribed were unlicensed. Treating patients with unlicensed medicines is higher risk than treating patients with licensed medicines, because unlicensed medicines may not have been assessed for safety, quality and efficacy. These medicines are not recommended by the National Institute for Health and Care Excellence (NICE). NICE Guidance states that clinicians must explain to women that the efficacy and safety of unregulated compounded bioidentical hormones are unknown. Patients completed a comprehensive consent form which explained the medicines were unlicensed and the possible effects these could have upon the patient.

Track record on safety and incidents

- Comprehensive risk assessments in relation to safety issues were available.
- We were informed that the lead GP received safety alerts including those issued by the Medicines and Healthcare products Regulatory Agency (MHRA). These were stored in a folder for reference. However, these were not discussed at governance meetings, and there was no evidence recorded to say what actions had been taken in response to the alert. For example, we discussed a recent safety alert about the monkeypox virus, and although the provider was aware of it, it had not been discussed or any actions recorded. We were informed that a system would be implemented to improve this following our inspection.

Lessons learned and improvements made

The service learned and made improvements when things went wrong.

- The practice provided us with a significant event policy.

Inadequate

Are services safe?

- We were informed that there was a system for recording and acting on significant events. The service used a self-administered feedback form (SAF) for staff to raise concerns and report incidents. However, we found that no incidents or near misses had been reported since our last site visit in late 2021. During the course of our inspection in June 2022, we identified several issues that could have been used as a significant event to consider learning and improvements. Therefore, we were not assured that the process for identifying and reporting adverse events was embedded.
- Staff had informed management that the completion of significant events was viewed as a means of attributing blame, although this had not been the intention. Therefore, the decision was taken to produce aide memoires which highlighted changes in practice which would take place in response to an event/near miss and which would improve the delivery of safe services to patients. It was felt that the aide memoires, circulated in hard copy and electronically and explained to each member of staff, was a way of informing everyone about changes and the reason for them.
- Following the inspection, the provider did provide us with a copy of a detailed significant event which was identified during our review of patient records. This identified a number of areas for action and follow up.
- Governance meetings did not include reference to significant events.
- At our previous inspection in 2021, we reviewed a significant event regarding intravenous vitamin therapy which was provided to patients as an energy boost, rather than as a first-line treatment modality. Four patients experienced a negative reaction during August 2021. The provider reported the incident to the MHRA under the yellow card scheme (a system for collecting and monitoring information on safety concerns such as suspected side effects or adverse incidents involving medicines and medical devices), and also instigated an independent review. When we visited the site in June 2022, we saw that the independent review was completed and recommendations had been made for improvements. The IV vitamin therapy service had been temporarily suspended since the incident, but we were informed that the recommendations would be fully considered and fully applied when this service restarted in the future.
- The provider was aware of and complied with the requirements of the Duty of Candour. The provider encouraged a culture of openness and honesty.

Requires Improvement

Are services effective?

We rated effective as Requires improvement because:

- Whilst the use of comprehensive consent forms had been greatly improved, these included reference to a statement absolving the prescriber of any issues that may arise from the prescribed medicines. This was not in line with the principles of prescribing.
- There was limited evidence that clinical audit was being used to drive improvements, or that there was an established programme of quality improvement.
- Staff training was incomplete.

Effective needs assessment, care and treatment

We saw evidence that clinicians assessed needs and delivered care and treatment in line with current legislation, standards and guidance (relevant to their service).

- There were 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.
- Templates to support functional and unlicensed medicine consultations and prescribing had been developed in the clinical system to ensure all necessary information was documented. The service planned to develop the use of Ardens templates in the near future. Ardens templates are designed to capture consistent, accurate data and can help streamline and speed up consultations.
- Patients' immediate and ongoing needs were assessed. Information was available on the service website prior to them accessing the service.
- Arrangements were in place to deal with patients who required any follow up. This could be a telephone consultation, or if they needed to be seen, they were given an appointment at the next scheduled clinic.
- We saw no evidence of discrimination when making care and treatment decisions.

Monitoring care and treatment

The service was not actively involved in quality improvement activity.

- The provider told us they used information about care and treatment to make improvements, but did not have a scheduled forward programme of clinical audit in place to impact on the quality of care and outcomes for patients.
- We were provided with copies of two audits that had been undertaken:
- One was a basic audit on hypertension based on NICE guidance with an aim to record blood pressure every five years for all patients aged over 35 in order to detect hypertension so that appropriate treatment and follow up could be organised. This was undertaken in June 2021 when 18% of appropriate patients attending for a consultation received a blood pressure check, and repeated in March 2022 when 25% of patients had received a blood pressure check. There was no indication as to whether these were all in normal ranges or if any follow up care was arranged. The plan was to take the blood pressure of all new patients aged 35 and over, and to contact all non-regular patients over 35 who had not had a blood pressure check in the last five years to attend for one. This was then be re-audited in October 2022. However, there was no indication on what this audit had achieved. We were informed that if blood pressures were elevated in patients attending the service on a one-off basis, these would be signposted back to the GP, and all regular patients, were advised to make a subsequent appointment for a blood pressure check or advised to purchase a home blood pressure monitor to take their own blood pressures regularly and report the results to the practice, but this was not apparent in the audit.

Requires Improvement

Are services effective?

- The other audit was a two-cycle audit on one of the prescribed unlicensed medicines to establish the efficacy of the treatment. This utilised a medical symptoms questionnaire (MSQ) which is a functional medicine tool used to assess patients initially, and their subsequent progress with treatment. There was a response from 50% (13) patients who were included in the audit, and seven showed an improvement, and another four showed some improvement in aspects of their condition without an improved MSQ score. All patients now had appropriate consent recorded following our previous inspection. It was difficult to determine efficacy due to other influencing factors, but the audit helped to demonstrate the overall progress of some patients being prescribed this particular off-license medicine.
- There had been no audit of cervical smears taken.
- External records audits had been undertaken since our previous inspection in line with the conditions imposed upon the provider's registration and this had resulted in a marked improvement in record keeping. However, we identified other areas where records needed improvement, for example in terms of summaries.
- Following our inspection, we were provided with some proposals for inclusion in the future audit programme.

Effective staffing

Staff had the skills, knowledge and experience to carry out their roles, but there were some gaps identified in the staff training programme.

- Evidence of the qualifications stated in applications were checked as part of the recruitment process. The provider had an induction programme for all newly appointed staff.
- Clinicians were registered with the General Medical Council (GMC) and were up to date with revalidation.
- The provider understood the learning needs of staff and told us staff were provided with protected time and training to meet them. Records of skills and training were maintained, although non-clinical staff had not completed all of the training modules identified as being required by the provider. For example, only two of the five staff had completed equality and diversity, complaints, sepsis and health & safety training. Key training modules such as safeguarding, basic life support, mental capacity act, and fire were up to date. There was no distinction between what training was mandatory and what was considered to be desirable.
- Since our previous inspection in 2021, the nurse had left and the service had reviewed if a replacement was required due to limited demand for nursing care. GPs were picking up the duties which would have normally been referred onto the nurses, for example, venepuncture, immunisations and cervical smears. An administrator had been trained up to undertake phlebotomy recently, but had left just prior to our inspection; the service was hopeful that they may be able to train another administrator to do this role. We saw some evidence of the assessment of competencies for the administrator undertaking health care assessments, but nothing was provided specifically for the phlebotomy duties.
- A new GP had commenced working at the service for one session/week. There were plans to have more GP input and develop the private routine GP consultation service further.
- We spoke with the new GP and were reassured by their approach to safety. For example, they explained how they described the possible effects of a particular unlicensed medicine to make sure the patient had an informed choice before proceeding with the medicine.

Coordinating patient care and information sharing

Staff worked together, but did not always communicate effectively with other organisations, to deliver effective care and treatment.

- Before providing treatment, doctors at the service tried to ensure they had adequate knowledge of the patient's health, any relevant test results and their medicines history. This was mostly dependent on the patient providing details of their own health history.

Requires Improvement

Are services effective?

- Patients were asked for consent to share details of their consultation, and any medicines prescribed (including antidepressant and unlicensed medicines) or test results, with their registered GP when they used the service. We saw evidence of letters sent to patients' registered GPs in line with GMC guidance.
- We saw examples of letters that had been received from other health care professionals that had been filed without action. We were told that administrators reviewed incoming correspondence for routine coding and then sent any queries onto the GP to review or action. However, we observed that this was not always happening and letters had not always been appropriately acted upon.

Supporting patients to live healthier lives

Staff were consistent in supporting patients to manage their own health and maximise their independence.

- Where appropriate, staff gave people advice so they could self-care. This was incorporated into patient consultations.
- 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.

- We observed that the service had significantly improved its procedures to obtain and record consent. A range of comprehensive consent forms had been introduced to cover all procedures where consent was required included the prescribing of unlicensed medicines.
- However, we observed that the consent forms for unlicensed medicines included the statement that the practitioner was completely absolved of all responsibility and indemnity in perpetuity, in the event of any problems whatsoever that may be associated with the prescription. This goes against the principles of prescribing.
- Consent was requested from patients to communicate with their registered NHS GP. This included details of any unlicensed medicines that were prescribed. When patients did not consent, this was documented and the patient was provided with a copy of their consultation notes and advised they should share these with their own GP.
- We were told that where appropriate, staff assessed and recorded a patient's mental capacity to make a decision.

Good

Are services caring?

We rated caring as Good.

Kindness, respect and compassion

Staff treated patients with kindness, respect and compassion.

- The service sought feedback from patients on their experience and quality of clinical care patients received.
- Feedback from patients was positive about the way staff treated them. The service provided us with examples of patient feedback which they had received, all of which were complimentary.
- 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.

Involvement in decisions about care and treatment

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

- We were told that interpretation services were available for patients who did not have English as a first language.

Privacy and Dignity

The service respected patients' privacy and dignity.

- Staff recognised the importance of people's dignity and respect, although not all staff had completed equality and diversity training.
- 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 available for the three consulting rooms.
- The service supported their own charitable foundation to help poverty, including projects locally and overseas.

Good

Are services responsive to people's needs?

Responding to and meeting people's needs

The service mostly organised and delivered services to meet patients' needs. However, it did not fully take account of patient needs and preferences.

- The provider understood the needs of their patients and delivered services in response to those needs.
- The premises were within a residential property and offered a welcoming and calm environment for patients to attend.
- There were steps into the building although we were informed a ramp was available, however access would still be problematic by wheelchair and electric scooter. Consultations took place on the second floor, and these were only accessible by stairs, although a small downstairs room had been developed for basic interventions such as taking bloods since our previous inspection. The provider was aware of the limitations posed by the residential nature of the premises and were actively seeking alternative premises at the time of our inspection in June 2022.

Timely access to the service

Patients were able to access care and treatment from the service within an appropriate timescale for their needs.

- The service opened from 8.30am until 5pm Monday to Thursday, and from 8.30am to 4.30pm on Friday.
- Patients had timely access to initial assessment, test results, diagnosis and treatment.
- Appointments were set at a minimum length of 15 minutes, but the appointment length was flexible depending on the individual's need and personal requirements.
- Waiting times, delays and cancellations were minimal and managed appropriately.
- Patients with the most urgent needs had their care and treatment prioritised.
- Patients reported that they were able to access care promptly and their preferred type of appointment was offered (face-to-face or remote). Home visits could be arranged for those patients who were unable to attend the practice.
- Referrals were undertaken in a timely way.

Listening and learning from concerns and complaints

The service took complaints and concerns seriously but did not always respond to them appropriately. Complaints were used to improve the quality of care.

- Three complaints had been received since our previous inspection at the end of 2021. The service had developed a complaints log to ensure easy tracking and to aid any analysis.
- Information about how to make a complaint or raise concerns was available. There was a written complaints procedure which reflected national guidance.
- We reviewed two patient complaints. We saw these were handled sympathetically and were responded to promptly.
- The provider told us that they learnt lessons from individual concerns and complaints. However, we did not see evidence that these were discussed with staff at meetings.

At our previous inspection in 2021, we were told that complaints information was documented on the patient's record. This practice had ceased when we inspected in June 2022 in line with national guidance.

Requires Improvement

Are services well-led?

We rated well-led as Requires improvement because:

- Governance arrangements had improved significantly but these needed time to become embedded and some actions were still in progress.
- The provider was unable to provide assurances that externally contracted clinicians were working competently with effective oversight of their work.

Leadership capacity and capability

Leaders did not have the capacity and skills to deliver high-quality, sustainable care.

- The Board had restructured since our inspection in 2021. It now consisted of the lead GP and operations director. The provider was aware of the need to develop Board membership and ensure independent representation. They were actively seeking to appoint to the Board at the time of our inspection. The Board met on a monthly basis.
- Leaders did not consistently display an adequate understanding of some issues and priorities relating to the quality and governance of services. There was a lack of clearly defined oversight and assurance of clinical processes in place, allowing for any emerging risk to be identified and subsequently addressed.
- Leaders were visible and approachable.
- The lead GP was a member of the Independent Doctors Federation (IDF) which is a designated body with its own Responsible Officer. This organisation provide the GPs with a regular appraisal and support with revalidation.
- The operations manager had applied to become the Registered Manager to relieve some of the duties on the lead GP. We were informed that the roles and responsibilities of the lead GP had been reviewed to reduce their workload, however, the absence of a nurse meant that additional duties had to be picked up by medics.
- We saw evidence of succession planning in that the operations manager was working with an administrator to develop their practice management skills.
- We found some evidence to support a closed culture operated in that the service mostly worked in an insular manner, for example, in terms of safeguarding processes, and independent oversight from the Board.

Vision and strategy

The service had a clear vision and strategy although this was not always reflected in the delivery of high quality care and the promotion good outcomes for patients.

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

Culture

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

- Staff mostly felt respected, supported and valued, although we saw evidence of some negative feedback in a recent staff survey.
- The service focused on the needs of patients.
- The provider was aware of and had systems to ensure compliance with the requirements of the duty of candour.
- We saw that there was a whistleblowing policy and procedure in place, and this was accessible to staff.

Requires Improvement

Are services well-led?

- All employed staff had received an appraisal in the previous year, and GPs participated in the GP appraisal programme. The service's staff appraisal programme had been relaunched by the new operations manager who had undertaken interim reviews with a plan to undertake an annual appraisal from October 2022 which would be aligned with the service objectives. Staff were supported to meet the requirements of professional revalidation where necessary.
- There were mostly positive relationships between staff and teams. Staff told us they worked together as a team to support each other.

Governance arrangements

There were mostly clear responsibilities, roles and systems of accountability to support good governance and management.

- Structures, processes and systems to support good governance and management were clearly set out but were not always working effectively. For example, a monthly clinical governance meeting had been established since our previous inspection. This was attended by the two GPs and the operations manager. Whilst this was a good development, we did not see evidence that this meeting was used as an opportunity to review safeguarding, complaints, incidents, new and revised guidance or safety alerts.
- Our review of patient records identified that governance processes were not working effectively in some aspects, for example in how entries were being made under an incorrect name or were being coded incorrectly.
- Leaders had established policies and procedures to ensure safety. These had been reviewed since our previous inspection and were now seen to be accurate, and up to date. They were readily accessible on the practice's intranet.
- Information was stored in organised electronic files to ensure information could be easily retrieved. This had been developed since our previous inspection.
- Staff were clear on their roles and accountabilities.

Managing risks, issues and performance

There was limited clarity around processes for managing risks, issues and performance.

- There were some process to identify, understand, monitor and address current and future risks including risks to patient safety.
- Performance of clinical staff could not be demonstrated through audit of their consultations, prescribing and referral decisions. We did not see clear evidence of how the provider sought assurance on the quality of services delivered by sub-contracted clinicians.
- Clinical audit was limited. We were unable to see how the practice could demonstrate the positive impact on quality of care and outcomes for patients.
- The provider had plans in place to respond to major incidents.

Appropriate and accurate information

The service did not have appropriate and accurate information.

- We did not see how quality and operational information was used to ensure and improve performance, although we observed that the provider did seek and review patient feedback.
- The information used to monitor performance and the delivery of quality care was not always accurate and useful. There was limited evidence of plans to address any identified weaknesses.

Requires Improvement

Are services well-led?

- The provider told us they submitted data or notifications to external organisations as required. For example, a yellow-card notification had been submitted to the MHRA following adverse patient reactions to intravenous therapy; and the provider contacted the CQC when any changes were required to their registration or a notifiable event took place which required he submission of a statutory notification. For example, the provider was in the process of applying to change their Registered Manager with the CQC.
- Effective arrangements were operational in line with data security standards for the availability, integrity and confidentiality of patient identifiable data, records and data management systems.

Engagement with patients, the public, staff and external partners

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

- The provider encouraged and heard views and concerns from the public, patients, and staff acted on them to shape services and culture.
- Due to the small number of employees, and different working patterns, staff meetings were not taking place. However, we were informed that staff received regular updates and communications and as a small team this was easy to facilitate.
- A staff survey had been undertaken in May 2022, and the results were mixed from the team members who responded. There was an indication that some staff found the workload quite difficult to manage. The operations manager informed us that they intended to discuss the results with the team and consider any areas where improvements could be made.
- A form with six questions was placed in the reception area together with a locked box for responses. The receptionist asked all patients whether they would please complete one after their consultation. We saw 26 responses which were all very positive about the patients' experiences. However, the questions were very generic and basic and did not provide feedback to drive improvement.
- There was useful information provided for patients on their website.

Continuous improvement and innovation

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

The provider informed us that they reviewed incidents and complaints. We saw some evidence that learning was shared from an 'aide memoire' process introduced from February 2022 to highlight changes in practice which would take place in response to an event/near miss and which would improve the delivery of safe services to patients.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Diagnostic and screening procedures Family planning services Services in slimming clinics Treatment of disease, disorder or injury Maternity and midwifery services	Regulation 17 HSCA (RA) Regulations 2014 Good governance There were limited systems or processes that enabled the registered person to assess, monitor and improve the quality and safety of the services being provided. In particular: • A scheduled programme of established clinical audit or quality improvement was not apparent. • The oversight of the work undertaken by contracted clinicians was unclear and not formalised in order to provide assurances, for example, audits of patient consultation notes and prescribing. Contracted staff should also contribute to the significant event process, and have systems to communicate with the registered provider effectively. • The provider must implement a process to ensure that all significant events are identified as part of an open reporting culture, and used as a learning experience to improve the service. • Outcomes of responses to safety alerts were not documented. • Independent representation on the Board was required to ensure that a closed culture was not in place. 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

Enforcement actions

Action we have told the provider to take

The table below shows the legal requirements that were not being met.

Regulated activity	Regulation
Diagnostic and screening procedures Family planning services Maternity and midwifery services Services in slimming clinics Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment • We found that information being recorded on the summary screen of patient records was limited. This meant that any clinician looking at a patient record would not have access to key information without having to search through previous entries in the record, meaning that some important information may be overlooked. Summaries of prescribed medicines did not always reflect the actual medicines currently being prescribed. Details of the patient's NHS GP were not clearly identified within the patient's record. • We found that clinical entries on records were often listed to a non-clinician, but when we reviewed the audit trail on the system we saw that these had been completed appropriately by a clinician. However the provider needed to review how the entries were inputted to make this clearer. Entries were also noted to have been inputted using incorrect codes for example, a non-clinician was listed against entries for a controlled medicines review and a care plan. • We saw examples of letters that had been received from other health care professionals that had been filed without the appropriate follow up actions being completed. • There was no procedure for the oversight of clinicians working on a contractual basis for the service. The provider was unable to assure us how they monitored this. • Medicines and Healthcare products Regulatory Agency (MHRA) and safety alerts were stored in an electronic folder for reference. However, these were not discussed at governance meetings, and there was no evidence recorded to say what actions had been taken in response to the alert.

This section is primarily information for the provider

Enforcement actions

This was in breach of Regulation 12 (1) (2)(g) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Regulated activity	Regulation
Diagnostic and screening procedures Family planning services Maternity and midwifery services Services in slimming clinics Treatment of disease, disorder or injury	Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment • We found that safeguarding registers were not up to date, for example, not all patients with a safeguarding alert were listed on the registers. • We saw that when a safeguarding concern had been identified, these were not always added to the safeguarding register or had been discussed at team meetings. • The provider told us they were in the process of collating a child safeguarding register, but this was not available at the time of our inspection on 22 June 2022. • We saw that the reviews of safeguarding patients were infrequent and limited. We were informed that safeguarding patients would be discussed at the service's governance meeting although there was no evidence to support this. The reviews of safeguarding patients were being undertaken by the lead GP, and did not involve other members of the team, or include any liaison with external providers (such as the patient's registered NHS GP), or other agencies. This was in breach of Regulation 13(2)(3) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.