Dr O'Keeffe's Practice

Inspection report

26, Eaton Terrace
London
SW1W 8TS
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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	Good
Are services safe?	**Good**
Are services effective?	**Good**
Are services caring?	**Good**
Are services responsive?	**Good**
Are services well-led?	**Requires improvement**

Overall summary

This service is rated as Good **overall.** (Previous inspection May 2018 – inspected but not rated).

The key questions are rated as:

Are services safe? – Good

Are services effective? – Good

Are services caring? – Good

Are services responsive? – Good

Are services well-led? – Requires improvement

We carried out an announced comprehensive inspection at Dr O'Keeffe's Practice to follow up on breaches of regulations.

CQC inspected the service on 11 May 2018 and asked the provider to make improvements regarding safe and effective care and well-led service. We checked these areas as part of this comprehensive inspection and found those concerns had been addressed; however, we identified some new issues during our recent visit. Following our previous inspection in May 2018, we issued two requirement notices for breaches of Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment and Regulation 17 HSCA (RA) Regulations 2014 Good governance.

Dr Guy O'Keefe's Practice provides a private general practice service to patients at 26 Eaton Terrace in the borough of Westminster in London. Dr O'Keefe's Practice is registered with the Care Quality Commission to provide the regulated activities of Treatment of disease, disorder or injury and Diagnostic and screening procedures.

Prior to our inspection, patients completed CQC comment cards telling us about their experiences of using the service. Fifteen people provided wholly positive feedback about the service. Dr O'Keeffe was described as caring, attentive and patients felt they were treated with respect.

Our key findings were:

- The service had suitable safeguarding processes and staff knew their responsibilities for safeguarding adults and children.
- The service had carried out a safety risk assessment of the premises and equipment; however, we found not all risks had not been fully assessed and mitigated.
- The premises were clean and well maintained, we saw evidence of actions taken to prevent and control the spread of infections. However, no annual infection control audit had been carried out since our inspection in May 2018.
- Not all emergency medicines were available as described in recognised guidance. There was no record kept of checks to make sure medicines were available, within their expiry dates, and in working order.
- At this inspection we found medical equipment had been calibrated to ensure it was safe to use.
- The service reviewed the effectiveness and appropriateness of the care it provided. It ensured that care and treatment was delivered according to evidence based guidelines.
- We found evidence of quality improvement measures including clinical audits and there was evidence of action taken to change practice. Follow up audits demonstrated that learning and quality improvement had been achieved.
- Staff involved and treated patients with compassion, kindness, dignity and respect.
- Services were provided to meet the needs of patients.
- There was a system for recording and acting on incidents, adverse events and safety alerts. The provider shared safety alerts with staff effectively.
- Staff felt involved and supported and worked well as a team.
- Patient feedback for the services offered was consistently positive.

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

- 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.

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

- Review the need to obtain a paediatric pulse oximeter.

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. The team included a GP specialist advisor.

Background to Dr O'Keeffe's Practice

Dr O'Keefe's Practice is a provider of private general practice services and treats both adults and children. The address of the registered provider is 26 Eaton Terrace, London SW1W 8TS. General medical services provided include routine medical consultations and examinations, vaccinations and travel vaccinations and health screening. The clinic is a yellow fever vaccination centre. There are currently 1500 registered patients and ten GP sessions are carried out weekly.

The clinic is located in a converted residential and business use property with street level access into a reception and waiting area. The building is not fully accessible to wheelchair users and does not have accessible facilities. There are patient toilets and baby changing facilities available. The premises consist of a patient waiting room and reception area, a consultation room, an office area, a storage area, a medicines storage room and kitchen space.

Services are available to any fee-paying patient. Services are available by appointment only between 8.30am and 1pm and 4pm to 5.30pm Monday to Friday. The service is closed at weekends. There is an on-call register of four locum doctors to cover weekends. The service operates a call out service 24 hours a day, every day. Services are available to people on a pre-bookable appointment basis.

Medical services are provided by a sole medical doctor. The doctor is supported by a practice manager and administrative support is provided by three reception staff members. The doctor is required to register with a professional body and was registered with a licence to practice.

How we inspected this service

Before visiting, we reviewed a range of information we hold about the service.

During our visit we:

- Spoke with doctor who was the provider of the service.
- Spoke with the practice manager and reception staff.
- Reviewed an anonymised sample of the personal care or treatment records of patients.
- Reviewed service policies, procedures and other relevant documentation.
- Inspected the premises and equipment used by the service.
- Reviewed feedback from service users including CQC comment cards.

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.

Good

Are services safe?

We rated safe as Good because:

We found that this service was providing safe care in accordance with the relevant regulations. At our last inspection in May 2018, the service had carried out a safety risk assessment of the premises and equipment; however, we found not all risks were fully assessed and well-managed:

- Medical equipment had not been calibrated.
- There was no evidence of a legionella risk assessment.
- Infection control audits had not been undertaken.
- Not all staff had received training appropriate to their role.
- There was no record of immunity for staff who handled specimens or dealt with spillages of waste or bodily fluids.
- At our previous inspection there were no formal arrangements for verifying a patient's identity and formal checks of adults accompanying child patients were not carried out. At this inspection there was a system for checking patients' identity. We found evidence that the service checked that the responsible adult attending had authority to consent to treatment.

At this inspection the service had started to implement a programme of health and safety assessment. The service had identified monitoring safety and recording what precautions and practical steps had been taken to remove or minimise risks for improvement.

Safety systems and processes

The service had some clear systems to keep people safe and safeguarded from abuse.

- The provider conducted safety risk assessments. It had appropriate safety policies, which were regularly reviewed and communicated to staff including locums. They outlined clearly who to go to for further guidance. The service had systems to safeguard children and vulnerable adults from abuse. Guidance was available for safeguarding both children and adults and contained contact numbers for local safeguarding teams.
- The service had systems in place to assure that an adult accompanying a child had parental authority.
- The provider had a number of policies and procedures which followed guidance from the Independent Doctor's Federation (IDF).
- 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. 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. Staff who acted as chaperones were trained for the role and had received a DBS check. The doctor had completed safeguarding adults and children level 3. All reception and administration staff had received safeguarding up to level 2. At our previous inspection there was no chaperone policy in place. At this inspection we found the service had a chaperone policy. All staff had completed online chaperone training.
- At the previous inspection we found staff had not completed all role appropriate training required to carry out their duties. For example, not all staff at the service had undertaken training in infection control, chaperoning and fire safety. At this inspection staff files we reviewed showed non-clinical staff had completed role appropriate training in basic life support, safeguarding, chaperoning, infection control, information governance and fire safety. At this inspection we saw the doctor had completed Mental Capacity Act training.
- 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. We saw a cleaning schedule and evidence of weekly audits of the cleaning carried-out.
- The service had not carried out an annual infection control audit although the service had an infection control policy which included guidance on universal infection control precautions. We saw evidence of actions taken to mitigate the spread of infection, for example there was a sharps injury procedure and touchless taps had been installed. Files we reviewed

showed all staff had completed infection control training. We spoke to the service about this and the service manager sent us a copy of an infection control audit completed after our inspection, with no actions identified.

- At our last inspection, there was no system of recording staff vaccinations. There was no record of immunity for staff who handled specimens or dealt with spillages of waste or bodily fluids. At this inspection we saw a record of staff vaccinations. We saw evidence of immunity for the doctor in line with current national guidance. There was a record of immunity for staff who handled specimens or dealt with spillages of waste or bodily fluids
- At our previous inspection, there was no evidence of a legionella risk assessment. At this inspection we saw evidence of tests to reduce the possibility of Legionella or other bacteria developing in the water systems, in line with a risk assessment. Staff showed us a water sample pathology report of tests for Legionella completed by an external company in February 2019. The provider told us the landlord of the building was responsible for legionella risk assessments of the building.
- The service stocked medicines. However, at this inspection we found the provider did not stock all recommended emergency medicines. We found there was no glucogel to treat hypoglycaemia in stock and no salbutamol nebules were in stock for use with the nebuliser. The provider addressed this immediately and ordered these recommended emergency medicines during our inspection. Emergency equipment was available as described in recognised guidance.
- There was no documented system for recording and monitoring checks of emergency medicines. We spoke to staff about this. We found checks of emergency medicines were done but had not been recorded.
- The provider ensured that facilities and equipment were safe, and that equipment was maintained according to manufacturers' instructions. At our last inspection in May 2018, the service had not ensured that medical equipment was safe and that equipment was maintained according to manufacturers' instructions. There were no arrangements in place for checking the working status of the defibrillator and no record of equipment calibration. At this inspection we saw clinical equipment which had been calibrated to give reliable readings, for example, a blood pressure machine, scales, pulse oximeter and a new nebuliser. The practice had a system in place to check the working status of the defibrillator. There was evidence that portable appliances had been tested for electrical safety within the last two years.
- The provider carried out appropriate environmental risk assessments, which took into account the profile of people using the service and those who may be accompanying them.

Risks to patients

There was a comprehensive system to assess, monitor and manage risks to patient safety.

- There were systems to identify, understand, monitor and address health and safety risks and risks related to the premises. At this inspection the service had started to implement regular safety checks however, not all procedural audits were fully embedded. For example, the service had not carried out an annual infection control audit although the service had an infection control policy which included guidance on universal infection control precautions. We spoke to the service about this and following the inspection, the service manager sent us a copy of a completed infection control audit.
- There were arrangements for planning and monitoring the number and mix of staff needed.
- 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 doctor offered a 24-hour emergency call out service.
- There were systems for managing fire risk. Fire extinguishers were checked annually. We saw evidence of a fire risk assessment dated 12 April 2019. However, this had not been carried out by a suitably qualified person. There were no fire alarms in the premises but we saw two smoke alarms. The practice had a system in place to check the working status of the smoke alarms and fire drills had been carried out.
- At our last inspection there was no evidence of fire safety training for the doctor. At this inspection we saw evidence of fire safety training for the doctor and all staff. There was a visible fire procedure in the areas of the premises used by patients.

Good

Are services safe?

- The service had a documented business continuity plan for major incidents such as power failure, flood or building damage.
- Patient records were stored securely on the service computer, which was backed up.
- There were appropriate indemnity arrangements in place to cover all potential liabilities.

Information to deliver safe care and treatment

Staff had the information they needed to deliver safe care and treatment to patients.

- Individual care records were written and managed in a way that kept patients safe. The care records we saw showed that information needed to deliver safe care and treatment was available to relevant staff in an accessible way.
- The service had systems for sharing information with staff and other agencies to enable them to deliver safe care and treatment.
- 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.
- The service treated children and staff told us they verified the identity of adults accompanying child patients, but this was not recorded.
- The practice asked patients whether they consented to details of their treatment being shared with their registered NHS GP when they initially registered with the practice. However, there was no formal policy in place to support decision making associated with patients consenting or declining consent for information to be shared with their GP.
- Referral letters included all the necessary information.
- 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 mostly had reliable systems for appropriate and safe handling of medicines.

- The systems and arrangements for managing medicines, including vaccines, emergency medicines and equipment minimised risks. However, we found the process for recording controlled drugs prescriptions required improvement. There was no record of serial numbers for the Controlled Drugs pad kept locked away in the doctor's desk. We spoke to the provider about this who addressed this concern straightaway and created a log. The service kept prescription stationery securely and monitored its use.
- There were effective systems for managing medicines stocked in the refrigerator. The provider kept records of daily refrigerator temperature checks. There was a storage of vaccines policy with guidance for staff on what to do in the event of a cold chain breach.
- The practice kept prescription stationery securely and monitored its use.
- All the medicines we checked were in date and stored securely.
- The doctor prescribed, administered or supplied medicines to patients and gave advice on medicines in line with legal requirements and current national guidance.
- Patients' health was monitored to ensure medicines were being used safely and followed up on appropriately. The service involved patients in regular reviews of their medicines.
- 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.

Track record on safety and incidents

The service mainly had a clear safety record as most risks had been fully assessed and mitigated.

- In some areas, the service had not monitored and reviewed activity to understand risks and where identified made necessary safety improvements. For example, there had been no infection control audit of the service. However, we saw evidence the service had carried out risk assessment regarding infection control.
- We saw information displayed next to sharps bins to instruct people on what to do if they sustained a needlestick injury.
- The service monitored and reviewed activity through a variety of meetings. Staff kept a message book with a

Good

Are services safe?

line for messages actioned, which was reviewed daily. This helped staff to understand risks and gave a clear, accurate and current picture that led to safety improvements.
- The service displayed information on what patients should do in the event of a fire.
- The practice carried out fire drills every three months.

Lessons learned and improvements made

The service learned and made improvements when things went wrong.

- There was a policy for recording and acting on significant events and incidents. Staff understood their duty to raise concerns and report incidents and near misses. Staff told us there had been no significant events over the last 12 months. The provider was aware of and complied with the requirements of the Duty of Candour. The provider encouraged a culture of openness and honesty.
- There were systems for reviewing and investigating when things went wrong. The practice learned and shared lessons and acted to improve safety in the practice.
- The provider told us that if there were unexpected or unintended safety incidents, they would give people reasonable support, truthful information and a verbal and written apology.
- There was a system for receiving and acting on safety alerts. The GP received alerts directly by email and would act where necessary. Copies of alerts were kept and shared with staff through a message book. For example, we saw a record of an MHRA yellow fever Stamaril alert and a pregabalin and gabapentin alert from April 2019. There was evidence that the practice had conducted system searches to identify patients who may have been affected by an alert.

Good

Are services effective?

We rated effective as Good because:

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

- At our previous inspection we found some safety training had not been undertaken. At this inspection staff files we reviewed showed staff had completed safety training.

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.
- The practice had systems to keep the GP up to date with current evidence-based practice. We saw that the GP assessed needs and delivered care and treatment in line with current legislation, standards and guidance; we saw evidence of quality assurance activities in place to allow the practice to assure themselves that these standards were being consistently met.
- Patients' immediate and ongoing needs were fully assessed. This included their clinical needs and their mental and physical wellbeing.
- We looked at 6 patient records. Records were clearly recorded and included comprehensive detail of consultations, treatment and advice.
- There was some evidence that the provider followed up on referrals made to specialist services and secondary care providers. For example, the doctor told us they monitored discharge summaries and if they received a hospital letter they would undertake follow up consultations with patients discharged from hospital.
- We saw no evidence of discrimination when making care and treatment decisions.
- Staff assessed and managed patients' pain where appropriate.
- Staff advised patients what to do if their condition got worse and where to seek further help and support.

Monitoring care and treatment

The service was actively involved in quality improvement activity.

The service used information about care and treatment to make improvements. The patient record system could be used effectively to gather data for clinical audits. The provider had a programme of clinical audit. The patient record system could be used effectively to gather data for clinical audits. We saw evidence of the provider conducting two audits each year as part of their annual appraisal process.

- There was evidence of some measures to review the effectiveness of the service provided and improve patient safety. For example, the doctor carried out a mammography audit of female patients aged 50-70 years to check they were being screened for cancer of the breast. The audit covered patients who were listed as regular patients and who had been seen by the doctor in the past two years. There were 149 patients and the doctor reviewed their records to see if they had received mammography in the last two years. There were 43 patients with no evidence of having had mammography, either through the service of through the NHS or specialist. The doctor contacted these patients to make sure they have had mammography by other means and to advise patients in the cohort who have not had screening, to do so.
- The doctor had carried out an audit of the use of in-line quick Strep testing for throat infections which had reduced his prescribing of antibiotics without risk of complications from Strep throat.
- There was a system of follow up where actions had been implemented and improvements monitored. For example, the doctor reviewed male patients between the ages of 50 and 70 to see if they had all had their PSA measured (a blood test that measures the amount of prostate specific antigen (PSA) in a patient's blood) in the last year. The doctor found 28 out of 30 patients had PSA test in the past two years. The doctor wanted to improve when important screening is performed and brought in annual test screens of patients which will be used as a baseline for future audits.
- Patient records were stored in lockable storage cabinets in a secure room.

Effective staffing

Staff had the skills, knowledge and experience to carry out their roles.

Good

Are services effective?

- The doctor was supported by a team of three reception staff and one practice manager. Their role was non-clinical and consisted of reception duties, administration and book keeping.
- The provider had an induction programme for all newly appointed staff. All staff had received an appraisal or performance review in the last year. There was evidence of appraisals and continuing professional development for the GP.
- Relevant professionals (medical and nursing) were registered with the General Medical Council (GMC) and were up to date with revalidation
- The provider understood the learning needs of staff and provided protected time and training to meet them. At our last inspection, there were no records to demonstrate that staff had completed role appropriate training to cover the scope of their work. At this inspection we saw up to date records of skills, qualifications and training were maintained. Staff were encouraged and given opportunities to develop.
- At our previous inspection we found some safety training had not been undertaken. At this inspection staff files we reviewed showed staff had completed safety training.
- 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.

- The practice had effective arrangements in place to share information with patients' registered NHS GPs and patients received co-ordinated and person-centred care. This included when they moved between services, when they were referred, or after they were discharged from hospital.
- Before providing treatment, doctors at the service ensured they had adequate knowledge of the patient's health, any relevant test results and their medicines history. We saw examples of patients being signposted to more suitable sources of treatment where this information was not available to ensure safe care and treatment.
- 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.
- 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.
- Risk factors were identified, highlighted to patients and where appropriate highlighted to their normal care provider for additional support. Staff encouraged and supported patients to be involved in monitoring and managing their health. The GP gave lifestyle advice during consultations.
- The practice supported initiatives to improve people's health, for example, cervical screening, stopping smoking and tackling obesity.
- Staff discussed changes to care or treatment with patients and their carers as necessary.
- 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

Good

Are services effective?

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. The doctor understood the requirements of legislation and guidance when considering consent and decision making. The practice policy required patients to sign consent forms and the signed forms were scanned into patient notes.
- At our last inspection, there were no formal arrangements for verifying a patient's identity. At this inspection we saw personal details were taken at registration and name and date of birth verbal checks were carried out by the receptionist when patients attended for appointments, and formal identification was checked.
- The service treated adults and children and all patients under the age of 16 were chaperoned by a parent or guardian. At our last inspection, formal checks of adults accompanying child patients were not carried out. At this inspection staff told us they verified the identity of adults accompanying child patients. There was evidence that the service checked that the responsible adult attending had authority to consent to treatment.

Good

Are services caring?

We rated caring as Good because:

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

Kindness, respect and compassion

Staff treated patients with kindness, respect and compassion.

- 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.
- We observed the consultation room was clean and private.
- Reception staff knew that if patients wanted to discuss sensitive issues or appeared distressed they could offer them a private room to discuss their needs.
- All the 15 patient Care Quality Commission comment cards we received were wholly positive about the service experienced. Patients described the GP as caring, attentive and efficient.

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 did not have a website which provided patients with information about the range of treatments available including costs. However, this information was displayed on notices in the reception area.
- At our previous inspection there was no interpreting and translation service made available for patients who did not have English as a first language. At this inspection we found interpretation services were available for patients who did not have English as a first language. We saw notices in the reception areas informing patients this service was available.
- There were no communication aids available, such as a hearing loop. We saw a sign language service poster in the reception area.
- Patients told us through comment cards, that they felt listened to and supported by staff and had sufficient time during consultations to make an informed decision about the choice of treatment available to them.
- For patients with learning disabilities or complex social needs, family, carers or social workers were appropriately involved. The service had a register of three patients with a learning disability.
- The practice supported recently bereaved patients. Staff told us that if families had experienced bereavement, they followed the practice's policy to support bereaved patients and their families.

Privacy and Dignity

The service respected patients' privacy and dignity.

- Staff recognised the importance of people's dignity and respect. The service had a privacy policy.
- Staff knew that if patients wanted to discuss sensitive issues or appeared distressed they could offer them a private room to discuss their needs.
- We observed the clinical room to be clean and private. Conversations being held in the consultation room could not be heard by those outside.
- The administrative staff desk and computers were not separated from the waiting area. We asked the receptionists how they manage patients' privacy. Staff told us they would avoid mentioning patients' names aloud over the phone and could speak to patients or make calls in private in the office at the rear of the premises.
- The reception computer screens were not visible to patients and staff did not leave personal information where other patients might see it.
- The practice complied with the Data Protection Act 1998. There was a record of confidentiality training for staff. Staff files we checked showed there was a confidentiality agreement for individuals carrying out administrative duties.

Good

Are services responsive to people's needs?

We rated responsive as Good because:

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, it allowed patients to contact the doctor directly by email. The service operated a call out service 24 hours a day, every day.
- Patients requesting an urgent appointment were seen the same day.
- The service had good facilities and was well equipped to treat patients and meet their needs. However, the service was located at street level and was accessed from some steps. Due to this and the internal size and layout, the premises were not suitable for patients with mobility difficulties and wheelchair users. Patients were informed the premises was not accessible if they used a wheelchair or mobility aid. The service directed patients to a local surgery which had disabled access.
- There was information in the reception area which included service charges and how to provide feedback.

Timely access to the service

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

- Patients had timely access to initial assessment, test results, diagnosis and treatment.
- Waiting times, delays and cancellations were minimal and managed appropriately.
- The service was open between 8.30pm – 1pm and between 4pm – 5.30pm Monday to Friday. Opening hours were displayed in the premises. Patients were advised to contact NHS emergency services for urgent medical needs.
- The service offered out of hours care on Monday – Thursday evenings. On Fridays and at weekends patients could contact the on-call locum doctors. The service operated a call out service 24 hours a day, every day.
- Patients with the most urgent needs had their care and treatment prioritised.
- Patients reported that the appointment system was flexible, the doctor was always available and they could contact the doctor for advice out of hours.
- Referrals and transfers to other services were undertaken in a timely way.

Listening and learning from concerns and complaints

The service took complaints and concerns seriously and responded to them appropriately to improve the quality of care.

- Information about how to make a complaint or raise concerns was available. Staff treated patients who made complaints compassionately.
- The complaint policy and procedures were in line with recognised guidance. The service had a system in place to manage complaints, although we were told no complaints had been made in the last 12 months.
- The service informed patients of any further action that may be available to them should they not be satisfied with the response to their complaint.
- The service had complaint policy and procedures in place. The service learned lessons from individual concerns and complaints. It acted as a result to improve the quality of care.

Requires improvement

Are services well-led?

We rated well-led as Requires improvement because:

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

- At our last inspection, we found there was insufficient leadership focus on adequate systems of governance and management of risks. At this inspection, we found it had improved slightly. 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.
- At this inspection we found the concerns raised at the previous inspection had been addressed, but some safety aspects of the service were not clearly known or prioritised to ensure high quality care was delivered.

Leadership capacity and capability

The leader had the clinical capacity and skills to deliver high-quality, sustainable care, however this could be managed more effectively to ensure high quality care was delivered.

- The doctor was the sole provider and owner of the service. They 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.
- Staff told us leaders were visible and approachable.

Vision and strategy

The service had a vision and credible strategy to deliver high quality care and promote 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. There was a comprehensive disaster handling and business continuity plan.
- There was a mission statement and statement of purpose visible in the patient waiting area.
- Staff were aware of and understood the vision, values and strategy and their role in achieving them.
- The service planned its services to meet the needs of service users. The provider aimed to continue providing an on-going high-quality service.

Culture

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

- 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.
- Openness, honesty and transparency were demonstrated when responding to incidents and complaints. The provider was aware of and had systems to ensure compliance with the requirements of the duty of candour.
- Staff told us they could raise concerns and were encouraged to do so. They had confidence that these would be addressed.
- There were processes for providing staff with the development they need. This included appraisal and development conversations. All staff had received an appraisal or performance review in the last year. There was a structure of inductions for staff.
- There was a commitment to the safety and well-being of all staff.
- The service demonstrated commitment to equality and diversity and had an equality and diversity policy. Staff had received equality and diversity training.
- There were positive relationships between staff and teams.

Governance arrangements

The provider had started to implement systems of accountability to support good governance and management however these were not yet fully embedded. At our previous inspection we found 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.

- At our previous inspection in May 2018, 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 were no clear

arrangements or lines of accountability for carrying out safety risk assessments for the premises and equipment. At this inspection we found some improvement however not all systems to manage safety were established. For example, although we found evidence of assessment of the risk of infection and assessments of legionella risk, there had been no infection control audit undertaken. At this inspection we found medical equipment had been calibrated to ensure it was safe to use.

- The provider told us that the practice manager nominated to have day to day responsibility for managing safety had left the service at the end of 2018. The provider had appointed a new practice manager in January 2019 who had responsibility for managing the safety of the premises and equipment at the service.
- The practice had arrangements to ensure the smooth running of the service. These included systems for providing care and treatment for patients in the doctor's absence.
- There was some evidence of minutes from monthly team meetings where all staff were involved in discussions; there was evidence that leaders discussed governance and addressed service issues.
- Staff were clear on their roles and accountabilities.
- The provider had a number of policies and procedures which followed guidance from the Independent Doctor's Federation (IDF). We found that some policies were not always reflective of day to day activities, for example, infection control.

Managing risks, issues and performance

At our previous inspection, we found there were processes in place for managing risks, issues and performance, although some areas were identified for improvement. At this inspection the service had taken some action to identify, monitor and address health and safety risks and risks related to the premises. However, the service had not always carried out comprehensive procedural audits and regular safety checks.

- At our last inspection in May 2018, there was no clear programme of role appropriate training for non-clinical staff. Systems for monitoring training were in place but some staff at the service had not undertaken training in the Mental Capacity Act (MCA), infection control, chaperoning, information governance and fire safety. At this inspection we found the programme of staff training had been formalised. The provider had completed training in information governance, GDPR, infection control and fire safety.
- There was no documented system for recording and monitoring checks of emergency medicines. We spoke to staff about this. We found checks of emergency medicines were done but had not been recorded.
- There were some systems for learning and improvement when things had gone wrong. Although there was a policy for reporting incidents and significant events, it was not clear whether the provider had a defined awareness of all types of incidents that could be classed as reportable. The provider gave us examples of significant events but they had not recorded them. The provider had a system in place to manage complaints, although there was no record that any complaints had been made.
- At our previous inspection, we found systems for monitoring training were in place but some staff had not completed all role appropriate training required to carry out their duties. At this inspection staff files we reviewed showed staff had completed essential safety training including infection control, fire safety, basic life support, confidentiality and information governance training
- The service had a business continuity plan in the event of an emergency affecting the running of the clinic. The provider had plans in place and had trained staff for major incidents.
- The service had processes to manage current and future performance. Performance of clinical staff could be demonstrated through audit of their consultations, prescribing and referral decisions. Leaders had oversight of safety alerts, incidents, and complaints.
- Clinical audit had a positive impact on quality of care and outcomes for patients. There was clear evidence of action to change services to improve quality.

Appropriate and accurate information

The service acted on appropriate and accurate information.

- The service used information from their computer system to monitor the quality of care provided. At our previous inspection there was limited evidence that quality and sustainability were discussed and acted on.

Requires improvement

Are services well-led?

At this inspection we found this had improved slightly. We saw quality and sustainability were discussed in weekly team meetings where all staff had sufficient access to information.

- There was some evidence that performance information was combined with the views of patients. Information gathered on the quality of the service was limited to feedback from patients. The provider had sent out a patient feedback questionnaire as part of their professional appraisal. Twenty-four patients responded to the request for feedback. The provider told us they had reflected on the feedback from patients. The service did not have a process of review to assess what changes have been made following patient feedback and patient survey results.
- The provider had systems in place which ensured patients' medical records remained confidential and secured at all times. Paper records were stored on open shelves in a locked room. We spoke to the provider about how they are managing the risk of fire. The provider told us they are updating their patient record systems to become a paperless organisation and already scan paper records. The service is piloting new software to facilitate the change from paper-based to electronic health records.
- Patient names and other identity information were handled by staff members who had signed confidentiality agreements in place.
- The service submitted information or notifications to external organisations as required.
- 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

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

- The service encouraged and heard views and concerns from the public, patients, staff and external partners and acted on them to shape services and culture.
- Staff could describe to us the systems in place to give feedback. We saw evidence of feedback opportunities for staff and how the findings were fed back to staff. We also saw staff engagement in responding to these findings.
- The service was transparent, collaborative and open with stakeholders about performance.

Continuous improvement and innovation

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

- The practice was committed to providing a high level of service to its patients.
- The doctor had well-established systems for continued professional development.
- The provider started and continued to run peer group monthly meetings of private doctors in the area. The group comes together to share experiences and discuss new developments in the field of medicine.
- There were systems to support improvement and innovation work. For example, the provider arranged weekly video learning for the whole team and encouraged staff to choose training that they felt would improve their skills and the quality of the service.

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 the service provider was not meeting. The provider must send CQC a report that says what action it is going to take to meet these requirements.

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.** **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:** • Safety audits; there were no clear governance arrangements for the undertaking of infection control checks of the premises and checking and monitoring the stock of emergency medicines. • There was no system for monitoring the controlled drug prescription pad. • There was no system of recording of significant events; the provider gave us examples of significant events but they had not recorded them. • There was no sufficient system to record how the provider verified the identity of adults accompanying child patients. • There was no formal policy in place to support decision making associated with patients consenting or declining consent for information to be shared with their GP. **This was in breach of regulation 17(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.**