Low Barn

Inspection report

Sheepway
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Bristol
BS20 7TF
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www.bristolmenopause.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	Good
Are services safe?	Good
Are services effective?	Good
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 Good overall with the well-led domain rated as requires improvement. This is the first inspection since the service registered with the Care Quality Commission (CQC).

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 Low Barn as part of our planned inspection programme.

Bristol Menopause Clinic was set up by the registered provider – Hazel Haydon – who is a registered nurse and a British Menopause Society Registered Menopause Specialist and trainer. We will refer to this person as the registered manager throughout the report. (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). The registered manager also holds the role of nominated individual.

The service is registered with CQC to provide the following regulated activities: diagnostics and screening, family planning and treatment of disease, disorder or injury.

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 provided. There are some exemptions from regulation by CQC which relate to particular types of regulated activities and services, and these are set out in Schedule 1 and Schedule 2 of the Health and Social Care Act 2008 (regulated Activities) Regulations 2014. Low Barn (Bristol Menopause Clinic) provides support and lifestyle advice to women regarding menopause which is not within the CQC scope of registration. Therefore, we did not inspect or report on these services. For example, guidance on the positive effects of diet, exercise and lifestyle on the peri-menopause and menopause and health promotion topics such as smoking, alcohol and sleep.

Our key findings were:

- The provider had good systems to safeguard adults and children, manage safety alerts and learn from any significant events. However, staff had not been trained to the level recommended within national guidance. The provider made arrangements, on the day of the inspection, for additional training to be undertaken.
- The premises were visually clean, hygienic and tidy. However, there were no infection control audits available on the day of inspection. This was rectified by the provider and submitted to us following the inspection.
- The provider had implemented safe systems to prescribe medicines for patients.
- Patients received effective care and treatment which met their needs. The provider followed national best practice guidelines and ensured care and treatment was based on up-to-date evidence. However, the provider had not formally reviewed or audited the care and treatment provided which could drive improvement.

Overall summary

- The provider had the skills, knowledge and experience to carry out their role. They were a registered nurse and had undertaken specialist training in women's health. Staff working within the service were supported to access specialist training.
- The provider involved and treated people with compassion, kindness, dignity and respect.
- The facilities were appropriate for the services delivered.
- There were no consistent clear and effective processes for managing risks, issues and performance. However, the provider had taken immediate action following the inspection to rectify this.
- Patient feedback was encouraged and reviewed on receipt. However, the feedback had not been formally audited to identify themes and trends.

We saw the following outstanding practice:

- The provider carried out outreach work to communicate and inform women in the workplace and within minority groups about the perimenopause and menopause.

The area where the provider **must** make improvements as they are in breach of regulation is:

- Establish and formalise effective systems and processes to ensure good governance in accordance with the fundamental standards of care. The provider had not carried out appropriate environmental risk assessments, which took into account the profile of people using the service and those who may be accompanying them.

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

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

- Provide appropriate information so that patients are knowledgeable about how to make a complaint.
- Review the training programme regularly to ensure it remains in line with national guidance.

Dr Sean O'Kelly BSc MB ChB MSc DCH FRCA

Chief Inspector of Hospitals and Interim Chief Inspector of Primary Medical Services

Our inspection team

Our inspection team was led by a CQC lead inspector supported by a second CQC inspector and had access to advice from a specialist advisor.

Background to Low Barn

Low Barn is a Menopause and Well Woman Clinic provided by Bristol Menopause Limited and is located at the following address:

Sheepway

Portbury

Bristol

BS20 TTF

We visited the service at Low Barn during this inspection to review records and documentation, speak with staff and inspect the premises.

The service registered with CQC in 2022 to provide the following regulated activities: diagnostics and screening, family planning and treatment of disease, disorder or injury.

Services are provided to people over the age of 18 and include consultations about and treatment for the menopause, contraception advice and treatment and well woman checks. A phlebotomy (taking blood) service is also provided.

The service employs four nurse practitioners, two of whom are British Menopause Society Accredited Specialists and all are non-medical prescribers. Nonmedical prescribing is the term used to describe any prescribing completed by a healthcare professional other than a doctor or dentist. Administrative support is provided by a receptionist and practice manager.

Further information regarding the service can be found through the website www.bristolmenopause.com

The service provides appointments between the hours of 08:30 and 18:00 on Mondays to Fridays. Out of hours appointments can be arranged when necessary.

The service is provided for women over the age of 18 who mainly self-refer to the clinic. Referrals can be made by the patients GP.

How we inspected this service

Before our inspection we reviewed information we held about the clinic. We also requested and reviewed information from the provider before the inspection and information available on the providers' website. The provider sent information following the inspection which showed additional systems, processes and policies had been implemented.

We carried out a site visit to the clinic, reviewed records and interviewed the provider.

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 identified a concern which related to formal systems and processes to demonstrate the safety of the service. The provider took action immediately, and information was submitted to us following the inspection, which showed these areas had been addressed and rectified. The likelihood of this happening again in the future was low and therefore our concerns for patients using the service, in terms of the quality and safety of clinical care were minor. (See full details of the actions we asked the provider to take in the areas to be improved in the requirement notice at the end of this report).

Safety systems and processes

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

- The provider conducted safety risk assessments. Clinical risk assessments were completed and included in patient records with appropriate referrals if risks had been identified. 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. Staff received safety information from the service as part of their induction and refresher training. The service had systems to safeguard children and vulnerable adults from abuse.
- 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.
- We saw records which showed how the service kept patients safe. For example, a patient was referred to their GP practice with information relating to potential safeguarding concerns. The service liaised with the practice to safeguard the patient.
- 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 in accordance with the providers recruitment policy. (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).
- The provider accepted a recent (within the last year) DBS check which had been carried out by a previous employer as part of the recruitment process. The provider planned to renew all staff DBS checks every three years to ensure there have been no newly identified issues since employment.
- Not all staff had 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 national intercollegiate guidance on safeguarding required all nurses to be trained to safeguarding level 3 by August 2021. Staff had completed level 2 safeguarding adults and children training within the last year. We discussed the intercollegiate guidance with the provider and arrangements were made for staff to complete level 3 safeguarding training immediately.
- There was a system to manage infection prevention and control (IPC) and the building appeared to be visually clean and tidy. Cleaning staff were employed to clean the building each week. They followed a cleaning schedule, and we noted that a deep clean had taken place on 13 April 2023. Clinicians cleaned their consulting rooms each day. The consulting rooms had access to handwashing facilities, hand gel and clinical waste was disposed of in a foot operated pedal bin. Sharps bins were signed and dated when opened and again when closed. We saw one sharps bin that had not been signed on opening and this was rectified at the time of the inspection.
- Chemicals and substances hazardous to health (COSHH) which were used for cleaning were identified in the building and were not all stored securely. For example, toilets which were accessible to patients contained cleaning products and a pesticide. This would be harmful if ingested by patients. The provider took action on the day of the inspection to ensure chemicals were secured.

Good

Are services safe?

- The registered manager acted as the IPC lead. There had not been an IPC audit completed to identify any risks from infection to patients or staff. We were told a hand hygiene audit had been completed but this had not been recorded. Following the inspection, the provider had implemented and recorded a weekly infection control check of the premises. This covered the environment, clinical waste, hand hygiene facilities and the cleanliness of the kitchen area. The check list was signed and dated.
- The IPC policy and procedure had been updated following the inspection and included information on the IPC checks and audits which were planned to take place each month.
- There were no Legionella checks carried out. (*Legionella* bacteria can cause a serious type of lung infection called Legionnaires' disease). While the premises did not have water storage facilities there were areas where water may have be stored in unused taps and pipes. This could pose a risk of infection from the legionella bacterium. Following the inspection, the provider had implemented a twice weekly procedure whereby all taps were to be run to flush through any standing water. A checklist recorded who had carried out the checks in each room.
- The provider ensured that facilities and equipment were safe, and that equipment was maintained according to manufacturers' instructions. There were systems for safely managing healthcare waste. There was a system for the storage and collection of clinical waste. We were told clinical waste was minimal due to the services provided and would be stored in a clinical waste bin inside the premises. An arrangement had been made for clinical waste collection with a local company who attended when requested. The registered manager planned to source a lockable storage bin to remain outside of the building.
- The provider had not carried out appropriate environmental risk assessments, which took into account the profile of people using the service and those who may be accompanying them. For example, there were stairs to access the reception area from the front entrance. The provider had made arrangements for patients with mobility difficulties to access through another entrance and be seen in a ground floor consulting room. This had not been recorded in a formalised risk assessment. However, following the inspection the provider had completed an environmental risk assessment of the premises which identified hazards, the action taken to mitigate the risk and any further action required. The risk assessment had timescales for completion and identified who was responsible for each action. An action plan had been developed following the risk assessment to mitigate against identified risks. For example, increasing the frequency of the collections of clinical waste and new flooring throughout the reception and hallways to provide an anti-slip surface.
- There had not been a fire risk assessment completed at the service and the fire extinguisher checks had expired in September 2022. This was addressed by the provider on the day of the inspection and a visit arranged for an external company to attend and carry out the checks. The provider completed a fire risk assessment of the premises following the inspection which was shared with the CQC. At the time of the inspection, staff had not had full fire training, for example a fire drill and there was no fire warden on the premises. Following the inspection, the provider submitted evidence which demonstrated a fire drill for all staff had been carried out. Two members of staff had been identified for the role of fire wardens.
- Electric portable appliance testing had not been carried out. During the inspection, the registered manager booked an external company to attend the following week to complete this.

Risks to patients

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

- There were arrangements for planning and monitoring the number and mix of staff needed. The service had developed to meet demand and additional staff had been recruited to support this.
- There was an effective induction system for staff tailored to their role. Newly employed staff were provided with induction training which took place over 3 months. All new staff worked as an addition to the existing staff team for 6 weeks and were provided with an additional 6 week supervised training before working alone. The service did not use temporary or agency staff.

Good

Are services safe?

- 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. Staff completed basic life support training and check lists provided an easy reference in clinical rooms regarding life support.
- There were suitable medicines and equipment to deal with medical emergencies linked to the service provided. For example, an electrocardiogram (ECG) machine and a pulse oximeter which were stored appropriately. There was no clear process for checking these regularly to ensure they were safe to use and available.A defibrillator was located in the local vicinity, but staff were not clear exactly where. This meant that should this be required there would potentially be a delay. The service had an accessible first aid kit, but no staff were first aid trained. Emergency medicines were available which were pertinent to the service delivered and staff were competent in their use.
- When there were changes to services or staff the service assessed and monitored the impact on safety.
- There were appropriate indemnity arrangements in place.

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. A full assessment was carried out of each patient's physical and mental health at the first appointment and available for staff to access and update at later appointments.
- The service used an electronic records system, which was password protected, to record and store patient records. Paper records were scanned and uploaded to the system. The service ensured paper records were shredded at the end of each day to protect personal and confidential information.
- The service had systems for sharing information with staff and other agencies to enable them to deliver safe care and treatment.
- The service had a 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 had reliable systems for appropriate and safe handling of medicines.

- The systems and arrangements for managing medicines. There were limited medicines stored and administered from the service. During inspection we saw medicines were not securely stored at all times. This was immediately rectified by the provider. Emergency equipment at the service included an electrocardiogram machine (An ECG is a simple test that can be used to check the heart's rhythm and electrical activity), first aid kit and a face mask for resuscitation. The service provided prescriptions electronically and therefore ensured security by password protection.
- The service does not prescribe Schedule 2 and 3 controlled drugs (medicines that have the highest level of control due to their risk of misuse and dependence). Neither did they prescribe schedule 4 or 5 controlled drugs.
- The clinical staff were all non-medical prescribers and prescribed medicines to patients and gave advice on medicines in line with legal requirements and current national guidance. Non-medical prescribing is prescribing completed by a suitably qualified healthcare professional, other than a doctor or a dentist. Staff had access to prescribing updates online and training had been attended online to ensure staff were up to date with all current best practice guidelines.
- Processes were in place for checking medicines and staff kept accurate records of medicines. Patient clinical records evidenced when medicines had been prescribed and to which pharmacy the prescription had been sent electronically. Medicines were prescribed in line with national guidance.

Good

Are services safe?

- The registered manager carried out checks of the prescribing of medicines. We were told this took place weekly but there were no written records to support the outcome of the checks / audit process. This meant learning may not have been identified and addressed. One nurse prescriber we spoke with had recognised auditing their own prescribing would be effective and had discussed this at a team meeting. The self-audit process had yet to start.
- There were effective protocols for verifying the identity of patients.
- The practice did not provide Bioidentical Hormone Replacement Therapy which is an unlicenced medicine. However, information was provided regarding this treatment on the service website, but it was not clear that treatment was not prescribed. The provider told us the website was being reviewed with a plan for development and agreed to review this information.

Track record on safety and incidents

The service had a good safety recording system.

- The provider was aware of potential to the service and patients but there were no documented risk assessments in relation to safety issues at the time of the inspection. However, the provider took immediate action following the inspection to rectify this.
- The service had informally monitored and reviewed activity. This meant there was limited activity to help understand risks and did not have a clear, accurate and current picture that led to safety improvements. However, the provider had formalised the process following the inspection.
- Staff held keys to the building and at times when opening or closing the building they worked alone. Staff we spoke with were not aware of a lone working policy and procedure to provide guidance on their safety when in the building on their own. However, to mitigate the risk there were always two staff in the building when patients arrived for their appointments and the door remained locked if a member of staff was alone in the building. A lone working policy and procedure was developed and implemented following the inspection.

Lessons learned and improvements made.

The service learned and made improvements when things went wrong.

- There was a system for recording and acting on significant events. Staff told us there had not been any reported significant events since the registration of the service. Staff understood their duty to raise concerns and report incidents and near misses. Leaders and managers supported them when they did so. The registered manager and practice manager had responsibility for recording, investigating and sharing learning for safety incidents, concerns and near misses.
- There were adequate systems for reviewing and investigating when things went wrong which meant the service could share learning to improve safety at the service if necessary.
- The provider was aware of and complied with the requirements of the Duty of Candour. The provider encouraged a culture of openness and honesty. The service had systems in place for knowing about notifiable safety incidents.
- The service acted on and learned from external safety events as well as patient and medicine safety alerts. The service had an effective mechanism in place to disseminate alerts to all members of the team including sessional and agency staff. The alerts were received through an external organisation to ensure staff were up to date with national guidelines and safety alerts.

Good

Are services effective?

We rated effective as Good because:

The provider demonstrated effective care and treatment was provided which was evidence based and followed national best practice guidance and standards. **Staff had the skills, knowledge and experience to carry out their roles and coordinated patient care and information sharing.**

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)

- The provider assessed needs and delivered care in line with relevant and current evidence-based guidance and standards. For example, the National Institute for Health and Care Excellence (NICE) best practice guidelines and The British Menopause Society.
- Patients' immediate and ongoing needs were fully assessed. Where appropriate this included their clinical needs and their mental and physical wellbeing.
- Clinicians had enough information to make or confirm a diagnosis.
- We saw no evidence of discrimination when making care and treatment decisions.
- Arrangements were in place to deal with repeat patients.
- Staff assessed and managed patients' pain where appropriate.

Monitoring care and treatment

The service was actively involved in quality improvement activity, but this was not always recorded.

- The service used information about care and treatment to make improvements. The service made improvements through the use of informal monitoring. This was used to identify the need for changes and we saw when those changes had been implemented. There was clear evidence of action to resolve concerns and improve quality. For example, a clinical records review audit led to a change in the sending of letters to the patients GPs. Administration staff now prepare and send the letters to relieve the clinical staff time. This has meant letters go out in a timelier way.
- All staff were non-medical prescribers. The registered manager carried out a number of checks of the prescribing by staff each week. The outcomes had not been formally recorded as an audit and therefore we were unable to see evidence of any issues identified and improvements made. However, the provider informed us they had not identified any issues.
- Nursing staff who were trained, carried out the fitting of contraceptive coils and cervical screening. Information was gathered regarding the number of contraceptive coils fitted and submitted to the Faculty of Reproductive and Sexual Health (FRSH).

Effective staffing

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

- All staff were required to complete mandatory training, which had been determined by the registered manager and was specific to their role. We saw that staff were up to date with their training.
- Staff had access to additional role specific training. For example, one registered nurse had been supported to become a British Menopause Society Specialist, with another part way through this training. Clinical staff had accessed the British Menopause Society annual conference as a learning opportunity and to keep their accreditation up to date.

Good

Are services effective?

- The provider had an induction programme for all newly appointed staff, with records maintained to show the content of the induction.
- The nursing staff were registered with the Nursing and Midwifery Council and were up to date with revalidation. The provider-maintained records of renewal dates which enabled a checking system to ensure nursing staff kept up to date with their registration and revalidation. The service reimbursed staff for their registration fees. Revalidation is the process that all nurses and midwives in the UK and nursing associates in England need to follow to maintain their registration with the NMC and promotes good practice.
- The provider understood the learning needs of staff and provided protected time and training to meet them. Staff training was reviewed during each appraisal. Staff were able to identify training courses relevant to their role and were supported in achieving such training. Up to date electronic records of skills, qualifications and training were maintained. Staff were encouraged and given opportunities to develop.
- All clinical staff had access to clinical supervision and were provided with time, within their working hours, to complete this.

Coordinating patient care and information sharing

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

- Patients received coordinated and person-centred care. Staff referred to, and communicated effectively with, other services when appropriate. For example, the patients GP and private health care services. Administration staff supported the clinicians in sending a letter containing relevant information to the appropriate external health provider. The letter followed a set template with administration staff obtaining the information from the patient record which the clinician had written. The referral letter was agreed by the referring clinician prior to it being sent to safeguard against any errors in the information.
- Before providing treatment, the staff carried out a comprehensive medical history to ensure they had adequate knowledge of the patient's health, any relevant test results and their medicines history. We were provided with examples of when patients had been signposted to more suitable sources of treatment where this information was not available to ensure safe care and treatment. 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 patient assessment records clearly evidenced the patient consent to share information with other clinicians. For example, their own GP. If the patient declined to consent to the sharing of information this was recorded in their records.
- The provider had risk assessed the treatments they offered. They had identified medicines that would not be prescribed, such as those which were unregulated.
- We saw that local GP practices and hospitals had referred patients to the service for support.
- Care and treatment for patients in vulnerable circumstances was coordinated with other services. For example, the staff had identified safeguarding concerns which potentially left a patient in a vulnerable situation. The provider had shared the concerns with the patients' GP.
- 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. The provider provided evidence of how patients were referred to other clinicians and services when necessary. For example, to a private gynaecologist and for ultrasound. The referral was made by letter or electronically. A follow up email or telephone call was made 4 weeks later to ensure the referral had been received and actioned.

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.

Good

Are services effective?

- 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. For example, within the post consultation letter to their GP.
- Where patients need could not be met by the service, staff redirected them to the appropriate service for their needs.
- The service monitored the process for seeking consent appropriately.
- The provider provided talks and information to hard to reach and minority groups who would otherwise encounter difficulties in accessing information relating to the menopause. The service had developed a menopause café for a local university and provided talks to external organisations and businesses. The provider had also contributed to radio shows to share information with listeners regarding the menopause.

Consent to care and treatment

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

- Staff understood the requirements of legislation and guidance when considering consent and decision making.
- Staff supported patients to make decisions. Where appropriate, they assessed and recorded a patient's mental capacity to make a decision. If there were concerns about the patient's mental capacity the service liaised with the patients GP.
- We saw records which demonstrated the patient's consent was sought to ensure the decisions made were their own and not the wish of a family member.

Good

Are services caring?

We rated caring as Good because:

The provider delivered a caring service in which patients were involved in decisions about their care and treatment.

Kindness, respect and compassion

Staff treated patients with kindness, respect and compassion.

- The service sought feedback on the quality of clinical care patients received. Following the initial appointment at the service, patients were telephoned to follow up on the treatment prescribed and check if they had any concerns or queries.
- Feedback from patients was positive about the way staff treat people. We reviewed feedback provided to the service and found patients felt supported, listened to and treated kindly and with empathy.
- 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. Patient feedback included comments that staff gave them information to inform decisions about their care and treatment, staff were knowledgeable and professional in their approach.

Involvement in decisions about care and treatment

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

- Interpretation services were available for patients who did not have English as a first language although the staff said they had never been required to use these services. Staff were able to access information leaflets in languages other than English and in easy read formats, to help patients be involved in decisions about their care.
- Feedback provided to the service by email demonstrated that patients had 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. Each patient was provided with a Bristol Menopause Clinic information booklet which provided information and resources about the menopause.
- For patients with learning disabilities or complex social needs family, carers or social workers were appropriately involved.
- Staff communicated with people in a way that they could understand, for example, communication aids and easy read materials were available. Health promotion leaflets were available in the reception area some of which were in large print.

Privacy and Dignity

The service respected patients' privacy and dignity.

- Staff recognised the importance of people's dignity and respect. The consulting room doors all had locks fitted to them to ensure privacy during appointments. There were no curtains fitted around the couches which would afford additional privacy for intimate procedures. However, the provider told us there was access to portable screens which could be used.
- Staff always saw patients in a private room which enabled sensitive issues to be discussed in private.

Good

Are services responsive to people's needs?

We rated responsive as Good because:

The provider responded to patients' requests for treatment and were clear regarding waiting times.

However, while the provider demonstrated they responded to complaints fully there was no clear and accessible information for patients on how to make a complaint should they need to do so.

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. The provider took note of feedback received online and provided explanations where necessary. For example, one person had commented the service was not as personal as it had been previously. The service had developed to meet demand and had employed additional staff including reception and clinicians. This meant the service was accessible to more patients.
- The facilities and premises were appropriate for the services delivered.
- Reasonable adjustments had been made so that people in vulnerable circumstances could access and use services on an equal basis to others. Patients were able to attend their appointment with family members, carers or support workers for additional support when required. Appointments were available at weekends or out of hours if required to meet the needs of the patients.
- The practice liaised with community groups to provide information and support to women who would otherwise not access menopause care. For example, working together with an external organisation who provided outreach support within minority groups.

Timely access to the service

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

- Patients had timely access to initial assessment, test results, diagnosis and treatment. There was a service line agreement with an external company for the collection of blood samples. A separate company carried out the testing of samples, in accordance with a service line agreement, with the results being sent to the provider and the patient's GP. The clinician who had carried out the testing checked the results on their return to the service and contacted the patient.
- Waiting times, delays and cancellations were minimal and managed appropriately. The waiting time for appointments was approximately two weeks.
- Patients with the most urgent needs had their care and treatment prioritised. Following the initial contact, if a patient required an urgent consultation, they would be prioritised for an earlier appointment.
- Patients reported that the appointment system was easy to use.
- Appointments at weekends and out of hours could be arranged if necessary but were not routinely available.
- Referrals and transfers to other services were undertaken in a timely way. Private referrals to secondary care and referrals to the patient's GP were made promptly and within timescales determined by the service. However, there had been no audit completed to ensure the timescales had been met.

Listening and learning from concerns and complaints

Good

Are services responsive to people's needs?

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

- The service had complaint policy and procedures in place which set out how the service would respond to complaints, included timescales and how complaints would be reviewed to ensure learning. The service learned lessons from individual concerns and complaints and acted to improve the quality of care. For example, changes were made, and additional administration support provided which meant letters to GP practices had been standardised and sent out within 10 days of the appointment. Following one complaint, the service was trialling sending less detail to the patient's GP. This was for a trial period and an audit was planned to take place at the end of April 2023 to assess any outcomes from this process.
- Information about how to make a complaint or raise concerns was not readily available. We discussed this with the registered manager who planned to include information on the service website. The registered manger had emailed a newsletter to all patients in December 2022 and asked for any feedback regarding the service they had received. There had previously been a complaint leaflets available in reception, but these were not evident on the day of inspection. Following the inspection the provider told us that each patient received an email the day after their appointment asking for feedback on how to improve the service. This included information on how to complain.
- Staff treated patients who made complaints with compassion. We saw evidence to support that the registered manager and practice manager had contacted a previous complainant to discuss their concerns and obtain full details prior to carrying out an investigation.
- 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.
- Information was shared with staff within organisational meetings regarding any complaints received and the associated investigation and outcome.

Requires Improvement

Are services well-led?

We rated well-led as Requires improvement because:

- There were no clear or evidenced systems of accountability to support good governance and management.
- The service had informal processes to manage current and future performance. For example, performance of clinical staff could not be demonstrated through audit of their consultations, prescribing and referral decisions.

However:

- The service had a clear vision and credible strategy to deliver high quality care and promote good outcomes for patients.
- The provider recognised the development and growth of the service and had employed additional staff to support the management of the service.
- The service had a good culture and leaders had the capacity and skills to deliver high-quality sustainable care.
- The service involved patients, the public, staff and external partners to support high-quality sustainable services.

Leadership capacity and capability;

Leaders had the capacity and skills to deliver high-quality, sustainable care.

- Leaders were knowledgeable about issues and priorities relating to the quality and future of services. They understood the challenges and were addressing them. For example, there were concerns regarding the limited space available to run additional clinics and accessibility for all patients. The provider was in the process of updating the service website to provide full and up to date information for patients.
- Management meetings took place each week where issues were identified and addressed.
- Leaders at all levels were visible and approachable. The management team comprised of the registered manager, practice manager and the clinical lead. There was management support in the clinic each day who worked closely with staff and others to make sure they prioritised compassionate and inclusive leadership. The finance director was readily available to staff either in the clinic or by telephone, email or text.
- The provider had effective processes to develop leadership capacity and skills, including planning for the future leadership of the service. The provider had recruited a practice manager who had previous administration and management experience. One of the clinicians had been promoted to clinical lead following discussions within annual appraisals.

Vision and strategy

The service had a clear 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.
- The service developed its vision, values and strategy jointly with staff. Staff had been included in a whole team development day to ensure all staff were aware of future plans developments.
- Staff were aware of and understood the vision, values and strategy and their role in achieving them.
- The service monitored progress against delivery of the strategy. Meetings attended by managers and staff had monitored the delivery of the planned strategy.
- The leadership team, consisting of the registered manager, practice manager, clinical lead and financial director met weekly to discuss any issues, strategy and development.

Culture

Requires Improvement

Are services well-led?

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. The service employed the support of an external business advisory service to assist with human resources systems and processes. We were provided with an example of staff performance management. The performance management had been recorded and minutes of meetings and a record of actions maintained.
- Openness, honesty and transparency were demonstrated when responding to incidents and complaints. The registered manager had reviewed the treatment of one patient to ensure there had been no indications for adverse effects prior to starting treatment. This was logged as a near miss but found the care and treatment had been delivered correctly. Feedback from this review was shared with all staff. The registered manager 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 all staff with the development they need. Each member of staff was provided with a role specific job description, clinical guide and expectations of their performance was detailed in their contract. All staff were required to complete mandatory training and additional role specific training was supported. All staff received regular annual appraisals in the last year. Annual appraisals and career development conversations were recorded. Staff were supported to meet the requirements of professional revalidation where necessary. Clinical staff, including nurses, were considered valued members of the team. They were given protected time for professional development and evaluation of their clinical work. The registered manager provided clinical supervision by directly working with and observing each member of staff for one week every three months. The outcomes of the clinical supervision fed into the appraisal process.
- There was a strong emphasis on the safety and well-being of all staff. Staff were supported to take a paid lunch every day, received a rewards package for working at the service and had access to a 24 hour wellbeing support line. An additional hour of administration time had been provided following a suggestion raised by a member of staff to ease pressure on clinical work.
- The service actively promoted equality and diversity. It identified and addressed the causes of any workforce inequality. Staff had received equality and diversity training.
- There were positive relationships between staff and teams.

Governance arrangements

There were no clear systems of accountability to support good governance and management.

- Structures, processes and systems to support good governance and management were not consistently or clearly set out, understood and effective. Auditing and monitoring of the service had not taken place formally in a routine documented way to assess and manage risk and drive improvement. For example, environmental risk assessments, infection prevention and control risk assessments and audits, fire risk assessments and feedback provided to the service from complaints and engagement. However, the provider took immediate action following the inspection to implement and record systems, processes and risk assessments.
- The governance and management of partnerships, joint working arrangements and shared services promoted co-ordinated person-centred care.
- Staff were clear on their roles and accountabilities. All staff had a job description which were updated when roles had developed and changed.
- Leaders had established proper policies to ensure safety and assured themselves that they were operating as intended. However, procedures and activities had not been formalised or recorded.

Requires Improvement

Are services well-led?

Managing risks, issues and performance

There were inconsistent processes for managing risks, issues and performance.

- The provider was aware of and understood current and future risks including risks to patient safety and the service. However, these were not documented, and action taken had not been recorded. Therefore, there was limited evidence to review the service and share learning with staff.
- The service had informal processes to manage current and future performance. Performance of clinical staff could not be demonstrated through audit of their consultations, prescribing and referral decisions. Leaders had oversight of safety alerts, incidents, and complaints.
- Clinical audit had not been completed and therefore could not demonstrate the quality of care and outcomes for patients. For example, medicines prescribing, and patients records were reviewed informally but not recorded as audited. Provider recognised the need to formally record clinical oversight and systems and processes were being developed following the inspection to address this.

Appropriate and accurate information

The service did not have appropriately documented and accurate information for all areas of the service.

- Informal operational information and knowledge was used to ensure and improve performance. Following the inspection systems and processes were being planned to address the recording of this information.
- Quality and sustainability were discussed in relevant meetings where all staff had sufficient access to information.
- The service used performance information, which was reported and monitored, and staff were held to account.
- The service submitted data or notifications to external organisations as required.
- There were robust arrangements in line with data security standards for the availability, integrity and confidentiality of patient identifiable data, records and data management systems. All staff were required to sign a confidentiality agreement.

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. Following each appointment, patients were encouraged to provide feedback to the service directly or through electronic feedback websites. We saw that the provider responded to feedback through these websites. For example, additional appointments had been provided out of hours to meet the needs of patients who could not attend in working hours.
- Patients were asked to contact the service four weeks after their initial appointment to provide an update on their care and treatment outcomes. The emails from patients were stored securely and reviewed by clinicians. There was no formal audit to demonstrate actions taken or where changes had been made. The provider told us clinicians responded to patients in response to this follow up contact when necessary.
- The service sent patients an electronic newsletter providing information about the service and the menopause. Within the newsletter patients had been requested to respond to a survey which included the question what could we do better? The surveys had not been audited but the provider told us patients had been satisfied with the service overall.

Requires Improvement

Are services well-led?

- 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. Staff meetings were held each month and were planned on different days, so all staff had an opportunity to attend some if not all of the meetings. Staff met over the lunchtime period each day for opportune discussions and information sharing.
- The service held regular staff meetings which were minuted to enable any staff who could not attend the meeting to keep up to date. The meetings followed a set agenda which included discussion and review of complaints, incidents, significant events and relevant learning.

Continuous improvement and innovation

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

- There was a focus on continuous learning and improvement.
- The service made use of internal and external reviews of incidents and complaints. Learning was shared and used to make improvements. Feedback from complaints or incidents was relayed to individual staff members. Learning for the wider staff team took place at team meetings where the agenda contained a section for discussion about these events.
- Leaders and managers encouraged staff to take time out to review individual and team objectives, processes and performance. Staff identified any training needs, objectives and performance prior to their appraisal. We saw that identified training needs had been met or planned from the records we reviewed.
- There were systems to support improvement and innovation work. The provider provided talks and information to hard to reach and minority groups who would otherwise encounter difficulties in accessing information relating to the menopause. The service had developed a menopause café for a local university and provided talks to external organisations and businesses. The provider had also contributed to radio shows to share information with listeners regarding the menopause.

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
Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance Regulation 17(1) (a)(b)(d)(2)(f)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 improve the quality and safety of the services being provided over time. There were no systems or processes that enabled the registered person to assess, monitor and mitigate the risks relating to the health, safety and welfare of service users and others who may be at risk The registered person had systems or processes in place that were operating ineffectively in that they failed to enable the registered person to seek and act on feedback from relevant persons and other persons on the services provided in the carrying on of the regulated activity, for the purposes of continually evaluating and improving such services. **In particular:** • Systems and processes to monitor the service provided were informal and were not documented. • For example, there were no formalised risk management systems or risk registers in place at the time of the inspection. • The provider did not have formal systems and processes that enabled them to identify and assess risks to the health, safety and/or welfare of people who use the service. There were limited risk assessments for lone working, infection prevention and control and environmental risks such as portable appliance testing. There had been limited fire precautions recorded and no fire drills undertaken.

This section is primarily information for the provider

Requirement notices

- There was a lack of formal risk assessments and clinical audits to assess, monitor and improve quality and safety of the service. For example: clinical and non-clinical audits of the service such as to provide oversight of medicines prescribing.

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