# Queens Clinic

## Inspection report

75 Wimpole Street
London
W1G 9RT
Tel: 07740944473

Date of inspection visit: 30 November 2021
Date of publication: 28/01/2022

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

## Ratings

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

# Overall summary

**This service is rated as Requires Improvement overall.** The service had previously been inspected on 13 February 2020, 9 February 2021 and 2 September 2021. Following the inspection on 9 February 2021 the service was rated as inadequate overall, and in the safe, effective and well led key questions. The responsive key question was rated as requires improvement, and caring was rated as good. The service was found to be in breach of regulations 12 and 17 of HSCA (RA) 2014 and urgent conditions were placed on the registration of the service. The specific issues found at the inspection were:

- Clinicians were not kept up to date with current evidence-based practice.
- Lack of understanding of the requirements of legislation and guidance when considering consent and decision making.
- They responded to all complaints, including informal ones in line with their complaints policy.
- Not all staff had the appropriate level of Disclosure and Barring Service check (DBS) check carried out.
- The staff that acted as chaperones had not received training for this role.
- The service did not have full infection control procedures in place.
- The care records were not clear as we found it was difficult to follow the reason for diagnosis or treatment rational.

We carried out an announced comprehensive inspection of Queens Clinic on 30 November 2021. At the time of the inspection the location was closed, but has subsequently re-opened. We are mindful of the impact of COVID-19 pandemic on our regulatory function. We will continue to discharge our regulatory enforcement functions required to keep people safe and to hold providers to account where it is necessary for us to do so. We found that some of the breaches of regulation from the previous inspection had been addressed, but others had not. Following this inspection, the key questions are rated as:

The key questions are rated as:

Are services safe? – Requires improvement

Are services effective? – Requires improvement

Are services caring? – Good

Are services responsive? – Good

Are services well-led? – Requires improvement

**Our key findings were:**

- The service had good systems to manage risk in most areas so that safety incidents were less likely to happen. When they did happen, the service learned from them and improved their processes. However, learning from incidents was not clearly demonstrated.
- At the time of the inspection, equipment required in an emergency was either not in place, or was not sufficiently accessible at the service.
- The service routinely reviewed the effectiveness and appropriateness of the care it provided. It ensured that care and treatment was delivered according to evidence- based guidelines.
- The organisation did not have sufficient procedures in place to ensure that effective staffing was being provided.
- Staff involved and treated people with compassion, kindness, dignity and respect.
- Patients were able to access care and treatment from the service. An adequate complaints system was in place, but the process for learning from complaints was not formalised.

# Overall summary

- The organisation had appropriate leadership functions in place. However, governance systems, particularly those whereby learning could be demonstrated, were unclear.
- Staff and former staff that we spoke to stated that the culture of the organisation was not supportive, and that they were not listened to. They reported that they were afraid to raise concerns.

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

- Ensure that care and treatment is provided in a safe way to patients. Systems or processes must be established and operated effectively to ensure compliance with the requirements of the fundamental standards as set out in the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.
- Ensure systems and processes are established and operated effectively to ensure compliance with the requirements of good governance. Systems or processes must be established and operated effectively to ensure compliance with the requirements of the fundamental standards as set out in the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.
- Ensure systems and processes are established and operated effectively to ensure compliance with the requirements of good staffing. Systems or processes must be established and operated effectively to ensure compliance with the requirements of the fundamental standards as set out in the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The service **should**:

- Undertake two-cycle audits to demonstrate quality improvement.

I am taking this service out of special measures. This recognises the improvements that have been made to the quality of care provided by this service.

**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 specialist adviser.

## Background to Queens Clinic

Queens Clinic is a private gynaecological service located on the second floor at 75-76 Wimpole Street, Marylebone, London, W1G 9RT. The building entrance lobby is accessed via steps from the pavement. Wheelchair access is via a ramp at the front of the building (patients are advised of this and a member of staff is available to assist patients). The service is easily accessible by public transport and is a short walk from Bond Street. There are two consultation rooms, one minor operations room, one reception room and a waiting area for patients

The opening hours are 9am to 9pm, Monday to Friday and between 9am to 6pm on Saturdays. Patients have access to the lead clinician by phone for out of hours emergencies.

The service provides private consultations to adults. A variety of services are offered including gynaecological diagnostic and minor surgery procedures.

**How we inspected this service**

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.

Requires Improvement

# Are services safe?

**We rated the service as requires improvement for providing safe services.**

We carried out this announced comprehensive inspection on 30 November 2021. We had previously carried out an announced comprehensive inspection on 9 February 2021, and a focussed inspection on 2 September 2021. Following these inspections the service was not providing safe services, and we found the following:

- Not all staff had the appropriate level of Disclosure and Barring Service check (DBS) check carried out.
- The staff that acted as chaperones had not received training for this role.
- The service did not have full infection control procedures in place.

At the time of the inspection visit on 30 November 2021, these issues had been addressed, but other breaches of CQC regulations were identified. Specifically:

- The oxygen bottle in place at the surgery was noted to be empty at the time of the inspection. Oxygen is required bearing in mind the procedures undertaken at the clinic. The service manager stated that the bottle had been recently filled but might be faulty, and contacted the supplier on the day of the inspection so that this was addressed.
- The service did not own its own defibrillator but shared one with another organisation in the building. Staff at the service were unaware of where this was located, and by the time it was found and staff returned to the clinic, five minutes had passed.
- Learning from incidents was not routinely shared within the team. We saw that the provider would take immediate action to improve services following incidents. However, there were instances (such as patient who passed out following a blood test) which should have been recorded as incidents but were not.

**Safety systems and processes**

**The service had 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. 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.
- 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.
- There was an effective system to manage infection prevention and control.
- 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.
- 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 were not systems to assess, monitor and manage risks to patient safety.**

Requires Improvement

# Are services safe?

- There were arrangements for planning and monitoring the number and mix of staff needed.
- There was an effective induction system for agency staff tailored to their role.
- 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 oxygen bottle in place at the surgery was noted to be empty at the time of the inspection. Oxygen is required bearing in mind the procedures undertaken at the clinic. The service manager stated that the bottle had been recently filled but might be faulty, and contacted the supplier on the day of the inspection so that this was addressed.
- The service did not own its own defibrillator but shared one with another organisation in the building. Staff at the service were unaware of where this was located, and by the time it was found and staff returned to the clinic, five minutes had passed.
- When there were changes to services or staff the service assessed and monitored the impact on safety.
- There were appropriate indemnity arrangements in place.
- There were suitable medicines to deal with medical emergencies which were stored appropriately and checked regularly.

**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.
- 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. The service kept prescription stationery securely and monitored its use.
- 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).
- 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. Where there was a different approach taken from national guidance there was a clear rationale for this that protected patient safety.

**Track record on safety and incidents**

**The service had a good safety record.**

- There were risk assessments in relation to safety issues.
- The service monitored and reviewed activity. This helped it to understand risks and gave a clear, accurate and current picture that led to safety improvements.

**Lessons learned and improvements made**

**The service did not learn and made improvements when things went wrong.**

Requires Improvement

# Are services safe?

- There was a system for recording and acting on significant events. Staff understood their duty to raise concerns and report incidents and near misses. Leaders and managers supported them when they did so.
- There were adequate systems for reviewing and investigating when things went wrong. However, learning from incidents was not routinely shared within the team. We saw that the provider would take immediate action to improve services following incidents, but there were instances (such as patient who passed out following a blood test) which should have been recorded as incidents but were not.

Requires Improvement

# Are services effective?

**We rated the service as requires improvement for providing effective services.**

We carried out this announced comprehensive inspection on 30 November 2021. We had previously carried out an announced comprehensive inspection on 9 February 2021, and a focussed inspection on 2 September 2021. Following these inspections the service was not providing effective services, and we found the following:

- The provider did not have systems to keep clinicians up to date with current evidence-based practice.
- Clinical records did not always record all the required details of consultations.
- The service was not actively involved in quality improvement activity. The provider could not demonstrate how they were monitoring care and treatment to patients. Although the provider had carried out one audit, they could not demonstrate how improvements were made to patients care and treatment using completed audits.
- Not all staff had the skills, knowledge and experience to carry out their roles. Some staff had not received specific training for their role.
- The provider had not risk assessed the treatments they offered. They had not identified medicines that were not suitable for prescribing if the patient did not give their consent to share information with their NHS GP.
- Staff did not understand the requirements of legislation and guidance when considering consent and decision making.

At the time of the inspection visit on 30 November 2021, these issues had been addressed, but other breaches of CQC regulations were identified. Specifically:

- Learning from audits was unclear. Audits of clinical records were routinely undertaken by the same clinician who had undertaken that consultation. Audits completed were not recorded in cycles, and as such it was not possible to determine whether or not performance had improved.
- The practitioner did not routinely send out letters to patients in a password protected format. We saw examples of where the practitioner had asked for consent to do this, but it was not routinely completed.
- On the day of the inspection, neither the lead clinician or service manager were able to show completed fire safety or information governance training, this was completed by the members of staff within 24 hours of the inspection.

**Effective needs assessment, care and treatment**

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

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

**Monitoring care and treatment**

**The service was actively involved in quality improvement activity**. **However, learning from quality improvement was unclear.**

- The service had provided audits as specified by CQC in urgent conditions following the last inspection. The majority of audits were of clinical notes, which were completed by the same clinician who undertook the consultation. On this basis the audits did not provide a full and independent view of the service that this clinician was providing.

Requires Improvement

# Are services effective?

- Audits completed were not recorded in cycles, and as such it was not possible to determine whether or not performance had improved.

**Effective staffing**

**Staff did not have the skills, knowledge and experience to carry out their roles.**

- On the day of the inspection, neither the lead clinician or service manager were able to show completed fire safety or information governance training, this was completed by the members of staff within 24 hours of the inspection. All other training was noted to be complete.
- Relevant professionals (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. Up to date records of skills, qualifications and training were maintained. Staff were encouraged and given opportunities to develop.

**Coordinating patient care and information sharing**

**Staff worked together, and worked well with other organisations, to deliver effective care and treatment. However, the service did not always ask for consent from patients for information to be shared in a non-secure way.**

- 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 practitioner did not routinely send out letters to patients in a password protected format. We saw examples of where the practitioner had asked for consent to do this, but it was not routinely completed.
- 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.

**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.

**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.

Good

# Are services caring?

**We rated the service as good for providing caring services.**

**Kindness, respect and compassion**

**Staff treated patients with kindness, respect and compassion.**

- The service sought feedback on the quality of clinical care patients received.
- We did not get specific feedback from patients, however we noted that patients' comments on the website 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.

**Involvement in decisions about care and treatment**

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

- Staff told us that interpretation services were available for patients who did not have English as a first language. Patients were also told about multi-lingual staff who might be able to support them.
- Communication aids were not available for patients who were hard of hearing or had vision impairment.

**Privacy and Dignity**

**The service respected patients' privacy and dignity.**

- Staff recognised the importance of people's dignity and respect.
- Staff knew that if patients wanted to discuss sensitive issues or appeared distressed they could offer them a private room to discuss their needs.

Good

# Are services responsive to people's needs?

**We rated the service as good for providing responsive services.**

We carried out this announced comprehensive inspection on 30 November 2021. We had previously carried out an announced comprehensive inspection on 9 February 2021, and a focussed inspection on 2 September 2021. Following these inspections the service was not providing responsive services, and we found the following:

- The service organised and delivered services to meet patients' needs.
- Patients were able to access care and treatment from the service within an appropriate timescale for their needs.
- The provider had a complaints policy, however they did not record or respond to informal complaints.

At the time of the inspection visit on 30 November 2021, the issue relating to complaints management had been addressed.

**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 facilities and premises were appropriate for the services delivered.
- The provider understood the needs of their patients. For example, patients could contact the doctor out of hours Monday to Friday and all-day Saturday and Sunday.
- Reasonable adjustments had been made so that people in vulnerable circumstances could access and use services on an equal basis to others. For example there was ramp access to the service.

**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.
- Patients with the most urgent needs had their care and treatment prioritised.
- Patients reported that the appointment system was easy to use.
- 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 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, complaints and from analysis of trends.

Requires Improvement

# Are services well-led?

**We rated the service as requires improvement for providing well led services.**

We carried out this announced comprehensive inspection on 30 November 2021. We had previously carried out an announced comprehensive inspection on 9 February 2021, and a focussed inspection on 2 September 2021. Following these inspections the service was not providing well led services, and we found the following:

- The service did not have a strategy or business plan in place.
- There was no evidence of formal discussions about the quality of service or clinical outcomes.
- Tasks were delegated to staff whose competence had not been assessed and staff were unclear about their roles.
- There were no systems to support improvement and innovation work.

At the time of the inspection visit on 30 November 2021, some of these issues had been addressed, but other breaches of CQC regulations were identified. Specifically:

- We spoke to several staff who either worked at the clinic or had worked there in the past. They told us that there was a non-supportive culture at the service. Several reported being publicly criticised by the provider, and they stated that they had no autonomy. They reported being afraid to raise issues of concern with the provider.
- Audits and significant events took place in the practice. However, learning was not routinely shared within the team.
- The service did not have either a risk register or other formal way of showing that risks were being identified, recorded, monitored and mitigated.
- Leaders at all levels were visible.
- The provider had effective processes to develop leadership capacity and skills, including planning for the future leadership of the service.

**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.

**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.
- Staff were aware of and understood the vision, values and strategy and their role in achieving them

**Culture**

**The service did not have a culture of high-quality sustainable care.**

- We spoke to several staff who either worked at the clinic or had worked there in the past. They told us that there was a non-supportive culture at the service. Several reported being publicly criticised by the provider, and they stated that they had no autonomy. They reported being afraid to raise issues of concern with the provider, and they felt that they might be criticised for doing so.
- The service focused on the needs of patients.

Requires Improvement

# Are services well-led?

- The provider was aware of and had systems to ensure compliance with the requirements of the duty of candour.
- There were processes for providing all staff with the development they need. This included appraisal and career development conversations. All staff received regular annual appraisals in the last year. Staff were supported to meet the requirements of professional revalidation where necessary.

**Governance arrangements**

**There were limited roles and systems of accountability to support good governance and management.**

- Structures, processes and systems to support good governance and management were effective in some areas, but not in driving improvement at the service. Audits and significant events took place in the practice. However, learning was not routinely shared within the team.
- Staff were clear on their roles and accountabilities
- Leaders had established proper policies, procedures and activities to ensure safety and assured themselves that they were operating as intended.

**Managing risks, issues and performance**

**There were some processes for managing risks, issues and performance.**

- The service did not have either a risk register or other formal way of showing that risks were being identified, recorded, monitored and mitigated.
- 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.
- The provider had plans in place and had trained staff for major incidents.

**Appropriate and accurate information**

**The service acted on appropriate and accurate information.**

- The service used performance information which was reported and monitored and management and staff were held to account
- The service submitted data or notifications to external organisations as required.
- There were arrangements in line with data security standards for the availability, integrity and confidentiality of patient identifiable data, records and data management systems.

**Engagement with patients, the public, staff and external partners**

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

- The service sought customer feedback from patients.
- The service was transparent, collaborative and open with stakeholders about performance.

This section is primarily information for the provider

# Requirement notices

## Action we have told the provider to take

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

| Regulated activity | Regulation |
|---|---|
| Diagnostic and screening procedures<br>Family planning services<br>Treatment of disease, disorder or injury | Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment<br>**How the regulation was not being met:**<br>• The oxygen bottle in place at the surgery was noted to be empty at the time of the inspection.<br>• The service did not own its own defibrillator but shared one with another organisation in the building. Staff at the service were unaware of where this was located.<br>This was in breach of regulation 12(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. |

| Regulated activity | Regulation |
|---|---|
| Diagnostic and screening procedures<br>Family planning services<br>Treatment of disease, disorder or injury | Regulation 17 HSCA (RA) Regulations 2014 Good governance<br>• We spoke to several staff who either worked at the clinic or had worked there in the past. They told us that there was a non-supportive culture at the service. Several reported being publicly criticised by the provider, and they stated that they had no autonomy. They reported being afraid to raise issues of concern with the provider.<br>• Audits and significant events took place in the practice. However, learning was not routinely shared within the team. However, there were instances (such as patient who passed out following a blood test) which should have been recorded as incidents but were not. As such, learning at the service was unclear. This was similarly reflected in audits, which were mostly notes audits. Audits completed were not recorded in cycles, and as such it was not possible to determine whether or not performance had improved.<br>• The service did not routinely send out letters to patients in a password protected format. |

This section is primarily information for the provider

# Requirement notices

- The service did not have either a risk register or other formal way of showing that risks were being identified, recorded, monitored and mitigated.

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

| Regulated activity | Regulation |
| --- | --- |
| Diagnostic and screening procedures<br>Family planning services<br>Treatment of disease, disorder or injury | Regulation 18 HSCA (RA) Regulations 2014 Staffing<br>• On the day of the inspection, neither the lead clinician or service manager were able to show completed fire safety or information governance training, this was completed by the members of staff within 24 hours of the inspection.<br>This was in breach of regulation 18(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. |