Dr. David O'Connell

CP Medical Clinic

Inspection report

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Overall summary

We carried out an announced comprehensive inspection on 5 June 2018 to ask the service the following key questions; Are services safe, effective, caring, responsive and well-led?

Our findings were:

Are services safe?

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

Are services effective?

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

Are services caring?

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

Are services responsive?

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

Are services well-led?

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

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the service was meeting the legal requirements and regulations associated with the Health and Social Care Act 2008.

CP Medical Clinic provides private medical services at 61-63 Sloane Avenue in the Royal Borough of Kensington and Chelsea and treats adults and children.

Eleven patients completed CQC comment cards telling us about their experience of using the service, all of which were very positive about the service and indicated that patients were treated with kindness and respect.

Our key findings were:

- There were limited systems in place to keep patients safeguarded from abuse.
- The service did not have clear systems for the management of vaccines.
- The premises were clean; however, no infection control audits or infection control training had been completed.
- There was minimal evidence that risks were assessed and well-managed; a number of health and safety and premises risk assessments had not been undertaken and equipment had not been calibrated.
- There was minimal evidence of suitable arrangements for assessing and managing fire risk.
- Procedures for managing medical emergencies including access to emergency equipment were not safe.

Summary of findings

- There were limited arrangements to identify, learn and improve where things had gone wrong. There was no clear system for reporting incidents and adverse events.
- The service did not have a process to manage patient safety alerts. There was no record kept of the action taken in response to patient safety alerts.
- There was minimal evidence of quality improvement activity.
- Staff treated patients with dignity and respect and took care to protect their privacy and personal information.
- There was evidence in place to support that the clinicians at the service carried out assessments and treatment in line with relevant and current evidence based guidance and standards.
- There was minimal evidence of systems to improve quality of care and treatment for patients.
- The service's recruitment policy had not been followed as some staff had not received a DBS check.
- The appointment system reflected patients' needs. Patients could book appointments when they needed them.
- The service had some processes for managing written and verbal complaints.
- There was a culture of integrity, openness and transparency and the provider was keen to address concerns found during the inspection.
- The service had a number of policies and procedures, most of which had not been reviewed and updated to reflect day to day practice in the service.
- Governance arrangements were not in place to ensure effective oversight of risk.
- The practice asked staff and patients for feedback about the services they provided.

We identified regulations that were not being met and the provider **must**:

- Ensure care and treatment is provided in a safe way to patients.
- Establish effective systems and processes to ensure good governance in accordance with the fundamental standards of care.
- Ensure persons employed in the provision of the regulated activity receive the appropriate support, training, professional development, supervision and appraisal necessary to enable them to carry out the duties.

You can see full details of the regulations not being met at the end of this report.

There were areas where the provider could make improvements and **should:**

- Review the arrangements for verifying a patient's and responsible adult's identity.
- Review procedures and policies for communicating with patients' GPs and following up urgent referrals.
- Review systems for monitoring the quality of medical records.
- Review the system for monitoring verbal complaints, concerns and comments.
- Formalise the processes for gaining consent to share information with patients' GPs.
- Review the governance arrangements for ensuring effective communication with medical staff.
- Review the recruitment policy and procedure to help them do staff checks and employ suitable staff.
- Review the system for providing appraisals.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?

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

We have told the provider to take action (see full details of this action in the Enforcement section at the end of this report).

- The service did not have effective policies and procedures in place to safeguard people from abuse.
- Chaperoning procedures were not clear and the policy required updating.
- There was minimal evidence that risks were assessed and well-managed; a number of health and safety and premises assessments had not been undertaken and equipment had not been calibrated. Following our inspection, the service told us they had addressed this concern and arranged for an external engineer to check that all medical equipment was calibrated.
- The premises were clean; however, no infection control audits or infection control training had been completed. Following our inspection, the service told us they had addressed this concern to develop a programme of infection control audits and put in place role appropriate training for all staff.
- Fire risk had not been assessed, there were no clear fire procedures for the premises and fire drills and fire training had not been carried out. Following our inspection, the service told us they had addressed these concerns and implemented a system of fire safety checks.
- The provider had a business continuity plan.
- The service did not have clear arrangements for managing medical emergencies.
- There were safe systems for management of emergency medicines and prescribing medicines; however, there were no safe systems for management of vaccines.
- The service did not have formal arrangements for verifying patients' identity.
- The service did not have a clear procedure to communicate information with a patient's GP.
- There was no comprehensive system for reporting, recording and learning from adverse events and incidents and no incidents had been reported.
- There was no comprehensive system for receiving and acting on medicines and safety alerts. Following the inspection, the service told us they had addressed this concern and had updated their medicines and safety alert protocols and had put a system in place to enable sharing of current guidance with medical staff.

Are services effective?

We found that this service was not providing effective care in accordance with the relevant regulations. We have told the provider to take action (see full details of this action in the Enforcement section at the end of this report).

- There was evidence in place to support that the doctor carried out assessments and treatment in line with relevant and current evidence based guidance and standards.
- The practice did not have clear systems to enable sharing of evidence based guidance with medical staff.
- We found minimal evidence of quality improvement measures to improve the care and treatment for patients. For example, the service had carried out a records audit and a hand hygiene audit but these were not two-cycle. We saw minutes of monthly clinical governance meetings for all staff.
- Staff at the service had not completed relevant training, including infection control, fire safety and information governance, basic life support and safeguarding adults and children. Following our inspection, the service told us they had addressed this concern and reviewed role appropriate training for all staff.

Summary of findings

- There was evidence of professional development for the doctor and evidence of appraisal.
- There was minimal evidence of a comprehensive induction programme and appraisals for staff.
- There were no formal systems for communicating with patients' GPs or following up on referrals made to specialist services.
- The provider understood the requirements of legislation and guidance when considering consent and decision making.

Are services caring?

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

- The service treated patients with kindness, respect, dignity and professionalism.
- Staff we spoke with were aware of their responsibility to respect people's diversity and human rights. We saw an Equality and Diversity policy.
- We received feedback from eight patients including Care Quality Commission comment cards. All comments were highly positive about the service experienced.
- The service helped patients be involved in decisions about their treatment and information about treatments were given if indicated.
- Where clients did not have English as a first language they were advised ahead of their appointments to bring a suitable interpreter..
- We saw that staff protected patients' privacy and were aware of the importance of confidentiality. Patients said staff treated them with dignity and respect.
- Patient information was stored and used in a way that maintained its security.

Are services responsive to people's needs?

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

- The facilities and premises were appropriate for the services delivered.
- The service's appointment system was efficient and met patients' needs
- There was no interpreter service for patients who had language barriers. However, the service was multi-lingual, a number of languages were spoken by staff.
- There were no communication aids and no hearing loop.
- Opening hours reflected the needs of the population and patients could book appointments when they needed them.
- The service had some processes for managing complaints.
- There was a confidentiality policy which included guidance on patient's access to medical records and information.

Are services well-led?

We found that this service was not providing well-led care in accordance with the relevant regulations. We have told the provider to take action (see full details of this action in the Enforcement section at the end of this report).

- The provider showed integrity and openness when safety concerns were raised during the inspection and demonstrated a drive to put actions in place to address concerns.
- There was minimal evidence of measures to improve the care and treatment for patients.
- There were systems for reviewing and acting on feedback from patients.

Summary of findings

- The service had a number of policies and procedures, most of which had not been reviewed and updated to reflect day to day practice in the service.
- Governance arrangements were not in place to ensure effective oversight of risk. This resulted in a number of safety assessments for the premises and equipment which had not been undertaken.
- The lack of suitable protocols meant there were limited arrangements to learn and improve where things had gone wrong. There was an incident policy, however the system for reporting incidents had not been reviewed and updated to reflect day to day practice in the service.
- There were insufficient systems and oversight to ensure safety training was undertaken.

CP Medical Clinic

Detailed findings

Background to this inspection

CP Medical Clinic is a private doctor's consultation service for adults and children in the Royal Borough of Kensington and Chelsea. Dr David O'Connell is registered as an individual provider with the Care Quality Commission to provide the regulated activity of treatment of disease, disorder or injury. Regulated activities are provided at one clinic location, 61-63 Sloane Avenue, London SW3 3DH.

The premises are located on the ground floor and in the basement of a converted residential property. The premises are leased by the director of CP Medical Clinic. There is a shared entrance, three consultations rooms, a waiting area, reception and toilet facilities. The director of CP Medical clinic runs a pharmacy on the ground floor. The service is open between 9am – 9pm, Monday to Saturday and 4pm – 8pm on Sunday.

General medical services provided include routine medical consultations and examinations, vaccinations and travel vaccinations and health screening. There are 20-30 consultations carried out weekly.

Medical services are provided by the registered provider and ten private GPs and 4 specialist consultants. The service operates a pharmacy on the premises. The registered person works 16 hours a week at the practice and performs approximately 12 consultations a week, the other consultations being performed by the other doctors. There is a practice manager who oversees all administrative and managerial duties. The provider employs a team of part time reception staff.

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.

Are services safe?

Our findings

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

Safety systems and processes

The service did not have clear systems to keep patients safe although there were some processes to ensure patients were safeguarded from abuse.

- The provider did not have effective systems to safeguard children and vulnerable adults from abuse. We saw policies for safeguarding adults and children, however these policies were not accessible to staff and had not been updated and reviewed. For example, we saw the practice's safeguarding policy for adults and children which did not contain contact numbers for local safeguarding teams or details of the internal safeguarding lead. Following our inspection, the service told us they had addressed this concern and had updated their safeguarding policies to include safeguarding adults and child protection contact details. The service told us the safeguarding policy and contact details were kept at the reception desk and were accessible to staff.
- At the time of our inspection, not all staff had completed or refreshed their training on safeguarding children and vulnerable adults. No reception staff had undertaken safeguarding adults and children training. We checked reception staff's understanding of how to keep people safe from the risk of abuse. They were not able to give examples of the types of abuse people may be at risk of or what action to take if they had concerns. Following our inspection, the service told us they had addressed this concern and reviewed role appropriate training in safeguarding for non-clinical staff. They told us they were recruiting for two part time receptionists.
- The doctors we spoke to knew how to identify and report safeguarding concerns. However, the doctor we spoke to did not know who the internal safeguarding lead was and told us there had never been any safeguarding concerns raised. We saw evidence of a PREVENT policy to safeguard people at risk of radicalization. PREVENT is a government safeguarding programme to safeguard people and communities from the threat of terrorism. The service had a Female Genital Mutilation Policy (FGM), however the service had not made this policy accessible to staff. For example, there was no record that the policy was available in a shared folder or electronic file .
- The two doctors we spoke to had received safeguarding adults and children training to level three. One of the doctors we spoke to had not received refresher training in safeguarding adults and children since February 2015.
- The provider had a recruitment policy however the recruitment policy had not been followed as some staff had not received a DBS check and there was no record in staff files of routine vaccinations to protect employees from communicable diseases, as per the Department of Health 'Green Book' guidance.
- There was no Hepatitis B status on record for the doctor that we interviewed. However, immediately following the inspection, the service sent us evidence of Hepatitis B immunity status. There was evidence of professional registration and indemnity for the provider.
- The receptionist was employed by the provider, their duties involved handling appointments and calls from patients and administration. We saw a signed confidentiality agreement and a signed employment contract. The provider had not assured themselves that there was a comprehensive system of role appropriate training to support the receptionist in their role and to ensure the system was safe for patients.
- There was evidence of a Disclosure and Barring Service (DBS) check for the provider. (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.)
- There was a chaperone policy in place. The receptionist acted as a chaperone; however, we saw no record of a DBS check for the receptionist. We saw evidence that the receptionist had completed chaperone training online. Following our inspection, the service told us they had addressed this concern and had applied for a DBS check for the receptionist.
- There was minimal evidence that safety risk assessments for the premises and clinic environment had been carried out. There had been no health and safety risk assessment, legionella risk assessment or assessment of risks related to the control of substances hazardous to health (COSHH). Following our inspection, the service told us they had addressed this concern and spoken to the landlord who they leased the premises

from, to review what health and safety checks of the building were carried out. The service had arranged for an external company to carry out a legionella risk assessment.

- There was evidence that a range of portable electrical equipment had been tested for safety, the last testing had been undertaken in May 2018, arranged by the provider.
- Medical equipment had not been tested and calibrated. We saw no record of when the last calibration date was. For example, there was no record of calibration of the single vaccine fridge thermometer or of the nebuliser. Following our inspection, the service told us they had addressed this concern and arranged for an external engineer to check that all medical equipment was calibrated including checking the calibration of the single vaccine fridge thermometer.
- There were some arrangements to manage infection prevention and control. The clinic appeared clean. There were regular cleaning arrangements and we saw cleaning records for the environment. However, cleaning records for clinical equipment were not kept. We saw evidence of a clinical waste protocol.
- The service had not carried out an infection control audit for the environment and had not undertaken infection control training. There was an infection control policy in place but the service did not follow the policy to help prevent and control infections. We found that two doctors and a reception staff member had not undertaken annual infection control update training. Following our inspection, the service told us they had addressed this concern to develop a programme of infection control audits and put in place role appropriate training for all staff.
- The service had policies which referred to the management of health and safety and premises risks, however there was limited evidence these were being followed. For example, we saw a sharps injury policy but the sharps containers were not fixed in place or dated. 'Sharps' are needles, blades (such as scalpels) and other medical instruments that are necessary for carrying out healthcare work and could cause an injury by cutting or pricking the skin.

Risks to patients

The provider did not have clear systems to assess, monitor and manage risks to patient safety.

- There was no record of planning and monitoring the number and mix of staff needed. The service did not employ locum or temporary staff. Cover was arranged using existing staff members. When the service was closed, patients were directed to call a 24-hour private medical company for routine appointments or call NHS emergency services if they required urgent medical attention.
- There were limited induction processes for new staff. We saw an induction checklist but this was not tailored to individual roles and did not include safety information or a record of role appropriate training.
- There was evidence of professional indemnity for the doctors.
- Home visits were undertaken.
- There were some systems for managing fire risk. Fire extinguishers were checked annually. There was a fire policy. There was no comprehensive system of fire risk assessment carried out to minimise the risk of a fire. The service told us they had arranged for an external company to carry out a fire risk assessment which was done just before our inspection. There was no record of a system in place to check the working status of the fire alarms and no fire drills had been carried out. There was no record of fire safety training for the clinicians. There was no visible fire procedure in the basement areas of the premises used by patients and staff. Following our inspection, the service told us they had addressed these concerns and implemented a weekly fire alarm test and a fire drill schedule. The service also ensured the fire procedure was visible to tell people what to do in the event of a fire.
- The service had a medical emergency policy. We found procedures for managing medical emergencies, including access to emergency equipment, were not safe. For example, there was no record that emergency equipment was checked regularly or that checks were logged. We checked the oxygen cylinder in the emergency grab bag but there were no oxygen masks in the bag. We saw child and adult masks in a storage tray in the consultation room. The service had a defibrillator. There was no record of checks of the working status of the defibrillator. Following our inspection, the service told us they had addressed concerns identified and arranged for one of the doctors to do weekly tests of the emergency medical equipment and log the tests.
- Medical staff we spoke to had an awareness of the signs of sepsis.

Are services safe?

- Staff had not received annual training in emergency resuscitation or basic life support. There was no record that staff had attended face to face basic life support training, we were told most staff completed this online but we did not see a record of this. There was no clear assessment of risk to demonstrate the decision making and mitigating arrangements in place. Following our inspection, the service told us they had addressed these concerns. We saw evidence that the practice manager had completed online training in emergency resuscitation, BLS and automated external defibrillation (AED) Level 2.The service told us that the pharmacy director had completed face to face basic life support training. Doctors at the service were responsible for updating basic life support annually as part of their appraisal.
- There was evidence of CPR training for the registered provider, although this had occurred more than 12 months ago. The registered provider told us they would call 999 in the event of an emergency.
- The service stocked a number of emergency medicines. All the emergency medicines we checked were in date. We saw no records that emergency medicine checks were carried out or recorded. There was no formal written risk assessment process to indicate which emergency medicines were stored in the clinic and the decision making surrounding this.
- The provider had a documented business continuity plan in place.
- The service did not have clear lines of responsibility for managing safety alerts. We saw recent alerts which had not been fully actioned. For example, we looked at a blood glucose testing strip alert dated 18 May 2018 which is a blood glucose testing system used by the doctors but the service had not done a search to see if their strips were in the affected batch. Following our inspection, the service told us they had addressed this concern and had updated their medicines and safety alert protocols. The service had introduced a system to review safety alerts and created a contact group to email the alerts to all clinicians at the service. Doctors were required to respond to the safety alert email with a read message. Medicines and safety alerts were also printed off and kept in a folder which was accessible to staff in two of the consultation rooms.
- From reviewing clinical meeting minutes, we saw examples of points raised which would have been appropriate to record under the practice's significant event process. This included failure to take action when a patient who attended the clinic with a fever, was diagnosed with chicken pox. The receptionist who was on duty at the time, had never had chicken pox. This was not dealt with under the practice's significant event process. Although this was not categorised as a significant event there was evidence of discussion and learning but details of the action taken in response was limited.

Information to deliver safe care and treatment

Some arrangements for recording and managing information were in place although improvements were required.

- Individual care records were written, managed and stored in a way that kept patients safe. The medical records we saw showed that information needed to deliver safe care and treatment was available to relevant staff in an accessible way. Patient records were stored in lockable storage cabinets in a secure room.
- There were information management policies in place; however, the doctor we spoke to had not undertaken information governance training. One of the doctors in the medical team was the information governance lead.
- Management of correspondence in the service including letters, referrals and results was safe and overseen solely by the practice manager.
- There were no formal processes for directly communicating with patients' GPs. Most of communications were via referrals to private consultants in secondary care.
- 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 attended for appointments, but formal identification was not checked.
- The service treated adults and children and all patients under the age of 16 were chaperoned by a parent or guardian. Formal checks of adults accompanying child patients were not carried out. The clinic treated children and staff told us they verified the identity of adults accompanying child patients, but this was not recorded.

Safe and appropriate use of medicines

Are services safe?

The provider had some systems for appropriate and safe handling of medicines although management of vaccines was not robust.

- The practice had not taken action when the cold chain had not been followed. Vaccines were stored in the pharmacy medicines refrigerator on the ground floor. We found that vaccines were not monitored according to the service's cold chain policy and governance arrangements.
- The service kept records of the daily refrigerator temperature checks. We saw no record that the service had calibrated the integral fridge thermometer to ensure readings were maintained. For example, we saw the pharmacy fridge temperature record sheets over the last 3 months and found fifteen readings where the fridge temperature was out of range. There was no record that the service had assessed these readings to ensure that the contents were safe.
- The service did not follow safety protocol to record the incident or seek advice following the cold chain breach from Public Health England or local medicines information services. Following our inspection, the service told us they had reviewed the cold chain breach with the pharmacy director. The service told us that locum staff had not closed the pharmacy fridge door properly and did not know the procedure to reset the fridge thermometer. The service told us they had taken action and discussed the incident with staff concerned and have updated their cold chain policy in line with General Pharmaceutical Council (GPC) guidance.
- The service stocked a number of emergency medicines. These were all in date. Emergency medicines could be obtained from the pharmacy on the premises. There was record of a formal written risk assessment process to indicate which emergency medicines were stored in the clinic and the decision making surrounding this.
- Clinicians prescribed medicines to patients and gave advice on medicines in line with legal requirements and current national guidance.
- All prescriptions were issued acutely; the longest prescription length was three months. No repeat prescribing occurred without a review from the doctor.
- The service kept prescription stationery securely and monitored its use.
- There was no record that the provider audited the quality of their prescribing.

Track record on safety

The provider did not have a clear safety record as a number of risks had not been fully assessed and mitigated.

- There were some risk assessments that had not been completed such as those for infection control, the control of substances hazardous to health, legionella, health and safety and medical emergencies. Following our inspection, the service told us they had addressed this concern and reviewed the system of risk assessments. The service told us they had looked at safety guidance on the Independent Doctor Federation (IDF) website and also NHS England's infection control guidance, to help them develop a system of checks and implement a programme of risk assessment.
- Following our inspection, the service told us they had spoken to the landlord of the residential estates company who they leased the premises from to find out what health and safety assessments are carried out by the landlord and how often safety checks are done. The service told us that following our visit, they had carried out a legionella risk assessment and safety checks of the premises and clinic environment.

Lessons learned and improvements made

- From reviewing clinical meeting minutes, we saw examples of points raised which would have been appropriate to record under the practice's significant event process. This included an incident when a patient who attended the clinic with a fever, was diagnosed with chicken pox. The receptionist who was on duty at the time, had never had chicken pox. This was not dealt with under the practice's significant event process. Although this was not categorised as a significant event there was evidence of discussion in the clinical governance minutes but details of the action taken in response was limited.
- The provider reported there had not been any instances where things had gone wrong over the previous three years of the service operating. It was not clear whether the provider understood all types of incidents that could be classed as reportable (including near misses, administrative and clinical incidents). There was an incident policy, however the system for reporting incidents had not been reviewed and updated to reflect day to day practice in the service. There was no clear process for the receptionist to follow if they needed to raise a concern. However, the provider had an accident book if any accidents were to occur.

Are services safe?

- The provider was aware of the requirements of the Duty of Candour and a policy was in place.
- 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.
  - They would keep written records of verbal interactions as well as written correspondence.
- The service did not have an effective system to manage patient safety alerts. There was no record kept of the action taken in response to patient safety alerts, and the service expected individual clinicians to look through a folder of printouts of safety alerts. Following the inspection, the service told us they had addressed this concern and had updated their medicines and safety alert protocols and had put a system in place to enable sharing of current guidance with medical staff.

Are services effective?

(for example, treatment is effective)

Our findings

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

Effective needs assessment, care and treatment

There was evidence in place to support that the doctor carried out assessments and treatment in line with relevant and current evidence based guidance and standards. The provider reported that they provided consultations for patients with routine medical problems. If patients presented with more complex medical issues, they were referred to specialists or to their GP.

- The doctors advised patients what to do if their condition got worse and where to seek further help and support.
- We looked at eight patient records. Records were clearly recorded and contained comprehensive detail of consultations, treatment and advice. From evidence we saw, the service carried out assessments and treatment in line with relevant and current evidence based guidance and standards including NICE and British National Formulary (BNF) guidance.
- The practice did not have clear systems to enable sharing of evidence based guidance or medicine safety alerts with medical staff. Following clinical guidance was clinician dependent as there was no system in place to enable sharing of current guidance with medical staff. Following the inspection, the service told us they had addressed this concern and had updated their medicines and safety alert protocols and had put a system in place to enable sharing of current guidance with medical staff.
- There was some evidence that the provider followed up on referrals made to specialist services and secondary care providers. Doctors told us they monitored discharge summaries and if they received a hospital letter they would undertake follow up consultations with patients discharged from hospital. However, there was no formal system for following up on referrals made to specialist services.
- We saw no evidence of discrimination when making care and treatment decisions.

Monitoring care and treatment

Patient records were hand written by the doctors. We saw that the patient record system was not able to be used effectively to gather data for clinical audits. The provider reported they were in the process of moving to an electronic record system shortly before the inspection. The provider was in the process of scanning hand written patient records into the new electronic record system. Patient records were stored in lockable storage cabinets in a secure room.

- There was limited evidence of quality improvement activity to monitor the medical services provided, however this did not include clinical audit. For example the practice doctors held monthly clinical governance meetings and the medical team were encouraged to invite specialists to give talks at the meetings.
- We asked to see minutes from the clinical governance meetings. From the minutes we looked at, we found some evidence that incidents and complaints were discussed and learning and actions from incidents was recorded.

Travel vaccination

- The practice did not have a clear system of travel management and travel risk assessment to ensure the safety of patients. The lead GP was registered with the GMC but had not undertaken immunisation training in the last three years.
- Information recording vaccines administered was in handwritten notes.
- The service had adrenaline on site to treat someone who had an adverse reaction to a vaccine, for example an anaphylactic reaction.

Effective staffing

Evidence reviewed showed that doctors had the skills and knowledge to deliver effective care and treatment, although some safety training topics had not been undertaken.

- There was no record that staff at the practice had undertaken appropriate safety training, including infection control, fire safety and information governance and updated training for basic life support and safeguarding adults and children. Following our inspection, the service told us they had addressed this concern and reviewed role specific training requirements for all staff. The service told us they had updated their induction process to include fire safety training, infection control, safeguarding and basic life support for all staff.

Are services effective?

(for example, treatment is effective)

- There was some evidence of an induction process and appraisals for staff.
- Clinicians had undertaken safeguarding adult and children's training level three although one doctor we spoke to had not undertaken safeguarding training in the last three years and required updating. We saw no record that the doctor had undertaken training in fire safety, infection control basic life support and information governance.
- There was no record that non-clinical staff had undertaken training in the Mental Capacity Act.
- There was evidence of appraisals and continuing professional development for the clinicians. The registered person had been revalidated by the General Medical Council (GMC).

Coordinating patient care and information sharing

We found that the service had some systems in place for coordinating patient care and sharing although improvements were required.

- The provider confirmed they referred patients to a range of specialists in primary and secondary care if they needed medical treatment the practice did not provide.
- There were limited formal systems for communicating with patients' registered GPs or following up on referrals made to specialist services. We saw evidence of GP contact details taken on registration.
- The provider understood the requirements of legislation and guidance when considering consent and decision making.
- The provider had an effective third-party arrangement with a private laboratory for blood test results.
- A number of incidents had occurred where doctors had called 999 to ensure patients received emergency treatment. The service had not recorded these as significant events.

Supporting patients to live healthier lives

The provider had some systems to support patients to live healthier lives.

- The medical team provided health checks to patients.
- Cancer screening services were not offered but advice was given to patients regarding accessing these services.
- The service identified patients who may need extra support and directed them to relevant services. This included patients in the last 12 months of their lives, patients at risk of developing a long-term condition and carers.
- The doctors gave lifestyle advice during consultations.
- Staff discussed changes to care or treatment with patients, as necessary.

Consent to care and treatment

Consent to care and treatment was obtained in line with legislation and guidance.

- The provider understood the requirements of legislation and guidance when considering consent and decision making.
- Verbal consent was obtained for all doctor interventions and treatment and we saw this was in line with General Medical Council (GMC) guidance.
- The service supported patients to make decisions. Where appropriate, they assessed and recorded a patient's mental capacity to decide.
- The service did not monitor the process for seeking consent. Records audits to monitor the process for seeking consent were not undertaken.

Are services caring?

Our findings

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

- The service treated patients with kindness, respect, dignity and professionalism.
- We received feedback from 11 patients who had filled in Care Quality Commission comment cards. All comments were positive about the service experienced.
- We saw that staff protected patients' privacy and were aware of the importance of confidentiality. Patients said staff treated them with dignity and respect.
- Patient information was stored and used in a way that maintained its security.

Kindness, respect and compassion

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

- The provider understood patients' personal, cultural, social and religious needs.
- The service gave patients timely support and information.
- We observed the consultation rooms to be 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 patient Care Quality Commission comment cards we received were wholly positive about the service experienced. Patients described the doctors as efficient, helpful and attentive.

Involvement in decisions about care and treatment

The service had facilities to assist patients with specific needs to be involved in decisions about their care.

- The service helped patients be involved in decisions about their treatment and information about treatments were given if indicated.
- Feedback from patients included comments that the GP was thorough and took time to talk through care and treatment options.
- The service's website provided patients with information about the range of treatments available including costs.
- Where clients did not have English as a first language they were advised ahead of their appointments to bring a suitable interpreter.
- There were no communication aids available, such as a hearing loop. We were told there had not been instances where the doctor had treated patients with visual or hearing difficulties.

Privacy and Dignity

The service respected patients' privacy and dignity.

- We saw that staff protected patients' privacy and were aware of the importance of confidentiality. The doctors and reception staff recognised the importance of patients' dignity and respect.
- We observed the clinical rooms 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 practice manager's office.
- The service complied with the Data Protection Act 1998. We saw a policy on information governance and security. There was a confidentiality agreement for individuals carrying out administrative duties.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

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

Responding to and meeting people's needs

- The facilities and premises were appropriate for the services delivered.
- The practice's appointment system was efficient and met patients' needs
- There was no interpreter service for patients who had language barriers. However, staff at the practice also spoke other languages including English. Where patients had language barriers, they were advised ahead of their appointment to bring someone to act as an interpreter.
- There were no communication aids and no hearing loop.
- Opening hours reflected the needs of the population and patients could book appointments when they needed them.
- The clinic organised and delivered services to meet clients' needs and expectations. Patients had a choice of booking with a male or female doctor.

Timely access to the service

- The service was open between 9am – 9pm, Monday to Saturday and 4pm – 8pm on Sunday. Opening hours were displayed in the premises and on the service website.
- Staff told us that patients who requested an urgent medical appointment were seen the same day. If they required an appointment with a specialist, this was booked in advance.
- The provider did not offer out of hours care; however, if medical attention was required patients were directed to a private 24-hour doctor service.
- Patients had timely access to initial assessment, test results, diagnosis and treatment. There were 20-30 consultations carried out weekly. Medical services were provided by the registered person and ten private GPs and four specialist consultants. The registered person performed approximately 12 consultations a week, the other consultations were undertaken by the team of private doctors. Specialist consultants who worked at the service included a consultant paediatrician, two orthopaedic surgeons and two consultant psychiatrists.

Listening and learning from concerns and complaints

- The service had some processes for managing complaints. The provider reported they had not received any complaints over the last 12 months. However, we found evidence of a complaint in the minutes we looked at from the clinical governance meeting. A patient had complained that they were unhappy with the diagnosis after having attended the practice with abdominal pain. The patient was given a second opinion the next day.
- The service did not record verbal complaints or concerns.
- We saw a complaints procedure notice in the reception area and we saw the practice's complaints form. There was no information on the service's website about how to complain.
- The practice manager was responsible for dealing with complaints. Staff told us they would tell the manager about any formal or informal comments or concerns straight away so patients received a quick response.
- There was a confidentiality policy which included guidance on patient's access to medical records and information.

Are services well-led?

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

Our findings

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

Leadership capacity and capability

- The provider showed integrity and openness when safety concerns were raised during the inspection and demonstrated a drive to put actions in place to address concerns.
- There was minimal evidence of a programme of quality improvement measures to improve the care and treatment for patients.
- Safety aspects of the service were not clearly known or prioritised to ensure high quality care was delivered. There was insufficient leadership focus on adequate systems of governance and management of risks.
- There were systems for reviewing and acting on feedback from patients.

Vision and strategy

The service had a clear vision to deliver high quality care and treatment, excellent customer care and an overall positive client experience.

- There was a mission statement and staff were aware of this.
- Although there was no formal business plan, the provider aimed to continue providing an on-going high-quality service. One of the practice doctors was the clinical governance lead.
- Leaders and managers had clear priorities to improve the electronic record system and increase the use of technology in monitoring health.

Culture

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

- Staff stated they felt respected, supported and valued. They were proud to work in the service.
- The service focused on the needs of patients.
- Although there had been no reported incidents and no recorded complaints, the provider was aware of and had systems to ensure compliance with the requirements of the duty of candour.
- Staff we spoke with told us they could raise concerns and were encouraged to do so. They had confidence that these would be addressed.
- There was a commitment to the safety and well-being of all staff.
- The service had an equality and diversity policy.

Governance arrangements

There was some evidence of systems to support good governance although a number of systems did not have clear governance arrangements and accountability.

- In some areas the service lacked formalised procedures to support good governance and management. There were no clear arrangements or lines of accountability for carrying out safety risk assessments for the premises, management of fire risks and infection prevention and control.
- Governance arrangements did not ensure effective oversight of risk. A number of safety assessments for the premises and equipment had not been undertaken. For example, there was no annual fire risk assessment carried out.
- There were limited arrangements to learn and improve where things had gone wrong. Verbal complaints were not captured. Although there was an incident policy, the system for reporting incidents had not been reviewed and updated to reflect day to day practice in the service.
- There were no clear arrangements for ensuring safety training was undertaken.
- 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 practice, for example, infection control and the safety of premises and equipment policies. It was not clear that the provider was aware of the contents of the policies and where they needed to be reviewed and updated.
- We saw evidence of minutes from monthly clinical governance meetings. One of the practice doctors was the clinical governance lead.

Managing risks, issues and performance

There were some processes in place for managing risks, issues and performance; however, in most areas these were under-developed and not formalised. The provider's risk management approach was not linked effectively into planning processes.

Are services well-led?

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

- The process for effectively identifying, understanding, monitoring and addressing current and future risks, including risks to patient safety, required review in some areas.
- Governance systems did not ensure that patients were safe. For example, there were limited 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 service had a system in place to manage complaints, although we were told no complaints had been made in the last 12 months.
- Systems for ensuring continued professional development were in place, however there were no clear arrangements for ensuring safety training was undertaken, including infection control, fire safety and information governance training.
- The service had no formal arrangements in place to ensure that staff carried out checks of patient identity and parental responsibility.
- The service did not have a process to manage patient safety alerts. There was no record kept of the action taken in response to patient safety alerts, and the service was unable to demonstrate that they had an effective process to manage these. Following our inspection, the service told us they had addressed this concern and had put a system in place to enable sharing of current guidance with medical staff.
- There were some measures to improve and address quality. The provider carried out case reviews to identify areas to improve the service delivered.

Appropriate and accurate information

Overall, the service acted on appropriate and accurate information; however, in some areas there was a lack of information gathered and maintained.

- Information gathered on the quality of the service was limited to feedback and online reviews from patients and discussions in clinical governance meetings around adherence to guidelines or evidence based practice.
- The service had systems in place which ensured patients' medical records remained confidential and secured at all times.
- Patient names and other identity information were handled by staff members who had signed confidentiality agreements in place.
- We saw no records of information governance or data protection training for the provider or receptionist.
- The service submitted information or notifications to external organisations as required.

Engagement with patients, the public, staff and external partners

The service involved patients and external colleagues to improve the service delivered.

- The provider gathered feedback from patients and external peers as part of their annual appraisal.
- The service encouraged feedback from clients. Staff told us they encouraged clients to leave online reviews.
- The service collected patient satisfaction information from their website and used this to inform their plans for developing the service.

Continuous improvement and innovation

There were some processes and opportunities for learning, continuous improvement and innovation.

- Leaders showed a commitment to learning and improvement and valued the contributions made to the team by individual members of staff; the medical team were encouraged to invite specialists to give talks at the clinical governance meetings.

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 18 HSCA (RA) Regulations 2014 Staffing How the regulation was not being met: **There were no systems or processes that enabled the registered person to assess, monitor and improve the quality and safety of the services being provided. In particular:** • The provider had failed to put processes in place to ensure that individuals working for the service had access to support, training, professional development, supervision and appraisal. • The provider had failed to put in place formal supervision and appraisal arrangements for non-clinical administrative staff. • Not all the people providing care and treatment had the qualifications, competence, skills and experience to do so safely. In particular, the registered person had not undertaken training in infection control, basic life support, fire safety and information governance.

This section is primarily information for the provider

Enforcement actions

Action we have told the provider to take

The table below shows the legal requirements that were not being met. 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 12 HSCA (RA) Regulations 2014 Safe care and treatment **How the regulation was not being met:** **Assessments of the risks to the health and safety of service users of receiving care or treatment were not being carried out. In particular:** • Health and safety risk assessments of the premises had not been carried out. • Annual fire risk assessments had not been carried out. • Medical equipment had not been calibrated. Equipment included a pulse oximeter, blood pressure monitor, scales, thermometer and a defibrillator. • There was no evidence of suitable arrangements for the control of substances hazardous to health (COSHH), such as a COSHH risk assessment or COSHH policy. • There was no evidence of a legionella risk assessment. **The registered persons had not done all that was reasonably practicable to mitigate risks to the health and safety of service users receiving care and treatment. In particular:** • Fire drills were not carried out and there was no visible fire procedure in patient areas. • There were no suitable arrangements to manage medical emergencies. Staff had not received annual BSL training and there was no evidence staff had undertaken BSL update training. There was no clear assessment of risk to demonstrate the decision making and mitigating arrangements in place. • The provider did not have an effective incident reporting policy or procedure. Staff were unsure how to identify a serious adverse event and how to report it. There had been no serious incidents reported in the last 12 months. • The provider was unable to evidence that non-clinical staff had received up to date adult and children safeguarding, or a DBS check.

This section is primarily information for the provider

Enforcement actions

Not all of the people providing care and treatment had the qualifications, competence, skills and experience to do so safely. In particular:

- The provider had no record of any staff having undertaken training in fire safety, basic life support and infection control.

There was no proper and safe management of medicines. In particular:

- There was no documented system for recording and monitoring checks of emergency medicines.
- Medicines were not managed in a way that was safe as the provider had not taken action when the vaccine fridge temperatures were out of range on numerous dates.

There was no assessment of the risk of, and preventing, detecting and controlling the spread of, infections, including those that are health care associated. In particular:

- There was no evidence that infection control audits had been undertaken by the provider.
- The practice had not taken action to mitigate all risks associated with infection control. They had not conducted any annual IPC audits. The practice was clean. However, sharps bins were not fixed or dated.

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

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance How the regulation was not being met: There were no systems or processes that enabled the registered person to assess, monitor and improve the quality and safety of the services being provided. In particular: • The provider did not have an effective incident reporting policy or procedure.

This section is primarily information for the provider

Enforcement actions

- The provider reported that there had been no incidents or events where things had gone wrong over the past three years the service had operated.
- There was no clear process for the receptionist to follow if they needed to raise a safety concern.
- The provider could not show that safety alerts had been monitored and actioned. The service did not have clear systems for cascading information to medical staff including learning from incidents and safety alerts.

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. In particular:

- There was minimal evidence safety risks had been assessed and mitigated.
- There were no clear governance arrangements for the undertaking of safety risk assessments for the premises, electrical checks, management of fire risks and business continuity in the event of emergencies.
- There were no clear arrangements to ensure the registered person had undertaken training in information governance, basic life support, infection control and fire safety.

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:

- There was a lack of oversight of whether risks had been assessed and mitigated to ensure suitability and safety of the premises for service users.
- The provider had a number of policies and procedures written in 2015, most of which had not been reviewed. Some policies were not always reflective of day to day practice, for example fire safety, basic life support and infection control policies.

This section is primarily information for the provider

Enforcement actions

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