Luxmedica Limited

Luxmedica Ealing

Inspection report

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Date of inspection visit: 28 June 2018
Date of publication: 02/10/2018

Overall summary

We carried out an announced comprehensive inspection on 28 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.

Luxmedica Ealing is an independent clinic in the London Borough of Ealing and provides private primary medical and dental healthcare services. The service offers services for adults and children. Most of the patients seen at the service are predominantly Polish patients. Medical consultations and diagnostic tests are provided by the clinic however no surgical procedures are carried out.

The clinic also provides dental services. A copy of the full report of the dental service is available on our website: www.cqc.org.uk.

The premises is not accessible for patients with mobility issues.

This service is registered with CQC under the Health and Social Care Act 2008 in respect of the services it provides. They provider employs the registered manager. A registered manager is a person who is registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

We spoke with three patients and received 13 patient Care Quality Commission comment cards. All of the

Summary of findings

comment cards we received were positive about the service. Patients said they were satisfied with the standard of care received and said the staff was approachable, committed and caring.

Our key findings were:

- Some systems and processes were in place to keep patients safe. However, we identified some shortfalls in relation to safeguarding children and adults training, staff recruitment checks and the management of legionella.
- The system for the reporting of significant events was not fully implemented in the service and staff we spoke with were not sure which template or form to use.
- Staff we spoke with informed us the patient record system did not electronically alert clinical and reception staff to vulnerable patients.
- There was a lack of clinical governance and limited evidence of quality improvement activity to review the effectiveness and appropriateness of the care provided.
- There was no evidence of formal clinical supervision, mentorship or support. Individual prescribing decisions were not monitored or reviewed by the medical advisor.
- Consent procedures were in place and these were in line with legal requirements. However, there was inconsistency in communication with NHS GPs.
- The service was unable to provide documentary evidence to demonstrate that all staff had completed training relevant to their role and received a formal internal appraisal within the last 12 months.
- Appointments were available seven days a week on a pre-bookable basis. The service provided only face to face consultations.
- Staff involved and treated patients with compassion, kindness, dignity and respect.
- Information about services and how to complain was available.
- The provider was aware of and complied with the requirements of the Duty of Candour.
- There was a clear leadership structure and staff felt supported by management. The service proactively sought feedback from staff and patients, which it acted on.

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

- Establish effective systems and processes to ensure good governance in accordance with the fundamental standards of care.

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

There were areas where the provider should make improvements:

- Review the provider's responsibilities to take into account the needs of patients with disabilities and to comply with the requirements of the Equality Act 2010.
- Review systems to verify a patient's identity on registering with the service.
- Ensure consistency in communication with NHS GPs and assure all the doctors are sharing consultation notes if the appropriate patient consent is given.
- Review the policy for offering the baby scans when consent to share information with the woman's NHS GP is not given.
- Develop a system to flag safeguarding concerns on patient record to alert clinical and reception staff to vulnerable patients.
- Ensure information about a translation service is available and displayed in the waiting area.
- Improve access to patients with hearing difficulties.
- Ensure a response to complaints includes information of the complainant's right to escalate the complaint if dissatisfied with the response.

Professor Steve Field CBE FRCP FFPH FRCGPChief Inspector of General Practice

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 Requirement Notices at the end of this report).

The impact of our concerns is minor for patients using the service, in terms of the quality and safety of clinical care. The likelihood of this occurring in the future is low once it has been put right. We have told the provider to take action (see full details of this action in the Requirement Notices at the end of this report).

This was because:

- Some systems and processes were in place to keep patients safe. However, we identified some shortfalls in relation to safeguarding children and adults training, staff recruitment checks and the management of legionella.
- Staff we spoke with informed us the patient record system did not electronically alert clinical and reception staff to vulnerable patients.
- The system for the reporting of significant events was not fully implemented in the service and staff we spoke with were not sure which template or form to use.
- The service ensured that facilities and equipment were safe and that equipment was maintained according to manufacturers' instructions.
- The service maintained appropriate standards of cleanliness and hygiene.
- The clinic had adequate arrangements in place to respond to emergencies and major incidents.
- There were systems in place to protect all patient information and records were stored securely.
- The provider was aware of and complied with the requirements of the Duty of Candour and encouraged a culture of openness and honesty.

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 Requirement Notices at the end of this report).

This was because:

- The provider carried out limited quality improvement activity.
- Individual prescribing decisions were not monitored or reviewed by the medical advisor, to identify areas for quality improvement.
- There were gaps identified in the staff training and the service was unable to provide documentary evidence to demonstrate that all staff had received training relevant to their role.
- The service was unable to provide documentary evidence to demonstrate that all the doctors had received a formal internal appraisal within the last 12 months.
- The service had not always kept the evidence of doctors' professional qualification in their staff files.
- The service had some arrangements in place to coordinate care and share information. However, there was inconsistency in communication with NHS GPs and not all the doctors we spoke with always shared consultation notes with the NHS GPs even after receiving the appropriate patient consent.
- Information shared by email with external providers was not password protected in order to ensure data security.

Summary of findings

- We observed that the doctors assessed patients' needs and delivered care in line with relevant and current evidence based guidance and standards.
- There was an appropriate system for recording and updating patient care and treatment information.

Are services caring?

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

We found areas where improvements should be made. This was because:

- Translation services were not available for patients who did not have English or Polish as a first language.
- The provider did not provide a hearing induction loop or alternative solution for patients with a hearing loss.
- Systems were in place to ensure that all patient information was stored and kept confidential.
- According to patient feedback, services were delivered with compassion, dignity and respect and they were involved in decisions about their care and treatment.
- We observed a relaxed and friendly atmosphere at the service and members of staff were courteous and helpful to patients.

Are services responsive to people's needs?

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

We found areas where improvements should be made. This was because:

- The facilities and premises were appropriate for the services being provided. However, the premises was not accessible for patients with mobility issues.
- The service had not carried out the Disabled Access Audit or Disability Discrimination Act (DDA) Audit.
- There was information available to patients to demonstrate how the service operated.
- The services were offered on a private fee basis. There was a range of payment options available to patients.
- Appointments were available seven days a week on a pre-bookable basis. There was timely access to appointments once requested. The consultation appointment was only offered face to face.
- There was a complaints policy which provided information about handling complaints from patients. The service monitored complaints, compliments and suggestions to ensure that the services offered to meet the needs of their patients.

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 Requirement Notices at the end of this report).

This was because:

- There were some arrangements for identifying, recording and managing risks, issues and implementing mitigating actions. However, monitoring of specific areas such as gaps in recruitment checks, no electronic system to flag safeguarding concerns on vulnerable patients and the management of legionella risk were not always managed appropriately.
- There was a lack of clinical governance to monitor and drive quality improvement.
- There was no evidence of formal clinical supervision, mentorship or support.
- The provider's vision to deliver high quality care and promote good outcomes for patients was not always supported by effective governance processes.
- Service specific policies were available.

Summary of findings

- There was a leadership structure in place and staff felt supported by management.
- The service encouraged and valued feedback from patients and staff.

Luxmedica Ealing

Detailed findings

Background to this inspection

Luxmedica Limited provides a private, non-NHS service. The service is run by two directors, supported by a medical advisor, an operation manager and a CQC registered manager.

Services are provided from: Luxmedica Ealing, 19 The Mall, London, W5 2PJ. We visited this location as part of the inspection on 28 June 2018.

Online services can be accessed from the practice website: www.luxmedica.co.uk.

The service offers services for adults and children.

The service offers general practice services, dental services and gynaecology services including 4D scans for babies. On average they offer 250 doctor consultations per month, 165 dental consultations per month and 225 scans per month.

In addition, the service offers consultations (per month) with Cardiologist (2 per month), Dermatologist (6), Diabetologist (12), Endocrinologist (11), Haematologist (42), NET laryngologist (30), Orthopaedics (25), Urologist (25), Cryotherapy (5), Physiotherapist (8), Psychiatrist (17) and Psychologist (10 per month).

The service has core opening hours from 9am to 9pm Monday to Saturday and 10am to 5pm Sunday.

The service is registered with the Care Quality Commission to provide the regulated activities of diagnostic and screening procedures, treatment of disease, disorder and injury, and surgical procedures. This service is registered with CQC under the Health and Social Care Act 2008 in respect of the services it provides.

On 28 June 2018, our inspection team was led by a CQC Lead Inspector. The team included a GP specialist advisor. A dental CQC inspector and a dental specialist advisor were also present to inspect the dental services of the organisation. The team was also supported by a Polish translator.

A dental report has been published separately.

Pre-inspection information was gathered and reviewed before the inspection. We spoke with the directors, the medical advisor, the doctors and administrative staff. We collected written feedback from two members of staff. We looked at records related to patient assessments and the provision of care and treatment. We also reviewed documentation related to the management of the service. We reviewed patient feedback received by the 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.

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 provider had some systems to keep people safe and safeguarded from abuse. However, improvements were required.

- The provider had systems to safeguard children and vulnerable adults from abuse. Policies were regularly reviewed and were accessible. Staff we spoke with understood their responsibilities to protect patients from abuse, neglect, harassment, discrimination and breaches of their dignity and respect. However, staff we spoke with informed us the patient record system did not electronically alert clinical and reception staff to vulnerable patients.
- On the day of the inspection, the provider was unable to provide evidence that some doctors had received adult and level three child safeguarding training in line with intercollegiate guidance for all staff working in healthcare settings. Three doctors had received level two child safeguarding training. The service was not following their own child safeguarding policy which required all doctors to undertake level three child safeguarding training. Two administrative staff had not received child safeguarding training and three administrative staff and a phlebotomist had not received adult safeguarding training relevant to their role.
- The service treated children and had a system in place to ensure that children were protected. The provider informed us that only one GP was authorised to treat children in the service. The GP had received adult and level three child safeguarding training relevant to their role.
- The service had processes in place to ensure that all children under the age of 16 years old attended the appointment with parent or guardian who had parental responsibility for them and they must be accompanied at all times during consultation and treatment. The service offered consultations on a one to one basis to patients aged 16-18 unless they requested to be accompanied by a chaperone. The service had a policy in place which required evidence of parental responsibility to be provided before a child could be seen by the doctor.
- A notice in the waiting room advised patients that chaperones were available if required. All administrative staff who acted as chaperones were trained for their role.
- 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).
- The service carried out staff checks, including checks of professional registration where relevant, on recruitment and on an ongoing basis. However, the 10 staff files we reviewed across the service showed that appropriate recruitment checks had not been always undertaken prior to employment as documents to evidence satisfactory conduct in previous employment, in the form of references, contract of employment and health checks (satisfactory information about any physical or mental health conditions) were not available on the day of the inspection for some staff.
- There was an effective system to manage infection prevention and control. We observed that appropriate standards of cleanliness and hygiene were followed. The provider had carried out an infection control audit. The provider was unable to provide documentary evidence that eight clinical staff and all administrative staff had completed infection control training.
- There were systems for safely managing healthcare waste. There was a contract for the removal of clinical waste and we saw that clinical waste and sharps bins were appropriately managed.
- On registering with the service patient's identity was not always verified. Patients were able to register with the service by verbally providing a date of birth and address. They were able to pay by the bank account, debit or credit card and cash. Patients could choose to provide their debit or credit card details during the registration process.
- The provider had a formal documented business continuity plan in place.

Risks to patients

Are services safe?

- There were arrangements for planning and monitoring the number and mix of staff needed. Staff told us there were usually enough staff to maintain the smooth running of the service and there were always enough staff on duty to keep patients safe.
- The staff understood their responsibilities to manage emergencies on the premises and to recognise those in need of urgent medical attention. The staff knew how to identify and manage patients with severe infections, for example, sepsis.
- On the day of the inspection, the provider was unable to provide documentary evidence that six clinical staff had received annual basic life support training. All administrative staff had received annual basic life support training.
- The service had a defibrillator and oxygen available on the premises. The defibrillator pads, battery and the oxygen were all in date and the oxygen cylinder was full. A first aid kit and accident book were available.
- The doctors had a professional indemnity insurance that covered the scope of their practice.

Information to deliver safe care and treatment

- Individual care records were written and managed in a way that kept patients safe. Patient records and consultation notes were stored securely using an electronic record system. Staff used their login details to log into the operating system, which was a secure programme. The doctors had access to the patient's previous records held by the service. Any paper records were stored securely in the locked room in the locked cabinets.
- The care records we saw showed that information needed to deliver safe care and treatment was available to relevant staff in an accessible way.
- Risks related to patients' diagnoses and other health and wellbeing risks were recorded in patients' records.
- Referral letters included all of the necessary information.
- The service was registered with the Information Commissioner's Office.

Safe and appropriate use of medicines

The service had reliable systems for appropriate and safe handling of medicines.

- The systems for managing medicines, including medical gases, and emergency medicines and equipment minimised risks.
- The private prescriptions were handwritten on the letterhead which included a company name and other necessary information. These paper prescriptions were prescribed and signed by the doctor. All paper prescriptions were scanned and saved online along with the patient consultation notes.
- All medicines were prescribed based on clinical need on an acute basis.
- Once the doctor prescribed the medicine and dosage of choice, relevant instructions were given to the patient regarding when and how to take the medicine, the purpose of the medicine and any likely side effects and what they should do if they became unwell.
- The provider had a repeat prescribing policy but repeat prescriptions were rarely issued. Patients were advised to attend a follow up appointment with the service, without which the doctors would not prescribe further medicines.
- The service did not prescribe any controlled drugs or any high risk medicines which required regular monitoring.

Track record on safety

The provider had some safety systems in place, however, improvements were required.

- There was an up to date fire risk assessment and the service carried out fire drills. The fire extinguishers were serviced regularly and smoke alarm checks had been carried out.
- On the day of the inspection, the provider was unable to provide documentary evidence that 10 clinical staff across the service had received fire safety training. All administrative staff had received fire safety training.
- The fixed electrical installation checks of the premises had been carried out.
- All clinical equipment was checked and calibrated to ensure clinical equipment was safe to use and was in good working order.
- We noted that the safety of electrical portable equipment was assessed at the premises to ensure they were safe to use.
- The service had a variety of other risk assessments to monitor the safety of the premises such as control of substances hazardous to health (COSHH), gas safety

Are services safe?

checks and an asbestos survey was carried out. This helped it to understand risks and gave a clear, accurate and current picture of safety that led to safety improvements.

- A legionella (a bacterium which can contaminate water systems in buildings) risk assessment was carried out by an external contractor. The legionella risk assessment had identified a number of high risk areas and recommended actions to ensure safety in the premises. On the day of the inspection, the practice was not able to demonstrate that they had developed an action plan to address the risks identified in the legionella risk assessment. However, the provider informed us a week after the inspection that a contractor would visit the premises on 11 July 2018 to carry out the remedial work.
- On the day of the inspection, the provider was unable to provide documentary evidence that 10 clinical staff and four administrative staff across the service had completed health and safety training.

Lessons learned and improvements made

- There was an accident book and a general incident reporting form available at the reception. However, the system for the reporting of significant events was not fully implemented in the service. The doctors we spoke with on the day of inspection were not sure which template or form to use for the reporting of significant events.
- We reviewed the record of a significant event that had occurred during the last 12 months, which was completed on the Care Quality Commission statutory notification form.
- The service had signed up to receive patient and medicine safety alerts. They provided examples of alerts they had received.
- The provider was aware of and complied with the requirements of the Duty of Candour. The provider encouraged a culture of openness and honesty. The service had systems in place for knowing about notifiable safety incidents.

When there were unexpected or unintended safety incidents:

- The service gave affected people reasonable support, truthful information and a verbal and written apology.
- They kept written records of verbal interactions as well as written correspondence.

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

The provider assessed needs and delivered care in line with relevant and current evidence based guidance and standards such as the National Institute for Health and Care Excellence (NICE) best practice guidelines.

- The provider offered services for adults and children. The service ensured that all patients were seen face to face for their consultation. The service offered a 20 to 30 minute initial consultation with a doctor.
- All patients completed a medical questionnaire at their first visit which included information about their past medical history, personal details, date of birth, drug allergies and NHS GP details (plus consent to update NHS GP of all consultations details).
- The service used a comprehensive assessment process including a full life history account and necessary examinations such as blood tests or scans to ensure greater accuracy in the diagnosis process. The assessments were tailored according to information on each patient and included their clinical needs and their mental and physical wellbeing.
- The outcomes of each assessment were clearly recorded and presented with explanations to make their meaning clear, which included a discussion on the treatment options. If a patient needed further examination they were directed to an appropriate agency. If the provider could not deal with the patient's request, this was explained to the patient and a record kept of the decision.
- We reviewed five examples of medical records which which were complete records. We saw that adequate notes were recorded and the GPs had access to all previous notes.

An ultrasound scan service was offered onsite which included scans for babies carried out by gynaecologist. In addition, the scans were also carried out by orthopaedic and urologist consultants to help diagnose the causes of pain, swelling and infection in the body's internal organs. (An ultrasound scan is a procedure that used high-frequency sound waves to create an image of the inside of the body).

- All doctors who conduct the scan were appropriately trained to operate the equipment and analyse the scan results.
- The scans were offered for clinical diagnostic purposes only after the consultation with the doctors. The ultrasound examination was not performed as a result of an external referral.
- The provider had a documented protocol relating to the ultrasound scans. The medical advisor had overall clinical responsibility to ensure protocol was followed correctly. The provider had carried out a medical notes audit to check the quality of clinical records, consent obtained and record keeping of patients' involvement in making decisions about their care and treatment, which also included the ultrasound scans and appropriate onward referrals as required. The provider was planning to carry out a separate ultrasound scans audit to ensure all doctors were following the documented protocol.
- The baby scans were offered in addition to the NHS maternity pathway. All women were advised to attend their NHS scans as part of their maternity pathway. All women who undertake these scans were given verbal information about the potential risks to the unborn child from additional use of ultrasound during the pregnancy so they could make an informed decision before proceeding with the scan. The woman's consent to care and treatment was always obtained and documented. The service shared information with the woman's NHS GPs with their consent. However, the service was required to review the policy for offering the baby scans when consent to share information with the woman's NHS GP was not given. The medical advisor we spoke with informed us they would share the information if they did not detect the baby's heart beat or suspected a multiple pregnancy or a possible deformity. For example, the medical advisor had shared the concerns with a woman's NHS GP after the unexpected findings of lymphatic cyst (a form of vessel malformation).

Monitoring care and treatment

The service was not able to provide sufficient evidence of systematic improvement in patients' healthcare due to quality improvement activity.

- There were no prescribing audits to monitor the individual prescribing decisions, for example, to monitor their antibiotic prescribing, but individual patients on

prescribed medicines were monitored to identify the appropriateness of their medicines. The doctors advised patients what to do if their condition got worse and where to seek further help and support.

- The medical advisor had plans to carry out individual prescribing audits to improve patient outcomes; this was not in place at the time of our inspection.
- On the day of the inspection, the provider was not able to demonstrate evidence of completed clinical audit cycles to ensure effective monitoring and assessment of the quality of the service.
- There was limited evidence of quality improvement activity to review the effectiveness and appropriateness of the care provided. For example, the provider had carried out an audit of random prescriptions to check the accuracy and record keeping of patients' details, dosage, frequency and amount of medicines prescribed, and to ensure all prescriptions were legible, signed and dated by the doctors.
- The provider had carried out reviews of random consultation notes to monitor appropriateness of the care provided which included to ensure treatment options were discussed, decisions documented and consent obtained.
- We found the service was following up on pathology results and had an effective monitoring system in place to ensure that all abnormal results were managed in a timely manner and saved in the patient's records. Patients we spoke with on the day of inspection informed us that the service was very pro-active to follow up and discuss the scan or blood test results.

Effective staffing

Staff had the skills, knowledge and experience to carry out their roles. However, some improvements were required.

- The service was run by two directors, supported by a medical advisor, an operation manager and a CQC registered manager. The management was supported by a team of administrative staff to deal with telephone, email and face to face queries and book appointments.
- The doctors were registered with the General Medical Council (GMC) the medical professionals' regulatory body with a license to practice.
- The medical advisor was registered with the Independent Doctors Federation (IDF) the independent medical practitioner organisation in Great Britain. (IDF is recognised as the nationwide voice of independent doctors in all matters relating to private medicine, their education and revalidation).
- The doctors had a current responsible officer. (All doctors working in the United Kingdom are required to have a responsible officer in place and required to follow a process of appraisal and revalidation to ensure their fitness to practice). The doctors were following the required appraisal and revalidation processes. However, all the doctors were self-employed and did not receive any formal internal appraisal within the last 12 months.
- We saw the CQC registered manager had received an appraisal within the last 12 months and all other administrative staff had started recently and were not due an appraisal yet. Staff we spoke with informed us they received regular coaching, mentoring and support through regular meetings.
- The service was unable to provide documentary evidence to demonstrate that all staff had received ongoing training relevant to their role. Not all staff had received training that included: safeguarding children and adults, infection control, basic life support, health and safety, equality and diversity and fire safety training. The provider informed us they had booked an external trainer to deliver in-house training sessions in July 2018. The provider had the policy to individually assess each doctor at the start of their work with the service and they would be only allowed to work with the children if they had relevant safeguarding children training and experience.
- The service had not always kept the evidence of doctors' professional qualification in their staff files.

Coordinating patient care and information sharing

- Patients received coordinated and person-centred care.
- If a patient needed further examination they were directed to an appropriate agency; we noted examples of patients being signposted to their own GP as well as referral letters to private consultants.
- When a patient contacted the service, they were asked if the details of their consultation could be shared with their NHS GP. If the patient did not agree to the service sharing information with their GP, then in case of an emergency the provider discussed this again with the patient to seek their consent. However, there was

Are services effective?

(for example, treatment is effective)

inconsistency in communication with NHS GPs and not all the doctors we spoke with always shared consultation notes with the NHS GPs even after receiving the appropriate patient consent.
- Correspondence was shared with external professionals but the service did not always ensure that the data was protected. For example, information shared by email with external providers was not password protected in order to ensure data security.

Supporting patients to live healthier lives

The doctors were consistent and proactive in helping patients to live healthier lives.

- They encouraged and supported patients to be involved in monitoring and managing their health.
- They discussed changes to care or treatment with patients as necessary.
- Patients had access to appropriate health assessments and checks. Appropriate follow-ups for the outcomes of health assessments and checks were made, where abnormalities or risk factors were identified.

Consent to care and treatment

- The doctors understood and sought patients' consent to care and treatment in line with legislation and guidance. If a patient's mental capacity to consent to care or treatment was unclear we were told the doctor would assess the patient's capacity and record the outcome of the assessment.
- The service had a consent policy in place and the doctors had received training on consent.
- The doctors demonstrated a clear understanding of the Gillick competency test. (These are used to help assess whether a child under the age of 16 has the maturity to make their own decisions and to understand the implications of those decisions).
- We were told that any treatment including fees was fully explained to the patient prior to the procedure and that people then made informed decisions about their care.

Are services caring?

Our findings

We found that this service was providing caring services in accordance with the relevant regulations. However, we found areas where improvements should be made.

Kindness, respect and compassion

- The staff we spoke with was aware of their responsibility to respect people's diversity and human rights.
- Staff understood patients' personal, cultural, social and religious needs.
- The service gave patients timely support and information.
- We obtained the views of patients who used the service. We spoke with three patients and received 13 patient Care Quality Commission comment cards. All of the comment cards we received were positive about the service.
- Patients said they felt the provider offered an excellent service and the staff was helpful, caring and treated them with dignity and respect. They told us they were satisfied with the care provided by the provider and said their dignity and privacy was respected. They said staff responded compassionately when they needed help and provided support when required.
- We saw that staff treated patients respectfully and politely at the reception desk and over the telephone.

Involvement in decisions about care and treatment

- The service gave patients clear information to help them make informed choices including details of the scope of services offered and information on fees.
- We saw that treatment plans were personalised and patient specific which indicated patient were involved in decisions about care and treatment.
- Patients told us they felt listened to and supported by the doctor and had sufficient time during consultations to make an informed decision about the choice of treatment available to them.
- Feedback suggested that patients felt diagnosis and treatment options were explained clearly to them.
- 95% of the patients seen at the service were Polish. We found that interpretation services were not available for patients who did not have Polish or English as a first language. Patients were also told about the multi-lingual staff who might be able to support them.
- The service did not provide a hearing induction loop for those patients who were hard of hearing.

Privacy and Dignity

The service respected and promoted patients' privacy and dignity.

- Staff recognised the importance of patients' dignity and respect.
- The service complied with the Data Protection Act 1998.
- The service had a confidentiality policy in place and systems were in place to ensure that all patient information was stored and kept confidential. Staff were mindful and adherent to the provider's confidentiality policy when discussing patients' treatments.
- Staff knew that if patients wanted to discuss sensitive issues or appeared distressed they could offer them a private room to discuss their needs.
- We noted that consultation room doors were closed during consultations and that conversations taking place in these rooms could not be overheard.
- The service had arrangements in place to provide a chaperone to patients who needed one during consultations.

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. However, we found areas where improvements should be made.

Responding to and meeting people's needs

- Patient's individual needs and preferences were central to the planning and delivery of tailored services. Services were flexible, provided choice and ensured continuity of care.
- The provider offered consultations to anyone who requested and paid the appropriate fee, and did not discriminate against anyone. No membership had been offered at the service.
- The facilities and premises were appropriate for the services delivered. However, the premises was not accessible for patients with mobility issues. There were a number of steps going up to the premises main entrance and a number of additional steps inside the premises. The services were offered on the first and second floors. There was no lift or ramp in the premises. The space at the main entrance was limited and the provider informed us that it was not feasible to make structural changes in the premises. The patients were signposted to other similar services with wheelchair access. This information was available in the practice leaflet or discussed if a patient contacted them. The provider informed us they made reasonable arrangements when pushchairs users access the premises to enable them to receive treatment.
- The service had not carried out the Disabled Access Audit or Disability Discrimination Act (DDA) Audit. We discussed this with the provider and they assured us they would get one completed.
- There was a patients' leaflet which included arrangements for dealing with complaints, information regarding access to the service, consultation and treatment fees, terms and conditions, and a cancellation policy.
- The service website was well designed, clear and simple to use featuring regularly updated information. The service website included a translation facility.

Timely access to the service

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

- Patients had timely access to initial assessment, test results, diagnosis and treatment. Patients were offered various appointment dates to help them arrange for suitable times to attend.
- Waiting times, delays and cancellations were minimal and managed appropriately.
- The appointment system was easy to use. Appointments were available on a pre-bookable basis. The service only offered face to face consultations.
- Consultations were available between 9am to 9pm Monday to Saturday and 10am to 5pm Sunday. The provider was flexible to accommodate consultations if required for working patients who could not attend during normal opening hours.
- Patients could access the service in a timely way by making their appointment over the telephone, in person or online.
- This service was not an emergency service. Patients who had a medical emergency were advised to ask for immediate medical help via 999 or if more appropriate to contact their own GP or NHS 111.
- The patient feedback we received confirmed they had flexibility and choice to arrange appointments in line with other commitments.

Listening and learning from concerns and complaints

The service had a system in place for handling complaints and concerns.

- The service had a complaints policy and there were procedures in place for handling complaints. The policy contained appropriate timescales for dealing with the complaint. There was a designated responsible person to handle all complaints.
- The complaints policy included information of the complainant's right to escalate the complaint to the Centre for Effective Dispute Resolution (CEDR), the General Medical Council (GMC), the Nursing and Midwifery Council (NMC) and the Care Quality Commission (CQC) if dissatisfied with the response.
- Information about how to make a complaint was available on the service's website and on the patients leaflet.
- We looked at 10 complaints received in the last 12 months and found that all complaints had been addressed in a timely manner and patients received a satisfactory response. There was evidence that the

Are services responsive to people's needs?

(for example, to feedback?)

service had provided an apology when required. However, complaint responses did not always include information of the complainant's right to escalate the complaint if dissatisfied with the response.

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

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

- Leaders were knowledgeable about issues and priorities relating to the quality and future of services. They understood the challenges to run the service.
- Leaders at all levels were visible and approachable. They worked closely with staff and others to make sure they prioritised compassionate and inclusive leadership.
- The service was run by two directors, supported by a medical advisor, an operation manager and a CQC registered manager. The medical advisor, who was a UK based GMC registered doctor, had overall responsibility for any medical issues arising. However, the new medical advisor was recently appointed and was in the process of implementing changes.

Vision and strategy

- The provider had a clear vision to provide a high-quality and effective healthcare service.
- The provider had a mission statement which included to provide the highest professional and excellent primary care services to enhance the quality of life and well-being, and treat all patients, carers and staff with dignity, respect and honesty.

Culture

- The service had an open and transparent culture. We were told that if there were unexpected or unintended safety incidents, the service would give affected patients reasonable support, truthful information and a verbal and written apology.
- The provider was aware of and had systems to ensure compliance with the requirements of the duty of candour. (The duty of candour is a set of specific legal requirements that providers of services must follow when things go wrong with care and treatment).
- The service focused on the needs of patients.
- Staff we spoke with told us they were able to raise concerns and were encouraged to do so. They had confidence that these would be addressed.
- There were positive relationships between staff and the leaders.
- There were processes for providing all staff with the development they need. However, the provider was unable to provide documentary evidence that all staff had completed training relevant to their role and all the doctors did not receive any formal internal appraisal within the last 12 months.

Governance arrangements

The service had a governance framework but this did not support the delivery of safe and effective care.

- There was a lack of good clinical governance to ensure effective monitoring and assessment of the quality of the service.
- There was limited evidence of quality improvement activity. For example, there was no programme of clinical audit cycles which was making it difficult to identify improvement areas and monitor continuous progress effectively. There were no medicine audits to monitor the quality of prescribing.
- The system for the reporting of significant events was not fully implemented in the service and staff we spoke with were not sure which template or form to use.
- There was a clear staffing structure and staff were aware of their own roles and responsibilities.
- Service specific policies were implemented and were available to all staff.

Managing risks, issues and performance

There were processes in place for managing risks, however, improvements were required.

- There were some arrangements for identifying, recording and managing risks, issues and implementing mitigating actions. However, monitoring of specific areas such as gaps in recruitment checks, no electronic system to flag safeguarding concerns on vulnerable patients and the management of legionella risk were not always managed appropriately.
- Service leaders had oversight of MHRA alerts and complaints.
- The service had insufficient quality monitoring processes to manage clinicians' performance. Performance of self-employed clinical staff could not be demonstrated through the audit of their consultations, prescribing and referral decisions.

Are services well-led?

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

- There was no peer review system in place.
- There were some checks in place to monitor the performance of the service.
- The service had plans in place and had trained staff for major incidents.

Appropriate and accurate information

The service acted on the appropriate and accurate information.

- Patient assessments, treatments and medications, including ongoing reviews of their care, were recorded on a secure electronic system. We reviewed anonymised assessment reports where a diagnosis was made. We found that the assessments included clear information and recommendations. The doctors responsible for monitoring patients' care were able to access notes from all the previous consultations.
- Care and treatment records were complete, legible and accurate, and securely kept.
- There were some arrangements in line with data security standards for the availability, integrity and confidentiality of patient identifiable data, records and data management systems. However, the system for dealing with patient correspondence by email with external providers was not password protected and did not ensure the safe sharing and delivery of sensitive information.
- The service was registered with the Information Commissioners Office (ICO).

Engagement with patients, the public, staff and external partners

The service encouraged and valued feedback from patients and staff.

- Comments and feedback were encouraged and reviewed. The service had carried out patients survey in August 2017 and staff survey in May 2017. This was highly positive about the quality of service patients received and staff satisfaction levels.
- The provider had implemented changes to improve the service following the feedback from the patients. For example, the provider had reminded all the clinicians to always ask for a permission before carrying out any physical examination.
- The service had initiated an online networking tool to communicate quickly with staff members. This networking platform was used to share information, staffing matters and monitor the resources.
- Staff meetings were held regularly which provided an opportunity for staff to learn about the performance of the service.
- The service was transparent, collaborative and open with stakeholders about performance.
- The provider had a whistleblowing policy in place. (A whistle-blower is someone who can raise concerns about practice or staff within the organisation.)

Continuous improvement and innovation

- The service consistently sought ways to improve. All staff were involved in discussions about how to run and develop the service.
- There was a focus on continuous learning and improvement. However, improvements were required.
- The doctors we spoke with informed us that they could raise concerns and discuss areas of improvement with the directors as and when required. All doctors were encouraged to identify opportunities to improve the service delivered.
- The new medical advisor was planning to introduce new monitoring protocols to ensure continuous improvement.

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 Surgical procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance **How the regulation was not being met:** • The provider did not have effective governance, assurance and auditing processes 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 clinical governance and we found breaches of regulation that had not been identified by the practice prior to inspection, which demonstrated that governance monitoring procedures were not always carried out consistently and effectively. • There was a limited evidence of quality improvement activity to review the effectiveness and appropriateness of the care provided. • There was insufficient quality monitoring of clinicians' performance. Individual prescribing decisions were not monitored or reviewed by the medical advisor. There was no evidence of formal clinical supervision, mentorship or support. The provider was unable to demonstrate that all the doctors had received an internal appraisal within the last 12 months. • The system for the reporting of significant events was not fully implemented in the service. The doctors we spoke with were not sure which template or form to use for the reporting of significant events. • The provider had not ensured that the information shared by email with external providers was password protected in order to ensure data security. • The provider was unable to demonstrate that all actions required in response to current legionella risk assessment were completed in a timely manner to address the risks identified in the risk assessment. • The provider was unable to demonstrate that they had undertaken appropriate recruitment checks prior to

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Requirement notices

employment. Evidence of satisfactory conduct in previous employment in the form of references, health checks and contracts of employment were not available for some staff.

- The service had not always kept the evidence of doctors' professional qualification in their staff files.
- The provider was unable to provide documentary evidence to demonstrate that all staff had received training suitable to their role, that included: safeguarding children and adults, infection control, basic life support, health and safety, equality and diversity and fire safety training.

Regulation 17(1)