# Luxmedica Ealing

## Inspection report

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

## Ratings

| Overall rating for this location | Good |
|---|---|
| Are services safe? | Requires improvement |
| Are services effective? | Good |
| Are services caring? | Good |
| Are services responsive? | Good |
| Are services well-led? | Good |

# Overall summary

**This service is rated as** Good **overall.** (This service was previously inspected in June 2018).

The key questions are rated as:

Are services safe? – Requires improvement

Are services effective? – Good

Are services caring? – Good

Are services responsive? – Good

Are services well-led? – Good

We carried out an announced comprehensive inspection at Luxmedica Ealing as part of our inspection programme, to follow up on breaches of regulations.

Our previous inspection in June 2018 found breaches of regulations relating to the safe, effective and well-led services. We found:

- There was a lack of good governance and limited evidence of quality improvement activity.
- Prescribing was not audited or reviewed to identify areas for quality improvement.
- There was insufficient quality monitoring of clinicians' performance.
- Risks to patients were assessed and well managed in some areas, with the exception of those relating to 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.

Previous reports on this service can be found on our website at: https://www.cqc.org.uk/location/1-2220453542

At this inspection, we found that the service had demonstrated improvements in most areas, however, they were required to make further improvements in some areas and are rated as requires improvement for providing safe services.

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 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 which were not included inspection.

The practice manager is going to be the new registered manager. They have submitted an application in May 2019 which is going through the registration process. 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 received 23 patient Care Quality Commission comment cards. All of the 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:**

- The service had reviewed and improved their clinical governance systems.
- The service was involved in quality improvement activity.
- The service had implemented systems to undertake quality monitoring of clinicians' performance.
- Risks to patients were assessed and well managed in most areas, with the exception of those relating to appropriate recruitment checks, child safeguarding training and fire evacuation plan.
- Care and treatment records were complete, legible and accurate, and securely kept.
- Consent procedures were in place and these were in line with legal requirements.
- Systems were in place to protect personal information about patients.
- Appointments were available seven days a week on a pre-bookable basis. The service provided only face to face consultations.
- The premises was not accessible for patients with mobility issues.
- Staff involved and treated patients with compassion, kindness, dignity and respect.
- The service had gathered feedback from the patients.
- Information about services and how to complain was available.
- The provider was aware of and complied with the requirements of the Duty of Candour.

# Overall summary

- There was a clear leadership structure and staff felt supported by management.
- We noted that the previous Care Quality Commission inspection report had not been shared on the service's website. However, the service informed us that it was shared on the service's website two weeks after the inspection and we noted it was shared on the website.

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

- Ensure care and treatment is provided in a safe way to patients.

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

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

- Consider arranging a translation service and displaying information in the reception area informing patients this service is available.
- Consider a response to complaints includes information of the complainant's right to escalate the complaint if dissatisfied with the response.

**Dr Rosie Benneyworth BM BS BMedSci MRCGP**Chief Inspector of Primary Medical Services and Integrated Care

## Our inspection team

Our inspection team was led by a CQC lead inspector**.**
The team included a GP specialist adviser.

## Background to Luxmedica Ealing

Luxmedica Limited provides a private, non-NHS service. Luxmedica Ealing started in September 2015 and has two directors who run the service. The service employs a number of self-employed doctors. All doctors are on the General Medical Council (GMC) register and have indemnity insurance to cover their work.

Services are provided from: Luxmedica Ealing, 19 The Mall, London, W5 2PJ. We visited this location as part of the inspection on 6 June 2019.

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

The service offers general practice services, dental services and gynaecology services including scans for babies. On average they offer 700 doctor consultations (non-dental) per month. The service offers consultations with Cardiologist, Dermatologist, Diabetologist, Endocrinologist, Haematologist, NET laryngologist, Orthopaedics, Urologist, Cryotherapy, Physiotherapist, Psychiatrist and Psychologist.

The service also offers dental care and treatment, but that did not form part of this inspection.

The service has core opening hours from 9am to 9pm Monday to Saturday and 10am to 4pm Sunday. The service offers services for adults and children.

The service is registered with the Care Quality Commission to provide the regulated activities of diagnostic and screening procedures, treatment of disease, disorder or 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.

**How we inspected this service**

Pre-inspection information was gathered and reviewed before the inspection. We spoke with two directors, two doctors, a practice manager and an administrative 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. We reviewed staff written feedback collected on the day of the inspection.

To get to the heart of patients' experiences of care and treatment, we always ask the following five questions:

- Is it safe?
- Is it effective?
- Is it caring?
- Is it responsive to people's needs?
- Is it well-led?

These questions therefore formed the framework for the areas we looked at during the inspection.

Requires improvement

# Are services safe?

When we inspected the practice in June 2018, we found that this service was not providing safe care in accordance with the relevant regulations. Specifically, we found:

- Risks to patients were assessed and well managed in some areas, with the exception of those relating to 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.
- The system for the reporting of significant events was not fully implemented in the service.
- The service had not ensured that the information shared by email with external providers was password protected in order to ensure data security.

At this inspection in June 2019, we found improvements had been made. However, the service was required to make further improvements.

**We rated safe as Requires improvement because:**

- The service had not always undertaken appropriate recruitment checks prior to employment. This issue was also highlighted during the previous inspection.
- Not all staff had received child safeguarding training relevant to their role in line with intercollegiate guidance for all staff working in healthcare settings.
- The fire evacuation plan had not included satisfactory information on how staff could support patients with mobility problems to vacate the premises nor had the provider carried out a documented risk assessment for such a situation.

**Safety systems and processes**

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

- The service conducted safety risk assessments. It had appropriate safety policies, which were regularly reviewed and communicated to staff. They outlined clearly who to go to for further guidance. Staff received safety information from the service as part of their induction and refresher training. The service had systems to safeguard children and vulnerable adults from abuse. The patient record system electronically alerted clinical and reception staff to vulnerable patients.
- The service had systems in place to assure that an adult accompanying a child had parental authority.
- The service worked with other agencies to support patients and protect them from neglect and abuse. Staff took steps to protect patients from abuse, neglect, harassment, discrimination and breaches of their dignity and respect.
- The service carried out most staff checks at the time of recruitment, including checks of professional registration where relevant. However, the four staff files we reviewed showed that appropriate documents to evidence satisfactory conduct in previous employment, in the form of recent references at the time of recruitment were not available on the day of the inspection. This issue was highlighted during the previous inspection. The service had recruited a clinical member of staff in September 2018 and they were relying on the references issued in 2014 and 2016. These references were not requested by the provider for the role the member of staff was recruited for. This meant the provider could not be assured they had up to date and the most relevant information about the individual they had employed to carry out regulated activities.
- Disclosure and Barring Service (DBS) checks were undertaken where required. (DBS checks identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable).
- All staff had received child safeguarding training relevant to their role in line with intercollegiate guidance for all staff working in healthcare settings, with the exception of two doctors, who had not undertaken level three child safeguarding training. However, they had received level two child safeguarding training and did not treat children at the service.
- Staff knew how to identify and report concerns. Staff who acted as chaperones were trained for the role and had received a DBS check.
- There was an effective system to manage infection prevention and control. We observed that appropriate standards of cleanliness and hygiene were followed. The service had carried out an infection control audit.
- The service ensured that facilities and equipment were safe and that equipment was maintained according to manufacturers' instructions. There were systems for safely managing healthcare waste.

Requires improvement

# Are services safe?

- The provider carried out appropriate environmental risk assessments, which took into account the profile of people using the service and those who may be accompanying them.
- The service had a formal documented business continuity plan in place.
- There were effective protocols for verifying the identity of patients including children.

**Risks to patients**

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

- There were arrangements for planning and monitoring the number and mix of staff needed.
- There was an effective induction system for staff tailored to their role.
- Staff understood their responsibilities to manage emergencies and to recognise those in need of urgent medical attention. They knew how to identify and manage patients with severe infections, for example sepsis.
- The 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.
- All staff had received basic life support training. We noted seven out of 15 doctors had received face to face basic life support training.
- When there were changes to services or staff the service assessed and monitored the impact on safety.
- There were appropriate indemnity arrangements in place to cover all potential liabilities.

**Information to deliver safe care and treatment**

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

- Individual care records were written and managed in a way that kept patients safe. The care records we saw showed that information needed to deliver safe care and treatment was available to relevant staff in an accessible way.
- 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 service had a system in place to retain medical records in line with Department of Health and Social Care (DHSC) guidance in the event that they cease trading.
- The service had systems for sharing information with staff and other agencies to enable them to deliver safe care and treatment.
- Clinicians made appropriate and timely referrals in line with protocols and up to date evidence-based guidance.
- 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 and arrangements for managing medicines, including vaccines, controlled drugs, 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 the clinical need on an acute basis. Staff prescribed medicines to patients and gave advice on medicines in line with legal requirements and current national guidance. Processes were in place for checking medicines and staff kept accurate records of medicines. Where there was a different approach taken from national guidance there was a clear rationale for this that protected patient safety.
- 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 carried out regular medicines audit to ensure prescribing was in line with best practice guidelines for safe prescribing.

Requires improvement

# Are services safe?

- The service did not prescribe any controlled drugs or any high risk medicines which required regular monitoring.

**Track record on safety and incidents**

**The service had a good safety record. However, some improvements were required.**

- There were comprehensive risk assessments in relation to safety issues.
- 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. However, we noted the fire evacuation plan had not included satisfactory information on how staff could support patients with mobility problems to vacate the premises nor had the provider carried out a documented risk assessment for such a situation.
- 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 monitored and reviewed activity. This helped it to understand risks and gave a clear, accurate and current picture that led to safety improvements.
- The service had up to date legionella risk assessment in place and regular water temperature checks had been carried out. (Legionella is a term for a particular bacterium which can contaminate water systems in buildings).

**Lessons learned and improvements made**

**The service learned and made improvements when things went wrong.**

- There was a system for recording and acting on significant events. Staff understood their duty to raise concerns and report incidents and near misses. Leaders and managers supported them when they did so.
- There were adequate systems for reviewing and investigating when things went wrong. The service learned and shared lessons identified themes and took action to improve safety in the service. For example, the service had reviewed their healthcare waste storage arrangements after an incident when waste storage space was left unlocked.
- The service 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.
- The service acted on and learned from external safety events as well as patient and medicine safety alerts. The service had an effective mechanism in place to disseminate alerts to all members of the team including sessional and agency staff.

Good

# Are services effective?

When we inspected the practice in June 2018, we found that this service was not providing effective services in accordance with the relevant regulations. Specifically, we found:

- There was limited evidence of quality improvement activity to review the effectiveness and appropriateness of the care provided.
- The provider was unable to provide documentary evidence to demonstrate that all staff had received training suitable to their role.
- Not all staff had received an internal appraisal within the last 12 months.

At this inspection in June 2019, we found improvements had been made.

**We rated effective as Good because:**

**Effective needs assessment, care and treatment**

**The service had systems to keep clinicians up to date with current evidence based practice.**

- The service 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.
- Patients' immediate and ongoing needs were fully assessed. Where appropriate this included their clinical needs and their mental and physical wellbeing.
- 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 service could not deal with the patient's request, this was explained to the patient and a record kept of the decision.
- Clinicians had enough information to make or confirm a diagnosis. We reviewed 25 examples of medical records which were complete records. We saw that adequate notes were recorded and the doctors had access to all previous notes. Consultation notes and the scan results were documented in the English language.
- We saw no evidence of discrimination when making care and treatment decisions.
- Staff assessed and managed patients' pain where appropriate.

An ultrasound scan service was offered onsite which included scans for babies carried out by gynaecologists. 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 service had a documented protocol relating to the ultrasound scans. The medical advisor had overall clinical responsibility to ensure protocol was followed correctly.
- 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 undertook 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. The service had

developed a protocol to consider how they would manage the risk (when consent to share information was not given) if a significant abnormality was detected during the baby scans.

**Monitoring care and treatment**

**The service was actively involved in quality improvement activity**.

- The service had appointed an internal medical advisor in January 2018 and an external medical advisor in November 2018. The service had implemented an effective system to assess and monitor the quality and appropriateness of the care provided.
- There was evidence of quality improvement activity to ensure effective monitoring and assessment of the quality of the service. For example, the service 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 service had carried out an ultrasound scans audit to ensure all doctors were following the documented protocol.
- The service had carried out prescribing audits to monitor the individual prescribing decisions.
- The service was not responsible for managing patients with long-term conditions and they were referred to their NHS GP or other private consultants with their consent.
- Patients' health was monitored to ensure medicines were being used safely and followed up on appropriately. Patients were required to attend a periodic check with the service, without which the doctor would not prescribe further medicines.
- The doctor advised patients what to do if their condition got worse and where to seek further help and support.

**Effective staffing**

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

- The service was run by two directors, supported by an internal medical advisor, an external medical advisor, a practice manager (going to be a CQC registered manager) and a reception 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 licence to practice.
- The internal 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. All the doctors were self-employed and had received internal appraisal within the last 12 months.
- All staff were appropriately qualified. The provider had an induction programme for all newly appointed staff.
- The service understood the learning needs of staff and provided protected time and training to meet them. Up to date records of skills, qualifications and training were maintained. Most staff had received training relevant to their role.

**Coordinating patient care and information sharing**

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

- Patients received coordinated and person-centred care. 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.
- Before providing treatment, doctors at the service ensured they had adequate knowledge of the patient's health, any relevant test results and their medicines history. The service informed us they would signpost patients to more suitable sources of treatment where this information was not available to ensure safe care and treatment.

Good

# Are services effective?

- The service had risk assessed the treatments they offered. They had identified medicines that were not suitable for prescribing. For example, medicines liable to abuse or misuse, and those for the treatment of long term conditions such as asthma.
- All patients were asked for consent to share details of their consultation and any medicines prescribed with their registered GP on each occasion they used the service.
- 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. We saw an example of consultation notes having been shared with the GP with the appropriate patient consent. The service had developed a protocol for following up on patients who have been referred back to their NHS GP.
- The service had developed a protocol to consider how they would manage the risk when consent to share information was not given.
- Patient information was shared appropriately, and the information needed to plan and deliver care and treatment was available to relevant staff in a timely and accessible way.

**Supporting patients to live healthier lives**

**Staff were consistent and proactive in empowering patients, and supporting them to manage their own health and maximise their independence.**

- Where appropriate, staff gave people advice so they could self-care. 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.
- Where patients needs could not be met by the service, staff redirected them to the appropriate service for their needs.

**Consent to care and treatment**

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

- Staff understood the requirements of legislation and guidance when considering consent and decision making.
- Staff supported patients to make decisions. Where appropriate, they assessed and recorded a patient's mental capacity to make a decision.
- The service monitored the process of seeking consent appropriately.
- 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).

Good

# Are services caring?

**We rated caring as Good because:**

**Kindness, respect and compassion**

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

- Staff understood patients' personal, cultural, social and religious needs. They displayed an understanding and non-judgmental attitude to all patients.
- The service gave patients timely support and information.
- We obtained the views of patients who used the service. We received 23 patient Care Quality Commission comment cards. All of the comment cards we received were positive about the service. We did not speak to patients directly on the day of the inspection.
- Feedback from patients was positive about the way staff treat people. Patients said they felt the provider offered excellent service and the staff was helpful, caring and treated them with dignity and respect. 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.
- The service had collected internal patient feedback. The results showed the service was performing well and the patients were satisfied with the service.

**Involvement in decisions about care and treatment**

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

- Patients told us through comment cards, that they felt listened to and supported by staff and had sufficient time during consultations to make an informed decision about the choice of treatment available to them.
- Staff communicated with people in a way that they could understand, for example, communication aids and easy read materials were available.
- The service provided a hearing induction loop for those patients who were hard of hearing.
- Comprehensive information was given about treatments available and the patients were involved in decisions relating to this.
- 90% 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.
- At each appointment, patients were informed which treatments were available at no cost through the NHS.
- 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.

**Privacy and Dignity**

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

- Staff recognised the importance of people's dignity and respect.
- Staff knew that if patients wanted to discuss sensitive issues or appeared distressed they could offer them a private room to discuss their needs.
- The service had a confidentiality policy in place and systems were in place to ensure that all patient information was stored and kept confidential.

Good

# Are services responsive to people's needs?

**We rated responsive as Good because:**

**Responding to and meeting people's needs**

**The service organised and delivered services to meet patients' needs. It took account of patient needs and preferences.**

- Patients' 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 were 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 carried out a Disabled Access Audit or Disability Discrimination Act (DDA) Audit on 3 July 2018.
- 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 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 appropriate timescale for their needs.**

- Patients had timely access to the 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 4pm 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 took complaints and concerns seriously and responded to them appropriately to improve the quality of care.**

- 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. However, it did not include information of the complainant's right to escalate the complaint to the Independent Doctors Federation (IDF) and Independent Healthcare Sector Complaints Adjudication Service (ISCAS) if dissatisfied with the response.

Good

# Are services responsive to people's needs?

- Information about how to make a complaint was available on the service's website and on the patient's leaflet.
- We looked at 11 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 service had provided an apology when required and refunded the consultation charges. However, complaint responses did not always include information of the complainant's right to escalate the complaint if dissatisfied with the response.

Good

# Are services well-led?

When we inspected the practice in June 2018, we found that this service was not providing well-led care in accordance with the relevant regulations. Specifically, we found:

- There was a lack of effective clinical leadership.
- There was a lack of good governance.
- There was insufficient quality monitoring of clinicians' performance.

At this inspection in June 2019, we found improvements had been made.

**We rated well-led as Good because:**

**Leadership capacity and capability**

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

- Leaders were knowledgeable about issues and priorities relating to the quality and future of services. They understood the challenges and were addressing them.
- 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 provider had effective processes to develop leadership capacity and skills, including planning for the future leadership of the service.

**Vision and strategy**

**The service had a clear vision and credible strategy to deliver high quality care and promote good outcomes for patients.**

- There was a clear vision and set of values. The service had a realistic strategy and supporting business plans to achieve priorities.
- Staff were aware of and understood the vision, values and strategy and their role in achieving them
- The service monitored progress against delivery of the strategy.
- The service 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 a culture of high-quality sustainable care.**

- Staff felt respected, supported and valued. They were proud to work for the service.
- The service focused on the needs of patients.
- Leaders and managers acted on behaviour and performance inconsistent with the vision and values.
- Openness, honesty and transparency were demonstrated when responding to incidents and complaints. The provider was aware of and had systems to ensure compliance with the requirements of the duty of candour.
- Staff told us they could raise concerns and were encouraged to do so. They had confidence that these would be addressed.
- There were processes for providing all staff with the development they need. This included appraisal and career development conversations. All staff received regular annual appraisals in the last year. Staff were supported to meet the requirements of professional revalidation where necessary. Clinical staff were considered valued members of the team. They were given protected time for professional development and evaluation of their clinical work.
- There was a strong emphasis on the safety and well-being of all staff.
- The service actively promoted equality and diversity. It identified and addressed the causes of any workforce inequality. Staff had received equality and diversity training. Staff felt they were treated equally.
- There were positive relationships between staff and teams.

**Governance arrangements**

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

- The service had reviewed and amended its clinical governance systems. At this inspection, we found improvements had been made.
- Structures, processes and systems to support good governance and management were clearly set out, understood and effective. For example, the service had carried out audits to ensure safe prescribing guidelines were followed. They had carried out prescribing audit to monitor the quality of prescribing.
- Staff were clear on their roles and accountabilities.

Good

# Are services well-led?

- Leaders had established proper policies, procedures and activities to ensure safety and assured themselves that they were operating as intended, with the exception of those related to appropriate recruitment checks prior to employment.

**Managing risks, issues and performance**

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

- There was an effective, process to identify, understand, monitor and address most current and future risks including risks to patient safety, with the exception of those related to the fire evacuation plan which had not included satisfactory information or they had not carried out a documented risk assessment to identify how staff could support patients with mobility problems to vacate the premises.
- The service had processes to manage current and future performance. Performance of clinical staff could be demonstrated through audit of their consultations, prescribing and referral decisions. Leaders had oversight of safety alerts, incidents, and complaints.
- There was evidence of quality improvement activity to review the effectiveness and appropriateness of the care provided.
- The service informed us they had regular meetings. There was a range of minuted meetings held centrally and available for staff to review. We reviewed copies of some of these meetings.
- There was a peer review system in place.
- The service had plans in place and had trained staff for major incidents.

**Appropriate and accurate information**

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

- Quality and operational information was used to ensure and improve performance. Performance information was combined with the views of patients.
- Quality and sustainability were discussed in relevant meetings where all staff had sufficient access to information.
- The service used performance information which was reported and monitored and management and staff were held to account
- The information used to monitor performance and the delivery of quality care was accurate and useful. There were plans to address any identified weaknesses.
- There were robust arrangements in line with data security standards for the availability, integrity and confidentiality of patient identifiable data, records and data management systems.

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

**The service involved patients and staff to support high-quality sustainable services.**

- The service encouraged and heard views and concerns from the patients and staff. The service had carried out a survey (based on the national GP survey pattern) in March/ April 2019 and compared the findings with the local practices. This was highly positive about the quality of service patients received and staff satisfaction levels. They had developed an action plan to shape services and culture. The service was in the process of implementing changes. For example, the service was in discussion with the doctors to increase the number of appointments in the late evening. They had reminded all reception staff to follow up on all missed calls and voice messages in a timely manner.
- 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**

**There were evidence of systems and processes for learning and continuous improvement.**

- There was a focus on continuous learning and improvement.
- The service made use of internal and external reviews of incidents and complaints. Learning was shared and used to make improvements.

Good

# Are services well-led?

- Leaders and managers encouraged staff to take time out to review individual and team objectives, processes and performance.

This section is primarily information for the provider

# Requirement notices

## Action we have told the provider to take

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

| Regulated activity | Regulation |
|---|---|
| Diagnostic and screening procedures<br>Surgical procedures<br>Treatment of disease, disorder or injury | Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment<br>**How the regulation was not being met:**<br>We found the registered person did not have suitable arrangements in place for assessing and managing risks in order to protect the welfare and safety of service users and others who may be at risk from the carrying on of the regulated activity. In particular:<br>• The service had not always undertaken appropriate recruitment checks prior to employment. This issue was also highlighted during the previous inspection.<br>• Not all staff had received child safeguarding training relevant to their role in line with intercollegiate guidance for all staff working in healthcare settings.<br>• The fire evacuation plan had not included satisfactory information on how staff could support patients with mobility problems to vacate the premises nor had the provider carried out a documented risk assessment for such a situation..<br>This was in breach of regulation 12(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. |