Susan Mary Horsewood-Lee

Susan Mary Horsewood-Lee - Oakley Street

Inspection report

34 Oakley Street
Chelsea
London
SW3 5NT
Tel: 020 7352 6748
Website: www.chelseadoctor.com

Date of inspection visit: 27 April 2018 and 10 May 2018
Date of publication: 20/07/2018

Overall summary

We carried out an announced comprehensive inspection on 27 April 2018 and 10 May 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 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.

Dr Susan Horsewood-Lee provides a private doctors GP service to patients at 34 Oakley Street in the Royal Borough of Kensington and Chelsea. The service is situated in premises which are owned by the provider.

Prior to our inspection, patients completed CQC comment cards telling us about their experiences of using the service. Eighty-one people provided wholly positive feedback about the service. Dr Horsewood-Lee was described as caring, attentive and efficient.

Our key findings were:

- There were arrangements in place to keep patients safeguarded from abuse.
- There was minimal evidence that the service assessed and managed risks so that safety incidents were less likely to happen; a number of health and safety and premises risk assessments had not been carried out.

Summary of findings

- The premises were clean and hygienic; however, no infection control audits of the service environment or infection control training of staff had been completed.
- There was minimal evidence of suitable arrangements for assessing and managing fire risk.
- Procedures for managing medical emergencies, including access to emergency medicines and equipment, was not safe. There were limited arrangements to identify, learn and improve where things had gone wrong. There was a policy for reporting incidents, however in some cases, these arrangements required a review in order to ensure that they effectively mitigated all risks.
- There was some evidence that the provider acted on safety and medicines alerts. However, the service did not have a process to manage patient safety alerts. There was no record kept of the action taken in response to patient safety alerts, and the service was unable to demonstrate that they had an effective process to manage these.
- The service delivered care according to evidence-based guidelines; however, they did not have processes in place to monitor how guidelines were followed.
- The service had a number of policies and procedures, most of which had not been reviewed and updated to reflect day to day practice in the service.
- Governance arrangements were not in place to ensure effective oversight of risk. There was minimal evidence of processes to monitor and improve quality and identify risk.
- There was some evidence of systems to improve quality of care and treatment for patients.
- The provider had a system for managing written complaints.
- Patients found it easy to access appointments with the doctor.
- Staff involved and treated patients with compassion, kindness, dignity and respect.
- Patient feedback for the services offered was consistently positive.

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

- Ensure care and treatment is provided in a safe way to patients.
- Establish effective systems and processes to ensure good governance in accordance with the fundamental standards of care.

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

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

- Review the need to have a written policy in place covering fitting contraceptive devices including managing complications after coil insertion.
- Review the need to carry out a formal written assessment, which is kept under review, to identify which emergency medicines it is and is not suitable for the practice to stock, and to keep appropriate records of checking expiry dates of those medicines.
- Review the need for arrangements to assist patients with communication needs.
- Review the need for guidance on checks of patient identity and, where appropriate, the responsible adult's identity.
- Review the need for a structured quality improvement programme that monitored the effectiveness of changes made to the service provided.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

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

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

- The provider had policies and procedures in place to safeguard people from abuse.
- The service did not have clearly defined systems and practices for effectively identifying, understanding, monitoring and addressing current and future risks; a number of health and safety and premises risk assessments had not been carried out.
- The premises were clean and hygienic; however, no infection control audits of the service environment or infection control training of staff had been completed.
- There was minimal evidence of suitable arrangements for assessing and managing fire risk.
- The provider did not have clear procedures for managing medical emergencies, including access to emergency medicines and equipment.
- There were safe systems for management of vaccines and prescribing of medicines.
- There were limited arrangements to identify, learn and improve where things had gone wrong. There was a policy for reporting incidents, however no incidents had been reported.
- The service had a number of policies and procedures, most of which had not been reviewed and updated to reflect day to day practice in the service.
- The provider did not have formal arrangements for verifying patients' identity.
- There was some evidence that the provider acted on safety and medicine alerts.

Are services effective?
We found that this service was providing effective care in accordance with the relevant regulations.

- The service delivered care according to evidence-based guidelines; however, they did not have processes in place to monitor how guidelines were followed.
- We found some evidence of quality improvement measures including case reviews; however, there was minimal evidence of clinical audit and there was no evidence of action to change practice.
- The provider did not have evidence of appropriate safety training, including infection control, fire safety and information governance.
- There was evidence of professional development for the doctor and evidence of appraisal.
- There were arrangements for communicating with patients' GPs and for following up on referrals made to specialist services.
- We saw evidence that the service obtained consent to care and treatment in line with legislation and guidance.
- There was some evidence of systems to improve quality of care and treatment for patients.

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

- The provider treated patients with kindness, respect, dignity and professionalism.
- All 81 Care Quality Commission comment cards were wholly positive about the service experienced.

Summary of findings

- The provider helped patients to be involved in decisions about their treatment and information about treatments were given if indicated.
- Opening hours reflected the needs of the population and patients could book appointments when they needed them.
- The serviced had a system for managing complaints.

Are services responsive to people's needs?

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

- Patient consultations lasted 30 minutes.
- The service provided an information for patients which detailed all services offered and a price list of consultation charges.
- All patient appointments were pre-bookable.
- The provider had a system for managing written complaints.
- The service had good facilities and was well equipped to treat patients and meet their needs. However, the premises did not have disabled access.
- Information about how to complain was available. There was a policy on handling complaints that included processes for learning from complaints.

Are services well-led?

We found that in some areas 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 section at the end of this report).

We found that, whilst the service had informal processes in place to ensure the provision of safe and effective care, the service did not have a comprehensive governance framework to support the delivery of high quality care. This included processes to monitor and improve quality and identify risk.

- Although the service had policies and procedures to govern activity, the service did not use quality and operational information to ensure and improve performance.
- There was some evidence of quality improvement measures to improve the care and treatment for patients. For example, the provider carried out case reviews.
- Governance arrangements were not in place to ensure effective oversight of risk. A number of safety assessments for the premises and equipment had not been carried out.
- There were limited arrangements to identify, learn and improve where things had gone wrong. There was a policy for reporting incidents, however no incidents had been reported. There were no clear arrangements for ensuring safety training was undertaken.
- The provider had a business continuity plan to manage major disruptions to the service.
- Staff had received inductions and appraisals.
- The provider was aware of and had systems in place to meet the requirements of the duty of candour.
- There was a culture of openness and honesty. The service had systems for being aware of notifiable safety incidents and sharing information with staff and ensuring appropriate actions was taken.
- The service had systems and processes in place to collect and analyse feedback from staff and patients.

Susan Mary Horsewood-Lee - Oakley Street

Detailed findings

Background to this inspection

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.

Dr Susan Mary Horsewood-Lee provides a private general practice service from a registered location at 34 Oakley Street, Chelsea, London SW3 5NT. Services are available to any fee-paying patient. Dr Horsewood-Lee is the sole doctor and there are no other clinical staff at the service. The doctor is supported by three medical secretaries. Services are available by appointment only between 7.30am and 6.00pm Monday to Friday. The service is managed by the practice doctor. The doctor is required to register with a professional body and was registered with a licence to practice.

The service is located in a converted residential and business-use property with below street level access into a reception and waiting area. The building is not accessible to wheelchair users and does not have accessible facilities. The service directs patients who need these to a local surgery which has disabled access. There are patient toilets and baby changing facilities available. There is one clinical consultation and treatment room, a reception area, a storage area, a medicines storage room and kitchen space.

The service is registered with the CQC to provide the regulated activities of diagnostic and screening procedures, family planning services and treatment of disease, disorder or injury.

We carried out an announced visit to Dr Susan Horsewood-Lee on 27 April 2018 and 10 May 2018. Our inspection team was led by a CQC inspector and included a GP specialist advisor.

Before visiting, we reviewed a range of information we hold about the service in advance of the inspection and asked other organisations to share what they knew. During our visit we:

- Spoke with the doctor and non-clinical staff which included two administrative staff.
- Inspected the premises and equipment used by the service.
- Reviewed an anonymised sample of the personal care or treatment records of patients;
- Reviewed a range of policies, procedures and management information held by the service.
- Reviewed 81 Care Quality Commission comment cards where patients and members of the public shared their views and experiences of 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 service did not have clear systems to keep patients safe although there were processes to ensure patients were safeguarded from abuse.

- The provider had systems to safeguard children and vulnerable adults from abuse. Policies were available for safeguarding both children and adults and these contained contact numbers for local safeguarding teams.
- 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.
- All staff had received up-to-date safeguarding and safety training appropriate to their role.
- Staff knew how to identify and report concerns. Reports and learning from safeguarding incidents were available to staff. Staff did not act as chaperones. Patients could bring a chaperone to consultations if they wished.
- The service carried-out staff checks, including checks of professional registration where relevant, on recruitment and on an ongoing basis; however, we found that the service's recruitment checks were inconsistent with their recruitment policy and Disclosure and Barring Service (DBS) checks. The doctor did not have an up to date DBS check and DBS checks were not in place for reception staff. (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). However, we saw evidence that immediately following the inspection, the service had applied for DBS checks for the doctor and staff members.
- The service did not have an effective system of risk assessment of the premises. Although the service had a safety policy there was minimal evidence that safety risk assessments for the premises and clinic environment had been carried out. For example, there was no system of safety checks or evidence to show how hazards are identified and dealt with.
- The provider had policies relating to 'safety and suitability of premises and equipment' which referred to the management of some health and safety and premises risks, however there was limited evidence that these were being followed. There were no records of monitoring safety or records of what precautions and practical steps had been taken to remove or minimise risks. For example, there were no systems for safely managing the risks relating to the Legionella bacteria.
- There was evidence that portable electrical equipment had been tested for safety. The last testing had been undertaken on 8 January 2018, arranged by the provider.
- There were some arrangements to manage infection prevention and control. Healthcare waste was managed appropriately and the service was visibly clean and tidy. There was a policy to manage infection prevention and control. There was no record of daily cleaning checks and the service did not have an annual infection prevention and control audit in place. However, we saw evidence immediately following the inspection that a cleaning schedule for the premises and clinical equipment, had been put in place, and that the service would be undertaking weekly audits of the cleaning carried-out. The cleaning schedule included procedures for dealing with spillages of blood and body fluids.
- There were systems for safely managing healthcare waste.
- The service had not ensured that facilities and equipment were safe and that equipment was maintained according to manufacturers' instructions. There was no record of equipment calibration. We spoke to the doctor who told us there was no equipment on the premises that needed calibration. However, we saw clinical equipment which had not been calibrated to give reliable readings, for example, a blood pressure machine, scales, pulse oximeter, thermometer and fridge thermometer.

Risks to patients

Are services safe?

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

- The service was equipped to deal with medical emergencies and staff were suitably trained in emergency procedures, there was a policy to ensure the safety of all staff and patients in the event of a medical emergency.
- There was oxygen with adult and children's masks. There was a first aid kit, and accident book. There was evidence of face to face basic life support training for the doctor and staff.
- Staff understood their responsibilities to manage emergencies on the premises and to recognise those in need of urgent medical attention. They knew how to identify and manage patients with severe infections including sepsis.
- The service stocked a number of emergency medicines. On the inspection day we were told that the medical director checked these daily. We saw that checks were recorded in a log book. There were limited risk assessment processes for storing emergency medicines in the service to identify which emergency medicines it was and was not suitable for the practice to stock.
- There were informal arrangements in place for managing the planned absence of the doctor. Prior to the doctor going on planned leave, patients would be contacted to encourage them to take account of this in managing their health needs; for example, when requesting repeat prescriptions. There was guidance in place to assist administrative staff in directing patients to appropriate alternative sources of care when the doctor was off sick.
- The service had arrangements for patients to access medical services outside of core hours. Emergency cover was provided in the absence of the doctor by two local independent services.
- The service did not have a lone working policy. Home visits were not undertaken.
- There was evidence of professional registration and medical indemnity for the doctor.
- There were some systems for managing fire risk. Fire extinguishers were checked annually. The next service date for fire extinguishers was December 2018. There was no record that the provider had arranged for a fire risk assessment of the premises to be carried out. There were no fire alarms in the premises but we saw two smoke alarms. The service had a system in place to check the working status of the smoke alarms and fire drills had been carried out.
- There was no evidence of fire safety training for the provider. Following the inspection the provider told us they would be attending a training course on 10 July 2018.While we did not see a visible fire procedure displayed in the areas used by patients on the first visit, we saw it in place on the second visit. Following the inspection the provider informed us that a member of staff had received Fire Marshal training through St Johns Ambulance.
- The service had a documented business continuity plan for major incidents such as power failure, flood or building damage.
- Patient records were stored securely on the service computer, which was backed up.

Information to deliver safe care and treatment

Overall, staff had the information they needed to deliver safe care and treatment to patients; however, there were areas where processes required review.

- Overall, individual care records were written and managed in a way that kept patients safe; the medical records we saw showed that information needed to deliver safe care and treatment was available to service staff in an accessible way.
- The doctor wrote out the patient's notes which were handed to a medical secretary to be typed in to the patient's electronic record manually. The doctor reviewed the electronic record to check they were transcribed properly.
- Management of correspondence in the service including letters, referrals and results was safe.
- There were information management policies in place; however, the doctor had not undertaken information governance training.
- The service had systems for sharing information with staff and other agencies to enable them to deliver safe care and treatment.

Are services safe?

- There were no formal processes for verifying a patient's identity. Personal details were taken at registration and name and date of birth verbal checks were carried out by the receptionist when patients booked appointments. Formal checks of adults accompanying child patients were not carried out.
- The service asked patients whether they consented to details of their treatment being shared with their registered NHS GP when they initially registered with the service. There were no arrangements for directly communicating with patients' GPs. The majority of communications were through referrals to private consultants in secondary care. The doctor gave patients copies of referral letters to give to their GP if required. The doctor advised us that a large number of patients had a registered family doctor outside London.
- Referral letters included all the necessary information.

Safe and appropriate use of medicines

The service had reliable systems for appropriate and safe handling of medicines although management of emergency medicines was not robust.

- There were effective systems for managing medicines stocked in the refrigerator. The provider kept records of daily refrigerator temperature checks.
- The service stocked a number of emergency medicines. The service had not carried out a formal risk assessment to identify emergency medicines that it should stock. , the service had introduced a protocol for ordering, storing and handling vaccines.
- The service kept prescription stationery securely and monitored its use.
- All the medicines we checked were in date and stored securely.
- The doctor prescribed, administered or supplied medicines to patients and gave advice on medicines in line with legal requirements and current national guidance.
- Patients' health was monitored to ensure medicines were being used safely and followed up on appropriately. The service involved patients in regular reviews of their medicines.

Track record on safety

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

- There were some risk assessments that had not been carried out in relation to infection control precautions, legionella, health and emergency medicines.
- In some areas, the service had not monitored and reviewed activity to understand risks and where identified made necessary safety improvements.
- We did not see evidence that the provider had arranged for a fire risk assessment of the premises to be carried out. The service did not display information on what patients should do in the event of a fire. We saw evidence that immediately following the inspection, the service had displayed a notice in the reception area advising patients about what to do in the event of a fire.
- There were regular tests of the fire safety equipment and the service carried out fire drills every six months. Following the inspection, the provider informed us that a member of staff had received Fire Marshal training through St Johns Ambulance.

Lessons learned and improvements made

There were some systems to enable learning and improvements when things went wrong.

- There was a system and policy for recording and acting on significant events and incidents. Staff understood their duty to raise concerns and report incidents and near misses. There had been no significant events over the last 12 months. The provider was aware of and complied with the requirements of the Duty of Candour. The provider encouraged a culture of openness and honesty.
- There were some systems for reviewing and investigating when things went wrong. The service learned and shared lessons and acted to improve safety in the service.
- The provider told us that if there were unexpected or unintended safety incidents, they would give people reasonable support, truthful information and a verbal and written apology.
- There was a system for receiving and acting on safety alerts The GP received alerts directly by email and

Are services safe?

would act where necessary. Copies of alerts were kept. There was evidence that the service had conducted system searches to identify patients who may have been affected by an alert.

Are services effective?

(for example, treatment is effective)

Our findings

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

Effective needs assessment, care and treatment

- The service had systems to keep the doctor up to date with current evidence-based practice. We saw that the doctor assessed needs and delivered care and treatment in line with current legislation, standards and guidance; however, there were no ongoing quality assurance activities in place to allow the service to assure themselves that these standards were being consistently met. For example, the provider did not have a written policy in place for fitting intrauterine contraceptive device (IUCD) including managing complications after IUCD insertion.
- Patients' immediate and ongoing needs were fully assessed. This included their clinical needs and their mental and physical wellbeing.
- We looked at two client records. Records were clearly recorded and included comprehensive detail of consultations, treatment and advice.
- We saw no evidence of discrimination when making care and treatment decisions.
- Staff advised patients what to do if their condition got worse and where to seek further help and support.

Monitoring care and treatment

The provider did not have a structured programme of clinical audit. There was evidence of some measures to review the effectiveness of the service provided through the undertaking of retrospective case reviews. For example, there was evidence of two case studies where the doctor had reflected on what lessons could be learned from the management of these cases.

- There was evidence of audit reviewing patients' referrals and one audit on cervical screening. There was no comprehensive system of follow up where actions had been implemented and improvements monitored.

Effective staffing

The doctor had the skills, knowledge and experience to deliver effective care and treatment, although some safety training had not been undertaken.

- The doctor had undertaken safeguarding children's training and basic life support training. The doctor's formal appraisal had identified that the doctor should update their knowledge of safeguarding of vulnerable adults.
- There was no evidence of training in the Mental Capacity Act.
- The doctor was supported by a team of three qualified medical secretaries. Their role was non-clinical and consisted of reception duties, administration and book keeping. We saw evidence of staff training in safeguarding, basic life support and first aid completed in August 2016.
- The learning needs of staff were identified through a system of appraisals, meetings and informal reviews.
- The service provided staff with ongoing support. The service had an induction programme for all newly appointed staff. Staff told us they attended a local independent health practice forum to network and share experiences.
- There was evidence of appraisals and continuing professional development for the doctor.

Coordinating patient care and information sharing

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

- The service had arrangements in place to share information with patients' registered NHS GPs and patients received co-ordinated and person-centred care. This included when they moved between services, when they were referred, or after they were discharged from hospital.
- When patients registered with the service they were asked whether they consented to information about their care being shared with their NHS GP. There were no arrangements for communicating with a patient's GP. The doctor gave patients copies of referral letters to give to their GP if required. The doctor advised us that a large number of patients had a registered family doctor outside London.
- There was no system for electronic patient records to be accessible to out of hours services at the point of need or for secondary care providers to access records

remotely. We spoke to the service who told us that patients' notes were owned by the patient and not shared with other providers or secondary care providers without patients' express consent. There was no evidence of a policy outlining these considerations.

- The doctor made referrals to private hospital specialists. If a referral was required, the doctor gave contact details of private hospital specialists to patients or if the doctor had urgent concerns, appointments could be arranged for a patient. The service ensured that end of life care was delivered in a coordinated way which considered the needs of different patients, including those who may be vulnerable because of their circumstances.

Supporting patients to live healthier lives

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

- The doctor provided health checks to patients.
- Cancer screening services were not offered but advice was given to patients regarding accessing these services.
- The service identified patients who may need extra support and directed them to relevant services. This included patients in the last 12 months of their lives, patients at risk of developing a long-term condition and carers.
- Staff encouraged and supported patients to be involved in monitoring and managing their health. The doctor gave lifestyle advice during consultations.
- Staff discussed changes to care or treatment with patients and their carers as necessary.
- The service supported initiatives to improve the people's health, for example, cervical screening, stopping smoking and tackling obesity.

Consent to care and treatment

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

- The provider understood the requirements of legislation and guidance when considering consent and decision making. The service policy required patients to sign consent forms and the signed forms were scanned into patient notes.
- The service supported patients to make decisions. Where appropriate, they assessed and recorded a patient's mental capacity to decide.
- The service did not monitor the process for seeking consent. The service did not undertake records audits to monitor the process for seeking consent.

Are services caring?

Our findings

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

Kindness, respect and compassion

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

- The provider understood patients' personal, cultural, social and religious needs.
- The service gave patients timely support and information.
- We observed the consultation room was clean and private.
- Reception staff knew that if patients wanted to discuss sensitive issues or appeared distressed they could offer them a private room to discuss their needs.
- All the 81 patient Care Quality Commission comment cards we received were wholly positive about the service experienced. Patients described the doctor as caring, attentive and efficient.

Involvement in decisions about care and treatment

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

- Feedback from patients included comments that the doctor was thorough and took time to talk through care and treatment options.
- The service's website provided patients with information about the range of treatments available including costs.
- Staff told us interpreting and translation services could be made available for patients who did not have English as a first language.
- There were no communication aids available, such as a hearing loop.
- Staff helped patients and their carers find further information and access community and support services.
- The service supported recently bereaved patients. Staff told us that if families had experienced bereavement, they followed the service's policy to support bereaved patients and their families.
- The service did not have any patients who were registered carers.

Privacy and Dignity

The service respected patients' privacy and dignity.

- The doctor and reception staff recognised the importance of patients' dignity and respect.
- We observed the clinical room to be clean and private. Conversations being held in the consultation room could not be heard by those outside.
- The administrative staff desk and computers were not separated from the waiting area. We asked the receptionists how they managed patients' privacy. Staff told us they would avoid mentioning patients' names aloud over the phone and could speak to patients or make calls in private in the office at the rear of the premises.
- The service complied with the Data Protection Act 1998. The practice doctor was registered with the Information Commissioner's Office (ICO). There was a confidentiality agreement for individuals carrying out administrative duties.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

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

Responding to and meeting people's needs

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

- The service understood the needs of its population and tailored services in response to those needs; for example, it offered early morning consultations and allowed patients to contact the doctor directly by email.
- The service was located at basement level and was accessed from stairs. Due to this and the internal size and layout, the premises were not suitable for patients with mobility difficulties and wheelchair users. Patients were informed the premises was not accessible if they used a wheelchair or mobility aid. Staff told us they referred people to a more suitable service locally.
- Where patients had language barriers, they were advised ahead of their appointment to bring someone to act as an interpreter if required.
- Information about how to make a complaint was displayed in the reception area and on the service's website.
- There was information on the service website which included service charges and a section to provide feedback.

Timely access to the service

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

- The service was open between 7.30am and 6.00pm Monday to Friday. Opening hours were displayed in the premises and on the service website.
- The service did not provide emergency appointments; patients were advised to contact NHS emergency services for urgent medical needs.
- The provider did not offer out of hours care; however, if medical attention was required patients were directed to a private 24-hour doctor service.
- Patients had timely access to initial assessment, test results, diagnosis and treatment.
- Patients reported that the appointment system was flexible, the doctor was always available and they could contact the doctor for advice out of hours.

Listening and learning from concerns and complaints

The service had a procedure for managing complaints.

- Information about how to make a complaint or raise concerns was available.
- The complaint policy and procedures were in line with recognised guidance. One complaint was received in the last 12 months. We reviewed the one complaint and found that it was satisfactorily handled, in a timely way.
- There was some evidence that the service learned lessons from individual concerns and complaints. It acted as a result to improve the quality of care. For example, the service had received a complaint from a patient who said their prescription had not been faxed to the pharmacy and was not available for collection. The service called the pharmacy and when the pharmacy double-checked, they had in fact received the prescription. The service contacted the patient to let them know. The service changed their process to call the pharmacy when a prescription has been faxed to make sure the pharmacy has received it.

Are services well-led?

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

Our findings

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

Leadership capacity and capability

The provider had the capacity and skills to deliver the service, however safety aspects of the service were not clearly known or prioritised to ensure high quality care was delivered.

- The provider was the sole provider and owner of the service. The provider had responsibility for managing the service as well as providing clinical care.
- The service had been in operation for 25 years at the time of the inspection.
- The provider showed integrity and openness when safety concerns were raised during the inspection and demonstrated a willingness to act and address concerns.

Vision and strategy

The service had a vision to deliver high quality care and an overall positive patient experience.

- There was a mission statement and statement of purpose visible in the patient waiting area.
- Although there was no formal business plan, the provider aimed to continue providing an on-going high-quality service.

Culture

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

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

Governance arrangements

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

- In some areas the service lacked formalised procedures to support good governance and management. There were no clear arrangements or lines of accountability for carrying out safety risk assessments for the premises, management of fire risks and infection prevention and control.
- The provider had a number of policies and procedures which followed guidance from the Independent Doctor's Federation (IDF). We found that some policies were not always reflective of day to day practice, for example, infection control and the 'safety and suitability of premises and equipment' policies. It was not clear that the provider was aware of the contents of the policies and where they needed to be reviewed and updated.
- We saw evidence of minutes from monthly team meetings where all staff were involved in discussions. There was no evidence that governance was addressed and issues discussed as the doctor was the sole provider of the service.

Managing risks, issues and performance

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

- The process for effectively identifying, understanding, monitoring and addressing current and future risks, including risks to patient safety, required review in some areas; for example, the service did not have a written policy in place for fitting intrauterine contraceptive device (IUCD) including managing complications after IUCD insertion.
- We found that there was no evidence of infection control audits, health and safety risk assessments, assessments of legionella risk and checks to ensure medical equipment was calibrated. However, there was evidence that portable appliances had been tested for electrical safety.
- There were regular tests of the fire safety equipment and regular fire drills. Following the inspection, the provider informed us that a member of staff had received Fire Marshal training through St Johns Ambulance.

Are services well-led?

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

- Risks related to the management of medical emergencies including access to emergency medicines and emergency equipment had not been adequately assessed and documented.
- The service had a business continuity plan in the event of an emergency affecting the running of the clinic.
- There were limited systems for learning and improvement when things had gone wrong. Although there was a policy for reporting incidents and significant events, it was not clear whether the provider had a defined awareness of all types of incidents that could be classed as reportable. The provider had a system in place to manage complaints, although only one complaint had been made.
- Systems for ensuring continued professional development were in place, however there were no clear arrangements for ensuring safety training was undertaken, including infection control, fire safety and information governance training. Following the inspection the provider told us they would be attending a training course on 10 July 2018.
- The service had no formal arrangements in place to ensure that staff carried out checks of patient identity and parental responsibility.
- The service did not have a process to manage patient safety alerts. There was no record kept of the action taken in response to patient safety alerts, and the service was unable to demonstrate that they had an effective process to manage these.
- There were some measures to improve and address quality. The provider carried out case reviews to identify areas to improve the service delivered.

Appropriate and accurate information

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

- Information gathered on the quality of the service was limited to feedback from patients and did not include information on patient outcomes or adherence to guidelines or best practice.
- The provider had systems in place which ensured patients' medical records remained confidential and secured at all times.
- Patient names and other identity information were handled by staff members who had signed confidentiality agreements in place.
- The service submitted information or notifications to external organisations as required.

Engagement with patients, the public, staff and external partners

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

- The provider gathered feedback from patients and external peers as part of their annual appraisal. We saw a copy of the appraisal form where the appraiser noted that some of the colleague and patient feedback statements submitted, show a very positive regard for the provider's professional ability.
- The service collected patient satisfaction information from their website and used this to inform their plans for developing the service.

Continuous improvement and innovation

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

- The service was committed to providing a high level of service to its patients. Reception staff attended local practice manager forum events to improve patients' experiences.
- The provider chaired local independent doctor network events to exchange ideas and communicate with colleagues.
- The provider delivered a holistic service to patients and was trained in psychotherapy and family therapy in order to expand the service they provided.
- The provider had developed health checks for patients to promote healthy living.

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 Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment How the regulation was not being met: Assessments of the risks to the health and safety of service users of receiving care or treatment were not being carried out. In particular: • Health and safety risk assessments of the premises had not been carried out. • Medical equipment had not been calibrated. Equipment included a pulse oximeter, blood pressure monitor, scales, and a thermometer. • There was no evidence of a legionella risk assessment. The registered persons had not done all that was reasonably practicable to mitigate risks to the health and safety of service users receiving care and treatment. In particular: • Fire risk assessment was not carried out and there was no visible fire procedure in patient areas. • There were no suitable arrangements to manage medical emergencies. There was no clear assessment of risk to demonstrate the decision making and mitigating arrangements in place. Not all of the people providing care and treatment had the qualifications, competence, skills and experience to do so safely. In particular: • The provider had not undertaken training in infection control and fire safety.

This section is primarily information for the provider

Requirement notices

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

- There was no evidence that infection control audits had been undertaken by the provider.
- There were no cleaning records or cleaning schedules.

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

Regulated activity	Regulation
Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance How the regulation was not being met: There were no systems or processes that enabled the registered person to assess, monitor and improve the quality and safety of the services being provided. In particular: • The provider reported that there had been no incidents or adverse events where things had gone wrong. There were no systems or processes that enabled the registered person to assess, monitor and mitigate the risks relating to the health, safety and welfare of service users and others who may be at risk. In particular: • There was minimal evidence safety risks had been assessed and mitigated. • There were no clear governance arrangements for the undertaking of safety risk assessments for the premises, management of fire risks and infection control and managing medical emergencies.

This section is primarily information for the provider

Requirement notices

- There were no clear arrangements to ensure the provider had undertaken training in information governance, infection control and fire safety.

The registered person had systems or processes in place that operated ineffectively in that they failed to enable the registered person to assess, monitor and mitigate the risks relating to the health, safety and welfare of service users and others who may be at risk. In particular:

- There was a lack of oversight of whether risks had been assessed and mitigated by the provider to ensure suitability and safety of the premises for service users.
- The provider had a number of policies and procedures some of which had not been reviewed. Some policies were not always reflective of day to day practice, for example infection control and the 'safety and the suitability of premises and equipment' policies.

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