112 Harley Street

Inspection report

112 Harley Street
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Date of inspection visit: 16 January 2020, 23 January 2020
Date of publication: 02/04/2020

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

Ratings

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

Overall summary

This service is rated as Requires improvement overall. (Previously inspected but not rated).

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? – Inadequate

We carried out an announced comprehensive inspection at 112 Harley Street (also known as Cooper Health Limited) on 16 and 23 January 2020. 112 Harley Street provides an independent doctors consulting service to private patients from consulting rooms at 112 Harley Street, London W1G 6HJ.

We previously inspected the service on 21 November 2018 at which time we identified governance concerns and served Requirement Notices under regulations 12 (Safe care and treatment), 17 (Good governance) and 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The full comprehensive report on the 21 November 2018 inspection can be found by selecting the 'all services' link for 112 Harley Street on our website at www.cqc.org.uk.

The service sent us a plan of action to ensure the service was compliant with the requirements of the regulations. We carried out this comprehensive inspection on 16 and 23 January 2020 to review the practice's action plan, look at the identified breaches set out in the Requirement Notice and to rate the service.

We based our judgement of the quality of care at this service on a combination of:

•what we found when we inspected

•information from our ongoing monitoring of data about services and

•information from the provider, patients, the public and other organisations.

This service is registered with CQC under the Health and Social Care Act 2008 in respect of some, but not all, of the services it provides. There are some general exemptions from regulation by CQC which relate to particular types of service and these are set out in Schedule 2 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We received six 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 staff were approachable, committed and caring.

Our key findings were:

•The delivery of high-quality care was not assured by the governance arrangements in place. For example, insufficient action had been taken since our last inspection to ensure oversight of risks relating to the premises. We also noted a continued lack of oversight of staff training and failure to ensure that policies governing the service reflected day to day practice.

•The provider could not demonstrate that all staff had undergone pre-employment checks at the time of recruitment.

•Although there were systems for reviewing and investigating when things went wrong, the recording of significant events lacked sufficient detail to be able to share learning and improve quality of care for patients.

•Staff involved and treated people with compassion, kindness, dignity and respect.

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

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

•Ensure recruitment procedures are established and operated effectively to ensure only fit and proper persons are employed.

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

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

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 CQC GP specialist adviser and a CQC specialist adviser practice manager.

Background to 112 Harley Street

The provider, 112 Harley Street, also known as Cooper Health Limited, is registered with the CQC as an organisation providing an independent doctors consulting service to private patients from consulting rooms at 112 Harley Street, London W1G 6HJ. The provider is registered to provide the regulated activities of treatment of disease, disorder or injury and diagnostic and screening procedures.

This service is registered with CQC under the Health and Social Care Act 2008 in respect of some, but not all, of the services it provides. There are some general exemptions from regulation by CQC which relate to particular types of service and these are set out in Schedule 2 of The Health and Social Care Act 2008 (Regulated Activities)Regulations 2014.

At 112 Harley Street most of the services are provided to patients under arrangements made by their employer with whom the servicer user holds a policy. These types of arrangements are exempt by law from CQC regulation. Therefore, at 112 Harley Street, we were only able to inspect the services which are not arranged for patients by their employers with whom the patient holds a policy.

One of the service's directors is the registered manager. A registered manager is a person who is registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

How we inspected this service

Pre-inspection information was gathered and reviewed before the inspection. Over the two inspection days we spoke with a doctor, two nurses, two directors and a practice manager. 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 and patient feedback received by the service.

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

•Is it safe?

•Is it effective?

•Is it caring?

•Is it responsive to people's needs?

•Is it well-led?

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

Requires improvement

Are services safe?

We rated safe as Requires improvement because:

•The provider could not demonstrate that all staff had had undergone pre-employment checks at the time of recruitment and on an ongoing basis.

•Although there were systems for reviewing and investigating when things went wrong, the initial recording of significant events lacked sufficient detail to be able to share learning.

Safety systems and processes

The service did not have clear systems to keep people safe and safeguarded from abuse.

•When we inspected in November 2018, we noted an absence of premises safety risk assessments. We asked the provider to take action. At this inspection we noted a fire risk assessment carried out by an external contractor in March 2019 had highlighted that the building's loft space was not compartmentalised and therefore posed a 'substantial' risk. However, the provider had not engaged with the landlord regarding this risk. Shortly after our inspection we were advised that the provider planned to meet with the landlord.

•The service had systems to safeguard children and vulnerable adults from abuse (although we noted local safeguarding contact details were out of date. These were shortly updated after our inspection). The service had systems in place to assure that an adult accompanying a child had parental authority.

•We could not be assured that staff underwent pre-employment checks at the time of recruitment and on an ongoing basis. For example, the personnel record of the service's most recent non-clinical staff member did not contain references or completed DBS check (to identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable). The record noted that whilst awaiting a DBS check the staff member should be monitored but it was unclear what this meant, and we did not see evidence of a risk assessment having been undertaken into the decision to employ a staff member without having had a DBS check.

•All staff received up-to-date safeguarding training appropriate to their role. They knew how to identify and report concerns. Staff who acted as chaperones were trained for the role and had received a DBS check.

•One of the two nurse files we reviewed did not contain references.

•We looked at systems to manage infection prevention and control and found that an Infection Prevention and Control Audit had taken place on 12 December 2019. However, we noted inconsistencies. For example, the audit stated that couches and curtains were free from dust but when we inspected only five weeks later on 16 January 2020 we observed an extensive build-up of dust on curtains and on couch fixtures.

•We also found that in February 2019, an external contractor had conducted a Legionella risk assessment and that water temperature monitoring was subsequently taking place. However, the provider had failed to act on water temperature readings between February 2019 and January 2020 which had consistently been outside the required range.

•The provider ensured that facilities and equipment were safe and that equipment was maintained according to manufacturers' instructions. There were systems for safely managing healthcare waste.

Risks to patients

There were not appropriate systems in place to assess, monitor and manage risks to patient safety.

•There were suitable medicines and equipment to deal with medical emergencies which were stored appropriately. However, staff were unclear who was responsible for checking the expiry dates of emergency medicines, such that when we inspected they were unaware that monthly checks had not been taking place since May 2019. We found one medicine had expired in November 2019 and noted it was not included on the monthly check list of medicines.

•There were arrangements for planning and monitoring the number and mix of staff needed.

•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.

•When there were changes to services or staff the service assessed and monitored the impact on safety.

•There were appropriate indemnity arrangements in place.

Requires improvement

Are services safe?

Information to deliver safe care and treatment

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

•Individual care records were written and managed in a way that kept patients safe. The care records we saw showed that information needed to deliver safe care and treatment was available to relevant staff in an accessible way.

•The service had systems for sharing information with staff and other agencies to enable them to deliver safe care and treatment.

•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.

•We saw that clinicians made appropriate and timely referrals in line with protocols and up to date evidence-based guidance.

Safe and appropriate use of medicines

We looked at systems for appropriate and safe handling of medicines.

•The systems and arrangements for managing medicines, including vaccines, emergency medicines and equipment minimised risks. The service kept prescription stationery securely and monitored its use.

•The service carried out medicines audit to ensure prescribing was in line with best practice guidelines for safe prescribing.

•The service does not prescribe Schedule 2 and 3 controlled drugs (medicines that have the highest level of control due to their risk of misuse and dependence). Neither did they prescribe schedule 4 or 5 controlled drugs.

•Staff prescribed, administered or supplied medicines to patients and gave advice on medicines in line with legal requirements and current national guidance. Processes were in place for checking medicines and staff kept accurate records of medicines. Where there was a different approach taken from national guidance there was a clear rationale for this that protected patient safety.

•There were effective protocols for verifying the identity of patients including children.

Track record on safety and incidents

We looked at the service's track record on safety.

•Although we saw evidence that comprehensive risk assessments had been commissioned in relation to safety issues, we saw little evidence that the provider had acted on recommendations. For example, regarding Legionella training.

•Also, although regular team meetings took place, we did not see evidence that they were used to monitor risks, review activity and drive safety improvements.

Lessons learned and improvements made

We looked at how the service learned and made improvements when things went wrong.

•There was a system for recording and acting on significant events.

•Although there were systems for reviewing and investigating significant events, the initial recording of events which took place prior to our inspection lacked detail. We noted however, that the recording of a 16 January 2020 significant event (concerning the absence of periodic checks of emergency medicines) contained sufficient detail to enable shared learning.

•The provider was aware of and complied with the requirements of the Duty of Candour. The provider encouraged a culture of openness and honesty. The service had systems in place for knowing about notifiable safety incidents.

When there were unexpected or unintended safety incidents:

•The service gave affected people reasonable support, truthful information and a verbal and written apology.

•They kept written records of verbal interactions as well as written correspondence.

•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?

We rated effective as Good:

•The service routinely reviewed the effectiveness and appropriateness of the care it provided. It ensured that care and treatment was delivered according to evidence-based guidelines.

•Action had been taken since our last inspection such that quality improvement activity supported the delivery of safe and patient centred care.

Effective needs assessment, care and treatment

The provider had systems to keep clinicians up to date with current evidence based practice (for example a monthly clinical newsletter). We saw evidence that clinicians assessed needs and delivered care and treatment in line with current legislation, standards and guidance.

•Patients' immediate and ongoing needs were fully assessed. Where appropriate this included their clinical needs and their mental and physical wellbeing.

•Clinicians had enough information to make or confirm a diagnosis.

•Arrangements were in place to deal with repeat patients.

•Staff assessed and managed patients' pain where appropriate.

Monitoring care and treatment

The service was actively involved in quality improvement activity.

•When we inspected in November 2018 we noted an absence of ongoing quality improvement activity. At this inspection we noted that the service had commenced a proposed two cycle clinical audit looking at disease-modifying anti-rheumatic drugs and dosage monitoring.

•We also saw evidence of additional quality improvement activity such as a monthly clinical newsletter covering recent National Institute for Health and Care Excellence (NICE) alerts and Central Alerting System (CAS) patient safety alerts.

Effective staffing

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

•All staff were appropriately qualified. The provider had an induction programme for all newly appointed staff.

•Relevant professionals (medical and nursing) were registered with the General Medical Council (GMC)/Nursing and Midwifery Council and were up to date with revalidation.

•The provider did not maintain up to date training records. For example, one of the personnel records did not confirm that fire safety training and training relating to the service's phlebotomy protocol had taken place. However, the provider told us that this was a filing error and that the training had taken place.

•The provider understood the learning needs of staff and provided protected time and training to meet them. Staff told us they were encouraged and given opportunities to develop.

•Staff whose role included immunisation and reviews of patients with long term conditions had received specific training and could demonstrate how they stayed up to date.

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. Staff referred to, and communicated effectively with, other services when appropriate.

•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.

•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.

•The provider had risk assessed the treatments they offered. They had identified medicines that were not suitable for prescribing if the patient did not give their consent to share information with their GP. Where patients agreed to share their information, we saw evidence of letters sent to their registered GP in line with GMC guidance.

•Patient information was shared appropriately (this included when patients moved to other professional services), and the information needed to plan and deliver

Good

Are services effective?

care and treatment was available to relevant staff in a timely and accessible way. There were clear and effective arrangements for following up on people who had been referred to other services.

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.

•Risk factors were identified, highlighted to patients and where appropriate highlighted to their normal care provider for additional support.

•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 for seeking consent appropriately.

Good

Are services caring?

We rated caring as Good:

•Feedback from people who used the service was positive about the way staff treated people.

•Staff across all sections of the service stressed the importance of putting patients first.

Kindness, respect and compassion

Staff treated patients with kindness, respect and compassion.

•The service sought feedback on the quality of clinical care patients received but we noted this was regarding customer satisfaction and not quality of clinical care received.

•Feedback from patients was positive about the way staff treat people.

•Staff understood patients' personal, cultural, social and religious needs. They displayed an understanding and non-judgmental attitude to all patients.

•The service gave patients timely support and information.

Involvement in decisions about care and treatment

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

•Interpretation services were available for patients who did not have English as a first language.

•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.

Privacy and Dignity

The service respected patients' privacy and dignity.

•Staff recognised the importance of people's dignity and respect.

•Staff knew that if patients wanted to discuss sensitive issues or appeared distressed they could offer them a private room to discuss their needs.

Good

Are services responsive to people's needs?

We rated responsive as Good:

•People could access the right care at the right time and access to appointments and services was managed to take account of people's needs, including those with urgent needs.

•The appointments system was easy to use and supported people to make appointments.

Responding to and meeting people's needs

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

•The provider understood the needs of their patients and improved services in response to those needs. For example, weekend openings by appointment.

•The facilities and premises were appropriate for the services delivered.

•Reasonable adjustments had been made so that people in vulnerable circumstances could access and use services on an equal basis to others. For example, wheel chair accessible toilets.

Timely access to the service

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

•Patients had timely access to initial assessment, test results, diagnosis and treatment.

•Waiting times, delays and cancellations were minimal and managed appropriately.

•Patients with the most urgent needs had their care and treatment prioritised.

•Patients reported that the appointment system was easy to use.

•Referrals and transfers to other services were undertaken in a timely way.

Listening and learning from concerns and complaints

The service took complaints and concerns seriously and responded to them appropriately to improve the quality of care.

•Information about how to make a complaint or raise concerns was available. Staff treated patients who made complaints compassionately.

•The service informed patients of further action that may be available to them should they not be satisfied with the response to their complaint although we noted this did not include reference to the Parliamentary and Health Service Ombudsman.

•The service had a complaint policy and procedures in place. The service learned lessons from individual concerns, complaints and from analysis of trends. It acted as a result to improve the quality of care.

Inadequate

Are services well-led?

We rated well-led as Inadequate because:

•The delivery of high-quality care was not assured by the governance arrangements in place. Insufficient action had been taken since our last inspection to ensure oversight of risks relating to the premises.

•We also noted a continued lack of oversight of staff training and continued failure to ensure that policies governing the service reflected day to day practice.

•Insufficient action had been taken since our last inspection to ensure an effective system for identifying and managing risks; so as to maintain patient safety.

Leadership capacity and capability

We looked at leaders' capacity and skills to deliver high-quality, sustainable care.

•Leaders at all levels were visible and approachable. They worked closely with staff and others to make sure they prioritised compassionate and inclusive leadership.

•However, administrative leaders lacked capacity to develop a thorough understanding of issues and priorities relating to the quality and future of the service. For example, following our last inspection external risk assessments had been commissioned but leaders lacked an understanding or oversight of the actions required to be completed.

•We also noted a continued lack of oversight of staff training and a continued failure since our last inspection to ensure that policies governing the service reflected day to day practice.

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.

•The service developed its vision, values and strategy jointly with staff.

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

Culture

We looked at the service's culture for delivering 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.

•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. Action had been taken since our last inspection such that staff in post for more than 12 months had received an annual appraisal. Staff were supported to meet the requirements of professional revalidation where necessary. Clinical staff, including nurses, were considered valued members of the team. They were given protected time for professional time for professional development. For example, nurses spoke positively about training opportunities.

•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

The delivery of high-quality care was not assured by the administrative governance arrangements in place. When we inspected in November 2018, there was limited evidence of systems and processes to support good governance and management. We asked the provider to take action. However at this inspection:

•Staff were unclear on roles and accountabilities regarding for example infection prevention and control, safeguarding and periodic checks of emergency medicines.

•Policies and procedures were not reflective of day to day practice and it was therefore unclear how leaders could

assure themselves that staff were working to the correct protocols. For example, the service's cold chain failure flowchart made reference to Patient Group Directions (PGDs) but we were advised that only doctors administered vaccinations; therefore, negating the need for PGDs.

•We noted a continued lack of oversight of staff training. For example, one of the two nurse files we reviewed did not contain confirmation of fire safety training (an omission previously highlighted for other staff members at our November 2018 inspection).

•We noted a lack of oversight of staff recruitment checks. For example, two of the four staff records we reviewed did not contain references.

Managing risks, issues and performance

There was no clarity around processes for managing risks, issues and performance.

When we inspected in November 2018, 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. We asked the provider to take action. However at this inspection:

•We noted limited processes to identify, understand, monitor and address current and future risks including risks to patient safety. For example, although regular team meetings took place, we saw limited evidence they monitored risk and drove safety improvements.

•Subsequently, we noted continued failures to manage risks relating to fire safety, Legionella and staff pre-employment checks.

•However, clinical audit aimed to have a positive impact on quality of care and outcomes for patients and there was clear evidence of action to change services to improve quality.

Appropriate and accurate information

We looked at how the service acted on appropriate and accurate information.

•We saw limited evidence that quality and sustainability were discussed in team meetings.

•The service submitted data or notifications to external organisations as required.

•We were advised the service was in the process of migrating over to a new clinical system and that there were arrangements in line with data security standards for the availability, integrity and confidentiality of patient identifiable data, records and data management systems.

Engagement with patients, the public, staff and external partners

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

•The service encouraged and heard views and concerns from patients and staff; and acted on them to shape services and culture.

•Staff could describe to us the systems in place to give feedback. For example, team meetings and individual supervision meetings.

Continuous improvement and innovation

We looked at systems and processes for learning, continuous improvement and innovation.

•There was a focus on continuous learning and improvement.

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

•There were systems to support improvement and innovation work (for example clinical audit and a monthly clinical newsletter).

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 Treatment of disease, disorder or injury	Regulation 19 HSCA (RA) Regulations 2014 Fit and proper persons employed How the regulation was not being met: The provider had failed to operate robust recruitment procedures, including undertaking any relevant checks. In particular: •References were not on file for two staff members.

This section is primarily information for the provider

Enforcement actions

Action we have told the provider to take

The table below shows the legal requirements that 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. We took enforcement action because the quality of healthcare required significant improvement.

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: The provider had failed to operate effective systems and processes to assess, monitor and mitigate any risks relating to the health, safety and welfare of people using services and others. In particular: •A continued 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. For example risks associated with Legionella and fire safety. •A continued failure to ensure that policies and procedures reflected day to day practice. For example, cold chain policy. •A continued failure to have ensure oversight of essential training for staff including fire safety training.