

21st Century Clinic Ltd

French Medical Clinic

Inspection report

14 Harley House
Brunswick Place
London
NW1 4PN
Tel: 0207 486 3903
Website: www.frenchmedical.org.uk

Date of inspection visit: 13 June 2017
Date of publication: 12/09/2017

Overall summary

We carried out an announced comprehensive inspection on 13 June 2017 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. We have told the provider to take action (see full details of this action in the Enforcement section at the end of this report).

Are services effective?

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

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

Background

We carried out this comprehensive 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, and to follow up on previous breaches of regulation.

The Care Quality Commission previously inspected French Medical Clinic on 22 July 2013, 19 August 2014 and 27 February 2015. Following these inspections, reports were issued identifying failures to comply with Regulations current at the time of inspection.

At the July 2013 inspection we issued compliance actions as there was no equipment or medicines available to respond to medical emergencies. We carried out a follow up inspection in August 2014 and found there was continuing non-compliance in the areas identified, including out of date emergency medicines and expired medical emergencies training. We issued further compliance actions and in February 2015 we found continuing non-compliance in the areas identified, including no medical emergencies training for

Summary of findings

non-clinical staff. We issued requirement notices under the new Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 for breaches of Regulation 12 Safe care and treatment. We checked these areas as part of the June 2017 comprehensive inspection and found arrangements had not been improved.

French Medical Clinic provides private general medical services from the lower ground floor of converted residential premises at 14 Harley House, Brunswick Place, London NW1 4PN. There are three consultation and treatment rooms, administrative offices, staff facilities, a reception and waiting area and patient facilities.

Services are available to any fee paying patient; however the service is predominantly aimed at French speaking patients from Britain and overseas. The service has a high number of patients from French speaking African nations, including Somalia, and British patients from Somali communities across England.

The service is operated by one full time male Professor, two part time female doctors and one male regular Locum doctor. All four clinicians were registered with the General Medical Council (GMC) with a licence to practise at the time of inspection. None of the doctors were on the General Medical Council (GMC) specialist register of clinicians licenced to provide specialist services. The medical team is supported by three part time administrative staff. The service operates Monday to Friday with pre booked appointments available between 10am and 5pm. Appointments and home visits can also be arranged to be conducted outside of these times by prior arrangement.

Professor Boyde is the registered manager of the service. 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.

As part of our inspection we asked for CQC comment cards to be completed by patients prior to our inspection. We received 27 comment cards which were all positive about the standard of care received. Comments included that all staff, including doctors, were kind, caring and treated patients with respect. We also spoke with two patients during the inspection who both said they were

satisfied with the care they received and told us that appointments were convenient, that doctors gave them enough time during their consultation and that they were involved in their care and treatment.

Our key findings were:

- The provider did not assess the risks to health and safety of service users and do all that was practicable to mitigate such risks.
- The provider did not have adequate arrangements in place for responding to medical emergencies; there was no Automatic external defibrillator (AED), emergency equipment including pulse oximeters and blood glucose meters were not working, emergency medicines including Benzylpenicillin and Chlorphenamine were not available and the Oxygen cylinder had expired and was empty.
- Persons providing care and treatment did not have the qualifications, competence, skills and experience to do so safely with regards to ultra sound scanning, gynaecological examinations and fertility treatments.
- The provider did not ensure the premises were safe to use for their intended purpose by having an up to date fire risk assessment carried out.
- The provider did not assess the risk of, prevent, detect and control the spread of infections including those that are healthcare associated.
- Equipment used by the provider for the care and treatment of service users was not properly maintained, serviced or calibrated.
- There was no evidence the provider was assessing, monitoring and improving the quality of care provided to service users.
- We did not see evidence of an induction programme in place or records of inductions provided to staff and the provider did not identify on-going training for staff.
- The provider did not have a system of appraisal and personal development in place to ensure the learning and development needs of non-clinical staff were identified and met.
- Patients told us they felt involved in decision making about the care and treatment they received. They also told us 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.

Summary of findings

- There was information in the reception area and on the service website which detailed the arrangements for dealing with complaints, the arrangements for respecting dignity and privacy of patients and the services available.
- The service offered appointments primarily to French speaking patients; however the service was open to any fee paying patient, with fees clearly set out and cost saving initiatives available.
- The service did not have an effective overarching governance framework supporting the delivery of good quality care.

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

- Ensure the risks to health and safety of service users are identified and assessed and do all that is practicable to mitigate such risks.

- Ensure persons providing care and treatment have the qualifications, competence, skills and experience to do so safely.
- Assess the risk of, prevent, detect and control the spread of infections including those that are healthcare associated.
- Ensure equipment used for the care and treatment of service users is properly maintained, serviced and calibrated.
- Establish and operate effective systems or processes to assess, monitor and improve the quality and safety of service users.

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

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 did not assess the risks to health and safety of service users and do all that was practicable to mitigate such risks.
- The provider did not have adequate arrangements in place for responding to medical emergencies; there was no Automatic external defibrillator (AED), emergency equipment including pulse oximeters and blood glucose meters were not working, emergency medicines including Benzylpenicillin and Chlorphenamine were not available and the Oxygen cylinder had expired and was empty.
- Persons providing care and treatment did not have the qualifications, competence, skills and experience to do so safely with regards to ultra sound scanning, gynaecological examinations and fertility treatments.
- The provider did not ensure the premises were safe to use for their intended purpose by having an up to date fire risk assessment carried out.
- The provider did not assess the risk of, prevent, detect and control the spread of infections including those that are healthcare associated. We found out of date medicines and equipment, carpeted treatment areas, no training or equipment to deal with bodily fluids spilled and no Legionella risk assessment.
- Equipment used by the provider for the care and treatment of service users was not properly maintained, serviced or calibrated, including blood pressure monitors and the ultra sound scanning equipment.

Are services effective?

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

- There was no evidence the provider was assessing, monitoring and improving the quality of care provided to service users. The provider did not have a quality improvement programme in place and there had been no clinical audits undertaken since 2012.
- The provider did not have a comprehensive induction programme in place and did not identify on-going training for staff.
- The provider did not ensure that those providing care and treatment had the qualifications, competence, skills and experience to do so safely with regards to ultra sound scanning, gynaecological examinations and fertility treatments.
- The provider did not have a system of appraisal and personal development in place to ensure the learning and development needs of non-clinical staff were identified and met.
- Staff told us that patient's capacity to consent to care or treatment was assessed and staff recorded the outcome of the assessment; however we did not see evidence to demonstrate this or that the process for seeking consent was monitored through patient records audits.

Are services caring?

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

Summary of findings

- We observed that members of staff were courteous and helpful to patients and treated them with dignity and respect.
- Patients told us they felt involved in decision making about the care and treatment they received. They also told us 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.
- Patient feedback from CQC comment cards we received was also positive and aligned with these views.

Are services responsive to people's needs?

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

- The service was open Monday to Friday with pre-booked appointments available between 10am and 5pm.
- The service offered appointments primarily to French speaking patients; however the service was open to any fee paying patient, with fees clearly set out and cost saving initiatives available.
- The service was only accessible via stairs; however this was clearly communicated via the service leaflet and website. The provider told us patients requiring level access or assisted access were offered a home visit and we saw records of home visits undertaken and planned.
- There was information in the reception area and on the service website which included arrangements for dealing with complaints, arrangements for respecting dignity and privacy of patients and the services available.
- All staff spoke French and English and also offered a range of other languages such as Arabic, Portuguese, Italian, Russian, Somali, Swahili and Lingala.
- The service had a system in place for handling complaints and concerns in line with recognised guidance for independent doctors in England; however there had been no complaints received in writing or records of any verbal complaints to assess the effectiveness of the process.

Are services well-led?

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

- The service did not have an effective overarching governance framework supporting the delivery of good quality care.
- Arrangements for identifying, recording and managing risks, issues and implementing mitigating actions were not effective. For example the service did not have adequate arrangements in place for dealing with medical emergencies, had not actioned recommendations in previous fire risk assessments including carrying out further fire risk assessments and there were infection prevention and control risks not identified such as out of date medicines and equipment.
- The service did not have a programme of continuous clinical and internal audit to monitor quality and to make improvements and weekly clinical meetings were not effective in monitoring and improving the safety and quality of care of service users.
- The provider did not have a system in place for identifying, recording, investigating monitoring and learning from significant events.
- Staff did not receive formal appraisals or development reviews and were not supported to perform their duties competently through identified required training.
- There was a suggestions box and patient comments and suggestions received were used by clinical staff in their appraisal process. Non-clinical staff told us patient feedback was used to make improvements, for example by providing bottled water at reception.

French Medical Clinic

Detailed findings

Background to this inspection

We carried out this comprehensive 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, and to follow up on previous breaches of regulation.

The Care Quality Commission previously inspected French Medical Clinic on 22 July 2013, 19 August 2014 and 27 February 2015. Following these inspections, reports were issued identifying failures to comply with Regulations current at the time of inspection.

At the July 2013 inspection we issued compliance actions as there was no equipment or medicines available to respond to medical emergencies. We carried out a follow up inspection in August 2014 and found there was continuing non-compliance in the areas identified, including out of date emergency medicines and expired medical emergencies training. We issued further compliance actions and in February 2015 we found continuing non-compliance in the areas identified, including no medical emergencies training for non-clinical staff. We issued requirement notices under the new Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 for breaches of Regulation 12 Safe care and treatment. We checked these areas as part of the June 2017 comprehensive inspection and found arrangements had not improved.

Our inspection team was led by a CQC Lead Inspector and included a GP specialist adviser and a

second CQC inspector.

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

- Spoke with a range of staff including the registered manager and medical director, two other doctors and three administrative staff.
- Spoke with patients who used the service.
- Reviewed an anonymised sample of the personal care or treatment records of patients.
- Reviewed comment cards where patients and members of the public shared their views and experiences of the service.
- Reviewed service policies, procedures and other relevant documentation.
- Inspected the premises and equipment in use.

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.

Reporting, learning and improvement from incidents

The service did not have a system for reporting and recording significant events.

- Staff told us they would inform the medical director of any incidents; however there was no process, policy or procedure for identifying, recording, monitoring or learning from significant events. We were not provided with safety records, incident reports or patient safety alerts. Staff told us there had been an incident and issues log created approximately six months prior to our inspection, however this had not been used. Minutes of meetings where significant events were discussed were presented, however these notes did not demonstrate the service had carried out thorough analysis of the significant events and incidents, identified or shared lessons and action taken to improve safety, identified trends in significant events or monitored and evaluated any action taken.
- The provider did demonstrate awareness of the requirements of the duty of candour (the duty of candour is a set of specific legal requirements that providers of services must follow when things go wrong with care and treatment) and had response arrangements in place for when things went wrong with care and treatment. Arrangements included that patients would be informed of the incident as soon as reasonably practicable, receive reasonable support, truthful information, a written apology and be told about any actions to improve processes to prevent the same thing happening again. However there were no recorded examples demonstrating the service complied with these requirements, and significant event management arrangements did not support this happening.

Reliable safety systems and processes (including safeguarding)

The providers systems, processes and procedures did not always keep patients safe and safeguarded from abuse, for example:

- Arrangements to safeguard children and vulnerable adults from abuse did not fully reflect relevant legislation. We saw a safeguarding policy with contact details for making safeguarding referrals. This had been recently reviewed by the safeguarding lead; however there was no reference to female genital mutilation (FGM), how to identify victims of or people at risk of harm from FGM or specific actions to take for these patients, including patients from African nations who are at higher risk.
- We were not able to see evidence of safeguarding children or adults training for all members of staff. We were told that the medical director was the safeguarding lead; however we did not see evidence they had undertaken required safeguarding training. We did see evidence that the two part time doctors had undertaken child safeguarding training to level 3 within the last three years. Non clinical staff had been trained to safeguarding children level 1 in the last three years.
- Non-clinical staff told us they would raise safeguarding concerns with the safeguarding lead or other clinical staff for any patients who were either vulnerable, had safeguarding concerns or suffered with a learning disability.
- The service had a chaperone policy in place and there were notices on display in the waiting room to advise patients that chaperones were available if required. Staff told us that patients were offered a chaperone for intimate examinations.
- All staff who acted as chaperones were trained for the role and had received a Disclosure and Barring Service (DBS) check. (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).

Medical emergencies

The service did not have adequate arrangements in place to respond to medical emergencies.

- The service did not have an automatic external defibrillator (AED) available on the premises, and no risk assessment mitigating the risk to service users of not having one.
- There was a system in place for the weekly checking of emergency equipment and we saw that these checks

Are services safe?

were recorded; however the checks were not effective as we found that the oxygen cylinder had expired on 27 August 2016 and was empty and the pulse oximeter and blood glucose meter were not working.

- Emergency medicines were easily accessible to staff in a secure area of the service and all staff knew of their location. All the medicines we checked were in date and stored securely; however there were recommended emergency medicines not present and no risk assessment mitigating the risk to service users of not having them. These medicines were Benzylpenicillin used for the treatment of suspected bacterial meningitis, and Chlorphenamine used to treat anaphylaxis.
- We saw evidence following the inspection that oxygen and missing medicines had been ordered.
- All staff had received annual basic life support training, there was an instant messaging system on all computers which alerted staff to any emergency and a first aid kit and accident book were available.

Staffing

- All four doctors were registered with the General Medical Council (GMC), the medical professionals' regulatory body, with a licence to practice.
- Persons providing care and treatment did not have the qualifications, competence, skills and experience to do so safely with regards to ultra sound scanning, gynaecological examinations and fertility treatments. The doctors provided care and treatment in gynaecology, fertility and dermatology; however we saw no evidence the doctors had the experience and qualifications to do so.
- We were told that all 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). We saw evidence that doctors were following the required appraisal and revalidation processes.
- We reviewed six personnel files and found appropriate recruitment checks had been undertaken prior to employment. For example, proof of identification, evidence of satisfactory conduct in previous employments in the form of references, qualifications, registration with the appropriate professional body, medical indemnity insurance and the appropriate checks through the DBS.

Monitoring health & safety and responding to risks

There were limited procedures in place for monitoring and managing risks to patients and staff safety.

- There was a health and safety policy available; however the clinic did not have a risk register in place or undertake risk assessments to monitor the health and safety of the premises, staff and service users.
- Clinical equipment was not serviced, regularly maintained, calibrated or checked to ensure it was working properly.
- The provider had an external fire risk assessment carried out in September 2013 where the premises were assessed as high risk. We did not see evidence all actions recommended had been taken or that any actions taken or still required had been recorded and monitored. Actions still outstanding included; a follow up fire risk assessment in October 2014, fire exits were not kept unlocked so as to be immediately available at all times the building was occupied, there was no log of fire drills and no evidence fire drills were conducted, staff training records did not demonstrate fire safety awareness and the gas fired boiler in the property had not been serviced.

Infection control

We observed the premises to be clean and tidy and there were cleaning schedules and an infection control protocol in place in place; however:

- Infection prevention and control policies and procedures were not effective in assessing the risk of, preventing, detecting and controlling the spread of infections.
- Infection prevention and control audits were undertaken but were not effective in identifying and mitigating risks such as expired equipment, carpeted treatment areas, risks associated with exposure to the Legionella bacteria in water systems and staff training and equipment to safely manage the spillage of bodily fluids in the service.

Premises and equipment

- Equipment in the premises had not been maintained, serviced or checked to ensure it was suitable for the purpose for which it was being used. The types of

Are services safe?

equipment included weighing scales, thermometers and blood pressure monitors which had not been calibrated and ultrasound screening equipment which had not been serviced, checked or regularly maintained.

- We did see evidence that electrical equipment had been checked under portable appliance testing (PAT) in January 2017 to ensure the equipment was safe to use.

Safe and effective use of medicines

During our inspection we looked at the systems in place for managing medicines.

- We did not see evidence of a medicines management policy or procedure.
- There was no evidence that the service received, acted on or shared learning from healthcare or medicines alerts.
- The clinic did not carry out audits of medicines or prescribing.
- We found out of date equipment and medicines alongside in date medicines and equipment ready for use. Items included sampling tubes expired in January 2016, liquid for containing cervical screening samples expired in May 2016, forceps that were to be used before March 2017, various needles which had expired in March and April 2017 and local anaesthetic that had expired in April 2017. Expired items were isolated during the inspection and following the inspection the provider reported they had disposed of the items in line with guidance.
- A domestic refrigerator was in use for the storage of medicines and medical supplies; however there were regular temperature checks recorded, from a thermometer inside the fridge, and we saw that temperatures recorded were within the range expected for the storage of the medicines contained within. There was no secondary thermometer, the thermometer in use had not been calibrated and the fridge had not been serviced or inspected to ensure it was safe and appropriate for its intended use. One of the items stored in the fridge, a tuberculosis testing kit, was out of date. The other medicinal product stored in the fridge (Pregnyl, used for hormone therapy as part of the fertility service offered) was in date.
- All prescriptions were issued on a private basis and we observed that prescription pads were stored securely.

Are services effective?

(for example, treatment is effective)

Our findings

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

Assessment and treatment

- The provider demonstrated that they assessed needs and delivered care in line with relevant and current evidence based guidance and standards, including the national institute of health and care excellence (NICE) guidelines which were accessed online.
- Relevant guidelines were discussed with other doctors in regular clinical meetings; however we did not see evidence that evidence based guidance was affecting change in practice and better outcomes for patients.

Monitoring and improving outcomes for patients

There was no evidence of quality improvement including effective clinical audit.

- There had been no clinical audits undertaken since 2012 and the provider did not have a quality improvement programme in place.
- We saw evidence of one, one cycle audit conducted in 2012 relating to the childhood dermatology services offered. There was no evidence of quality improvement recorded.

Staff training and experience

- The provider did not have an induction programme in place and did not identify on-going training for staff. There was no evidence of induction plans or records in personnel files for clinical or non-clinical staff.
- Non-clinical staff we spoke with told us they did not have specific required training requirements, but that they were able to take part in online training of their choice. We saw evidence that most non-clinical staff had undertaken on line e-learning modules in information governance and safeguarding and that basic life support training was provided in-house.
- We were told that individual doctors kept records of their own training and continued professional development (CPD). We saw evidence that the two part time doctors had regular CPD training records and had attended training sessions through local hospital training programmes; however we did not see evidence

that those providing care and treatment had the qualifications, competence, skills and experience to do so safely with regards to ultra sound scanning, gynaecological examinations and fertility treatments.

- The provider did not have a system of appraisal and personal development in place to ensure the learning and development needs of non-clinical staff were identified and met.
- Clinical staff felt supported by the provider and demonstrated evidence of having taken part in the revalidation process with their nominated responsible officer.

Working with other services

- There was no evidence of working with other organisations. The provider told us that patients were advised to inform their own doctor of the treatment they were receiving and were expected to make follow up appointments with their own doctors. There was no system to check patients did this.
- Patients were provided with letters explaining the consultation, tests and treatments carried out and were referred to accident and emergency departments and other healthcare services where required.

Consent to care and treatment

Staff sought patients' consent to care and treatment in line with legislation and guidance.

- Staff understood the relevant consent and decision-making requirements of legislation and guidance, including the Mental Capacity Act 2005.
- When providing care and treatment for children and young people, staff told us they carried out assessments of capacity to consent in line with relevant guidance; however we did not see evidence to demonstrate this in the patient records we looked at.
- Where a patient's mental capacity to consent to care or treatment was unclear, staff told us they would assess the patient's capacity and record the outcome of the assessment; however we did not see evidence to demonstrate this in the patient records we looked at.
- The process for seeking consent was not monitored through patient records audits.
- We were told that any treatment including fees was fully explained to the patient prior to the procedure and that

Are services effective?

(for example, treatment is effective)

people then made informed decisions about their care. Standard information about fees was detailed on the clinic website and leaflets and notices provided at the service.

Are services caring?

Our findings

Kindness, dignity, respect and compassion

During our inspection we observed that members of staff were courteous and very helpful to patients and treated them with dignity and respect.

- Curtains or separate rooms were provided in consulting rooms to maintain patients' privacy and dignity during examinations, investigations and treatments.
- Consultation and treatment room doors were closed during consultations; conversations taking place in these rooms could not be overheard.
- Reception staff knew that if patients wanted to discuss sensitive issues or appeared distressed they could offer them a private area to discuss their needs.
- Patients could be treated by a clinician of the same sex.

We received 27 comment cards which were all positive about the standard of care received. Comments included

that all staff, including doctors, were kind, caring and treated patients with respect. We also spoke with two patients during the inspection who both said they were satisfied with the care they received and told us that appointments were convenient, that doctors gave them enough time during their consultation and that they were involved in their care and treatment.

Involvement in decisions about care and treatment

Patients told us they felt involved in decision making about the care and treatment they received. They also told us 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. Patient feedback from the comment cards we received was also positive and aligned with these views.

All staff spoke French and English and also offered a range of other languages such as Arabic, Portuguese, Italian, Russian, Somali, Swahili and Lingala.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting patients' needs

- The service was only accessible via stairs; however this was clearly communicated via the service leaflet and website. Patients requiring level access or assisted access were offered a home visit.
- There was information in the reception area which included arrangements for dealing with complaints, arrangements for respecting dignity and privacy of patients and the services available.
- Information was also available on the service website.
- All patients attending the service referred themselves for treatment; none were referred from NHS services.

Tackling inequity and promoting equality

- The service offered appointments primarily to French speaking patients; however the service was open to any fee paying patient.
- Patient fees were clearly set out and structured according to seniority of doctor, with follow up appointments attracting a lower price and tests incurring additional fees.

- Patients were offered a cost saving initiative whereby they could pay an annual fee equivalent to three consultations and receive as many consultations as required in a 12 month period.

Access to the service

- The service was open Monday to Friday with appointments available between 10am and 5pm.
- Appointments were prebookable over the phone.
- Appointments were often available for the same day, with patients seeking urgent or emergency treatment referred to other services and the NHS.

Concerns & complaints

- The service had a system in place for handling complaints and concerns in line with recognised guidance for independent doctors in England.
- There was a designated responsible person who handled complaints.
- The service had not received any complaints in the last 12 months.
- The service had responded to feedback from patients. For example patients had requested a water dispenser in the reception area, the service responded by offering bottled water at reception.

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.

Vision and strategy

- The service had a patient focussed ethos and a vision to deliver good, inexpensive care; however deficiencies in governance arrangements meant that care was not always delivered safely and effectively.
- The service did not have a strategy or business plans supporting the service and reflecting the vision.

Governance arrangements

The service did not have an effective overarching governance framework supporting the delivery of good quality care.

- The registered manager was the lead in all aspects of the service and staff were aware of their own roles and responsibilities.
- Service specific policies were available to all staff. These were updated and reviewed regularly; however some policies and procedures were not effective in managing risks to service users, including the safeguarding policy.
- Clinical meetings were held weekly which provided an opportunity for staff to share and learn, however records and discussions with staff did not demonstrate these were effective in monitoring and improving safety and quality of care.
- There was no evidence of any system in place to monitor the quality of clinical care and make improvements including audits.
- Arrangements for identifying, recording and managing risks, issues and implementing mitigating actions were not effective. For example the service did not have adequate arrangements in place for dealing with medical emergencies, had not actioned recommendations in previous fire risk assessments

including carrying out further fire risk assessments and there were infection prevention and control risks not identified such as out of date medicines and equipment.

- We saw records of meetings that the structure of meetings and records did not allow for lessons to be identified, learned and shared following significant events and complaints.

Leadership and culture

- The registered manager was the service lead and staff told us they were approachable and staff felt supported; however staff did not receive formal appraisals or development reviews and were not supported to perform their duties competently through identifying required training.
- Staff told us the service held regular team meetings, that there was an open culture within the service and that they had the opportunity to raise issues at meetings and felt confident and supported in doing so. Although staff were able to provide examples of when they had raised concerns; records did not demonstrate learning identified by staff, or that learning had taken place from identified risks and issues.

Seeking and acting on feedback from patients, the public and staff

The service collected feedback from patients and staff.

- There was a suggestions box and patient comments and suggestions received were used by clinical staff in their appraisal process. Non-clinical staff told us they used patient feedback to make improvements, for example by providing bottled water at reception.
- Staff feedback was collected informally through staff meetings and discussion. Staff told us they would not hesitate to give feedback and discuss any concerns or issues with colleagues and the provider.