Queens Clinic

Inspection report

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

Ratings

Overall rating for this location	Inadequate
Are services safe?	Requires Improvement
Are services effective?	Inadequate
Are services caring?	Good
Are services responsive to people's needs?	Good
Are services well-led?	Inadequate

Overall summary

This service is rated as inadequate overall. The service had previously been inspected on 13 February 2020, 9 February 2021, 2 September 2021 and 30 November 2021, and in each case, there were breaches of CQC regulations. Following the inspection on 30 November 2021 the service was rated as requires improvement overall, and in the safe, effective and well led key questions. The responsive and caring key questions were rated as good. The service was found to be in breach of regulations 12, 17 and of HSCA (RA) 2014 and requirement notices were put in place. The specific issues found at this inspection were:

- The oxygen bottle in place at the surgery was noted to be empty at the time of the inspection.
- The service did not own its own defibrillator but shared one with another organisation in the building. Staff at the service were unaware of where this was located, and by the time it was found and staff returned to the clinic, five minutes had passed.
- Learning from incidents was not routinely shared within the team.
- Learning from audits was unclear. Audits completed were not recorded in cycles, and as such it was not possible to determine whether or not performance had improved.
- The practitioner did not routinely send out letters to patients in a password protected format.
- On the day of the inspection, neither the lead clinician or service manager were able to show completed fire safety or information governance training.
- We spoke to several staff who either worked at the clinic or had worked there in the past. They told us that there was a non-supportive culture at the service. Several reported being publicly criticised by the provider, and they stated that they had no autonomy. They reported being afraid to raise issues of concern with the provider.
- The service did not have either a risk register or other formal way of showing that risks were being identified, recorded, monitored and mitigated.

We carried out an announced comprehensive inspection of Queens Clinic on 30 September 2022. We found that some of the breaches of regulation from the previous inspection had been addressed, but others had not. Following this inspection, the key questions are rated as:

Are services safe? – Requires improvement

Are services effective? – Inadequate

Are services caring? – Good

Are services responsive? – Good

Are services well-led? – Inadequate

Our key findings were:

- The service had good systems to manage risk in most areas so that safety incidents were less likely to happen. The service had limited quality improvement mechanisms in place, so it was unclear how the service was determining if the care was of sufficient standard, and incidents were not being missed.
- The service undertook procedures under local anaesthetic, but in the event of an adverse reaction to local anaesthetic, the lead clinician was the only person available to manage this. The lack of a second clinician had not been adequately risk assessed.
- The service had not reviewed the effectiveness and appropriateness of the care it provided. Records reviewed were also unclear regarding the exact nature of procedures, and what had been discussed with the patient.
- Staff at the service had not received appraisals.

Overall summary

- Staff treated people with compassion, kindness, dignity and respect.
- Patients were able to access care and treatment from the service. An adequate complaints system was in place.
- The organisation had appropriate leadership structures in place. However, governance systems, particularly those whereby learning could be demonstrated, were unclear.
- The service had not addressed issues identified as requiring improvement in previous CQC inspections, and continuing breaches of CQC regulations were evident.

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

- Ensure systems and processes are established and operated effectively to ensure compliance with the requirements of good governance.
- Ensure systems and processes are established and operated effectively to ensure compliance with the requirements of good staffing.

The service **should**:

- Review the notes tracker on the patient records database, which was incomplete.

I am placing this service in special measures. Services placed in special measures will be inspected again within six months. If insufficient improvements have been made such that there remains a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating the service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve.

The service will be kept under review and if needed could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement we will move to close the service by adopting our proposal to remove this location or cancel the provider's registration.

Special measures will give people who use the service the reassurance that the care they get should improve.

Dr Sean O'Kelly BSc MB ChB MSc DCH FRCA

Chief Inspector of Hospitals and Interim Chief Inspector of Primary Medical Services

Our inspection team

Our inspection team was led by a CQC lead inspector**.** The team included an obstetrics and gynaecology specialist adviser.

Background to Queens Clinic

Queens Clinic is a private gynaecological service located on the second floor at 75-76 Wimpole Street, Marylebone, London, W1G 9RT. The building entrance lobby is accessed via steps from the pavement. Wheelchair access is via a ramp at the front of the building (patients are advised of this and a member of staff is available to assist patients). The service is easily accessible by public transport and is a short walk from Bond Street. There are two consultation rooms, one minor operations room, one reception room and a waiting area for patients

The service is staffed by a lead clinician, who is the sole owner of the business, and registered manager. At the time of the inspection, the service also employed three health care assistants (HCAs), with clinical staff supported by a service manager, a clinic manager, a deputy manager, plus two further administrative members of staff.

The opening hours are 9am to 9pm, Monday to Friday and between 9am to 6pm on Saturdays. Patients have access to the lead clinician by phone for out of hours emergencies.

The service provides private consultations to adults. A variety of services are offered including gynaecological diagnostic and minor surgery procedures.

How we inspected this 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 the service as requires improvement for providing safe services.

We carried out this announced comprehensive inspection on 30 September 2022. We had last carried out an announced comprehensive inspection on 30 November 2021 Following this inspection, the service was not providing safe services, and we found the following:

- The oxygen bottle in place at the surgery was noted to be empty at the time of the inspection. Oxygen is required bearing in mind the procedures undertaken at the clinic. The service manager stated that the bottle had been recently filled but might be faulty, and contacted the supplier on the day of the inspection so that this was addressed.
- The service did not own its own defibrillator but shared one with another organisation in the building. Staff at the service were unaware of where this was located, and by the time it was found and staff returned to the clinic, five minutes had passed.
- Learning from incidents was not routinely shared within the team. We saw that the provider would take immediate action to improve services following incidents. However, there were instances (such as patient who passed out following a blood test) which should have been recorded as incidents but were not.

At the time of the inspection visit on 30 November 2021, these issues had been addressed, but other breaches of CQC regulations were identified. Specifically:

- We noted that during surgical procedures undertaken under local anaesthetic, the surgeon was the only regulated health professional present. The service had not adequately risk assessed not routinely having a second clinician available.
- In review of clinical records and consent forms, we saw examples where it was not possible to ascertain what procedures had been undertaken, and/or what consent process had been followed, including the explanation of risks and provision of information.

Safety systems and processes

The service had clear systems to keep people safe and safeguarded from abuse.

- The provider conducted safety risk assessments. It had appropriate safety policies, which were regularly reviewed and communicated to staff including locums. They outlined clearly who to go to for further guidance. Staff received safety information from the service as part of their induction and refresher training. The service had systems to safeguard children and vulnerable adults from abuse.
- The service worked with other agencies to support patients and protect them from neglect and abuse. Staff took steps to protect patients from abuse, neglect, harassment, discrimination and breaches of their dignity and respect.
- The provider carried out staff checks at the time of recruitment and on an ongoing basis where appropriate. Disclosure and Barring Service (DBS) checks were undertaken where required. (DBS checks identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable).
- All staff received up-to-date safeguarding and safety training appropriate to their role. They knew how to identify and report concerns.
- There was an effective system to manage infection prevention and control.
- 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.
- The provider carried out appropriate environmental risk assessments, which took into account the profile of people using the service and those who may be accompanying them.

Risks to patients

Requires Improvement

Are services safe?

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

- We noted that during surgical procedures undertaken under local anaesthetic, the surgeon was the only regulated health professional present. In surgical procedures carried out under local anaesthetic in the NHS, a regulated and registered nurse would also be required. Although a second clinician is not an absolute requirement in independent healthcare, the presence of only the lead clinician for such procedures had not been adequately risk assessed by the service. We discussed the risk factors with the lead clinician, who did not consider the lack of a second regulated clinician to be a risk.
- There were arrangements for planning and monitoring the number and mix of staff needed.
- There was an effective induction system for agency staff tailored to their role.
- Staff understood their responsibilities to manage emergencies and to recognise those in need of urgent medical attention.
- When there were changes to services or staff the service assessed and monitored the impact on safety.
- There were appropriate indemnity arrangements in place.
- There were suitable medicines and equipment to deal with medical emergencies which were stored appropriately and checked regularly. If items recommended in national guidance were not kept, there was an appropriate risk assessment to inform this decision.

Information to deliver safe care and treatment

Staff did not have the information they needed to deliver safe care and treatment to patients.

- In review of clinical records and consent forms, we saw examples where it was not possible to ascertain what procedures had been undertaken, and/or what consent process had been followed, including the explanation of risks and provision of information.
- 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.

Safe and appropriate use of medicines

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

- There were systems and arrangements for managing medicines. The service kept prescription stationery securely and monitored its use.
- 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).
- 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.

Track record on safety and incidents

The service did not have a good safety record.

- There were comprehensive risk assessments in relation to safety issues.

Requires Improvement

Are services safe?

- The service had limited systems in place to monitor and review activity. It was therefore difficult to ascertain how risk management protocols were triggered at the service.

Lessons learned and improvements made

The service had systems in place for when things went wrong when things went wrong.

- There was a system for recording and acting on significant events. Staff understood their duty to raise concerns and report incidents and near misses. The service had not raised any clinical incidents in the last year.
- There were adequate systems for reviewing and investigating when things went wrong. However, in the absence of specific incidents, CQC was not able to review how this worked in practice.
- 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.

Inadequate

Are services effective?

We rated effective as Inadequate because:

We carried out this announced comprehensive inspection on 30 September 2022. We had last carried out an announced comprehensive inspection on 30 November 2021. Following this inspection, the service was not providing effective services, and we found the following:

- Learning from audits was unclear. Audits of clinical records were routinely undertaken by the same clinician who had undertaken that consultation. Audits completed were not recorded in cycles, and as such it was not possible to determine whether or not performance had improved.
- The practitioner did not routinely send out letters to patients in a password protected format. We saw examples of where the practitioner had asked for consent to do this, but it was not routinely completed.
- On the day of the inspection, neither the lead clinician or service manager were able to show completed fire safety or information governance training, this was completed by the members of staff within 24 hours of the inspection.

At the time of the inspection visit on 30 November 2021, some of these issues had been addressed, but others had not, and other breaches of CQC regulations were identified. Specifically:

- The service had not completed any two cycle audits to either assure that care being provided was safe, or to demonstrate quality improvement. The lack of two cycle audits was first raised in an inspection by CQC of the service in February 2020, and a lack of two cycle audits was also subsequently raised in inspections in February 2021, and November 2021.
- Consent procedures at the service were not adequate. Consent forms did not detail discussions of risk or management options with patients, or information sharing.
- A lack of explicit detail in clinical records meant that it was not possible to ascertain what procedures had been carried out.
- Staff at the service had not been appraised.

Effective needs assessment, care and treatment

The provider did not have systems to keep clinicians up to date with current evidence-based practice. We saw evidence that clinicians did not assess needs and delivered care and treatment in line with current legislation, standards and guidance (relevant to their service).

- During a review of clinical records, we noted that it was not possible to identify procedures that had been undertaken, and in one case it appeared that an inappropriate procedure had been carried out. In the notes of an 18 year old patient, all that was written in the notes was "vaginal reconstruction". When questioned about this, the lead clinician told CQC that the procedure was actually a hymenoplasty, a procedure that is currently illegal in the United Kingdom. The lead clinician told us subsequently that it was not a hymenoplasty either, but an operation to manage post-sexual pain. In either event, this was not clear from the clinical records, nor was there any record of having considered the appropriateness of undertaking such a procedure in a patient of this age.
- Clinical records did not contain sufficient relevant information to determine whether or not clinicians had made an appropriate diagnosis, or were managing the patient in line with guidelines.
- We saw no evidence of discrimination when making care and treatment decisions.
- Staff assessed and managed patients' pain where appropriate.

Monitoring care and treatment

The service was not actively involved in quality improvement activity.

Inadequate

Are services effective?

- Following a previous CQC inspection the service had provided clinical notes audits undertaken by the same clinician that had treated the patients.
- The service had not completed any two cycle audits to either assure that care being provided was safe, or to demonstrate quality improvement. The lack of two cycle audits was first raised in an inspection by CQC of the service in February 2020, and a lack of two cycle audits was also subsequently raised in inspections in February 2021, and November 2021.

Effective staffing

Staff had skills, knowledge and experience to carry out their roles, but appraisal processes were not in place.

- 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 understood the learning needs of staff and provided protected time and training to meet them. At the time of the inspection, a majority of staff were new to the service. However, one longstanding member of staff at the service had not been appraised.
- 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.

- Before providing treatment, doctors at the service told us that they ensured they had adequate knowledge of the patient's health, any relevant test results and their medicines history. However, this was not documented.
- All correspondence was sent to patients and their general practitioners in a password protected format.
- 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, or they were not registered with a GP. For example, medicines liable to abuse or misuse, and those for the treatment of long-term conditions such as asthma. Where patients agreed to share their information, we saw evidence of letters sent to their registered GP in line with GMC guidance.

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.

Consent to care and treatment

The service did not obtain consent to care and treatment in line with legislation and guidance.

- Clinical staff did not follow or adhere to the requirements of legislation and guidance when considering consent and decision making. For example, in the case of one patient who attended for a labial reduction, no risks were documented as having been discussed with the patient other than "pains". The procedure required a two-stage consent process where the patient could return to the service after a period of reflection, but the procedure had been

Are services effective?

carried out on the same day as the first appointment. There was no evidence of leaflets provided, or that the doctor had discussed management options with the patient. This meant the patient may not have had time to review the risks and benefits of the procedure and may not have had full knowledge of other options before going ahead with the procedure.
- Clinical records did not show that clinical staff supported patients in making decisions.

Good

Are services caring?

We rated the service as good for providing caring services.

Kindness, respect and compassion

Staff treated patients with kindness, respect and compassion.

- The service sought feedback on the quality of clinical care patients received.
- We did not get specific feedback from patients, however we noted that patients' comments on the website was positive about the way staff treat people.
- 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.

- Staff told us that interpretation services were available for patients who did not have English as a first language. Patients were also told about multi-lingual staff who might be able to support them.
- Communication aids were not available for patients who were hard of hearing or had vision impairment.

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 because:

Responding to and meeting people’s needs

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

- The facilities and premises were appropriate for the services delivered.
- The provider understood the needs of their patients. For example, patients could contact the doctor out of hours Monday to Friday and all-day Saturday and Sunday.
- Reasonable adjustments had been made so that people in vulnerable circumstances could access and use services on an equal basis to others. For example there was ramp access to the service.

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 any further action that may be available to them should they not be satisfied with the response to their complaint.
- The service had complaint policy and procedures in place. The service learned lessons from individual concerns, complaints and from analysis of trends.

Inadequate

Are services well-led?

We rated well-led as Inadequate because:

We carried out this announced comprehensive inspection on 30 September 2022. We had previously carried out an announced comprehensive inspection on 30 November 2021. Following these inspections, the service was not providing well led services, and we found the following:

- We spoke to several staff who either worked at the clinic or had worked there in the past. They told us that there was a non-supportive culture at the service. Several reported being publicly criticised by the provider, and they stated that they had no autonomy. They reported being afraid to raise issues of concern with the provider.
- Audits and significant events took place in the practice. However, learning was not routinely shared within the team.
- The service did not have either a risk register or other formal way of showing that risks were being identified, recorded, monitored and mitigated.

At the time of the inspection visit on 30 September 2022, some of these issues had been addressed, but other breaches of CQC regulations were identified. Specifically:

- The service had not developed leadership and governance procedures to address breaches of CQC regulations identified in previous inspections.
- The lack of two cycle audits had been noted in three previous CQC inspection reports, but the service had not taken steps to address this.
- There was a lack of clear clinical governance procedures at the service to show that the service was providing safe and effective care.
- At the time of the inspection, most of the staff at the service were new, and it was therefore not possible to determine if Leaders at the service were visible and supportive to staff.

Leadership capacity and capability;

Leaders did not have the capacity and skills to deliver high-quality, sustainable care.

- The provider had appointed new service managers at the service, and they had addressed administrative and operational concerns detailed in the report.
- Leaders at the service had not implemented clear clinical governance systems and protocols to ensure safe and effective care.

Vision and strategy

The service had a vision and credible strategy to deliver care, but this was not clinically focussed at delivering high quality care for patients

- There was a clear vision and set of values. The service had a realistic strategy and supporting business plans to achieve priorities.
- It was unclear how the service was measuring the service’s vision aim of delivering high quality care for patients.

Culture

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

Inadequate

Are services well-led?

- At previous CQC inspections, we spoke to people who either worked at the clinic or had worked there in the past. They told us that there was a non-supportive culture at the service. At the time of the inspection the majority of staff were new starters, so it was not possible to determine if this culture had changed.
- The service focused on the needs of patients.
- The provider was aware of and had systems to ensure compliance with the requirements of the duty of candour.
- There were processes for providing all staff with the development they need.

Governance arrangements

There were limited roles and systems of accountability to support good governance and management.

- Structures, processes and systems to support good governance and management were effective in some areas, but not in driving improvement at the service. The service had no effective quality assessment and improvement systems in place for its clinical case, and clinical records reviews showed that best practice was not being followed.
- Clinical processes at the services had not been sufficiently risk assessed to assure that safe and effective processes were being provided.
- Staff were clear on their roles and accountabilities.

Managing risks, issues and performance

There were some processes for managing risks, issues and performance.

- The service had a risk management strategy and a risk register in place, but it was unclear how clinical risks were being identified.
- Leaders had oversight of safety alerts, incidents, and complaints.
- The provider had plans in place and had trained staff for major incidents.

Appropriate and accurate information

The service did not have appropriate and accurate information.

- The service used performance information, which was reported and monitored, and management and staff were held to account.
- The service submitted data or notifications to external organisations as required.
- The clinical records reviewed did not contain sufficient information about procedures undertaken and assessment of and discussions with patients.
- The service had recently changed the patients records database that it used. At the time of the inspection, the notes tracker in the patient records was incomplete.

Engagement with patients, the public, staff and external partners

The service involved patients, the public, staff and external partners to support high-quality sustainable services.

- The service sought customer feedback from patients.
- The service was transparent, collaborative and open with stakeholders about performance.

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 were not being met.

Regulated activity	Regulation
Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing The provider had failed to ensure all staff received an appraisal.

Regulated activity	Regulation
Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance The provider was failing to comply with the requirements of good governance.