132 Harley Street Limited

Inspection report

132 Harley Street
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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	Requires Improvement
Are services safe?	Requires Improvement
Are services effective?	Requires Improvement
Are services caring?	Good
Are services responsive to people's needs?	Good
Are services well-led?	Requires Improvement

Overall summary

This service is rated as Requires improvement overall. (Previous inspection August 2013 unrated).

The key questions are rated as:

Are services safe? – Requires improvement

Are services effective? – Requires improvement

Are services caring? – Good

Are services responsive? – Good

Are services well-led? – Requires improvement

We carried out an announced comprehensive inspection at 132 Harley Street Limited as part of our inspection programme, to check whether the service was meeting the legal requirements and regulations associated with the Health and Social Care Act 2008. This was a first rated inspection for the service that was registered with the Care Quality Commission (CQC) in August 2020. During this inspection we inspected the safe, effective, caring, responsive and well-led key questions.

The service was previously inspected in August 2013, and we found it was providing care in accordance with the relevant regulations. At the time of inspecting this service in 2013, CQC did not have the statutory powers to rate the service.

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 exemptions from regulation by CQC which relate to particular types of regulated activities and services and these are set out in Schedule 1 and Schedule 2 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The service manager 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.

Our key findings were:

- There were some internal risk assessment processes, but these did not always function well and were inconsistent in their implementation and impact.
- There was evidence some safety risks were assessed however, this was not always well-managed; the service did not have an effective system of health and safety checks. For example, there was no evidence of control measures to identify risks from exposure to Legionella.
- There were safe procedures for managing medical emergencies including access to emergency medicines and equipment.
- The service did not manage medicines appropriately. For example, prescription stationery was not always stored securely, in line with recommendations.
- Records were written and managed in a way that keep people safe. Staff helped patients to be involved in decisions about their care and treatment.

Overall summary

- Patients were treated with kindness, respect and compassion. Feedback from patients was positive about the way staff treat people.
- The service had a complaint policy and procedures in place. We found that complaints were dealt with in a timely manner and with openness and transparency.
- The provider had quality improvement processes in place. We saw staff had completed audits to monitor quality and improve outcomes for patients.
- Staff whose files we reviewed had not completed all essential training at an appropriate level.
- The processes for providing all staff at every level with the development they need, required improvement. Some staff had not received an annual appraisal in the last year. There was no effective system of documenting staff appraisals.
- 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.
- Staff said that they felt happy to raise concerns or issues to the provider.
- The way the practice was led and managed promoted the delivery of high-quality, person-centre care. However, the governance arrangements in place were not effective, there were some areas where control measures had been put in place to manage risk, but leaders did not have oversight.

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

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

We spoke to the provider about the concerns identified and the risk to people's safety and wellbeing. Under Regulation 17(3)(a)(b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, we asked the provider to send us a report on actions they planned to take to meet the associated HSCA regulations. The impact of our concerns is minor for patients using the service, in terms of the quality and safety of clinical care. The likelihood of this occurring in the future is low once it has been put right.

We have told the provider to take action (see specific details of this action in the Requirement Notices at the end of this report).

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

- Improve the facilities in place for people with visual and hearing impairments.
- Establish protocols for verifying the identity of patients.
- Take action to review the appraisal policy to ensure all staff have an annual appraisal.

Dr Sean O'Kelly BSc MB ChB MSc DCH FRCA

Chief Inspector of Health Care

Our inspection team

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

Background to 132 Harley Street Limited

132 Harley Street Ltd is a consultant outpatient facility at 132 Harley Street, London, W1G 7JX and provides private outpatient diagnostic and treatment services to adults. The main speciality is gynaecology. The service provides consultation rooms as well as outpatient pathology services and colposcopy. It also offers ultrasound service as well as urodynamics testing.

The service rents consulting rooms to a variety of conventional specialists as well as complementary therapists. The specialists are all registered with the General Medical Council and all offer consultations at the clinic, as well as working in hospitals. The patients are required to pay consultants individually for consultation and treatment. There are no practising privileges arrangements.

132 Harley Street Limited occupies part of a building managed by an estate management company. The service is located across five floors, with clinical rooms on the ground floor and two upper floors. Services are available to any fee-paying patient. The service is open Monday to Friday 8.30am to 5.30pm. The service is not open at the weekends. The service is led by two directors who are both NHS consultants, Mr J Richard Smith and Mr Michael K Stafford. The service manager is the registered manager. They are supported by a clinic nurse, healthcare assistant, practice personal assistant and receptionist.

The location is registered with the CQC to provide the following regulated activities; treatment of disease, disorder or injury and diagnostic and screening procedures and family planning. The service carries out diagnostic colposcopy (biopsy of the cervix) procedures. The provider told us that no hysteroscopy, cautery or cryotherapy procedures are carried out at the service.

How we inspected this service

Throughout the pandemic CQC has continued to regulate and respond to risk. However, taking into account the circumstances arising as a result of the pandemic, and in order to reduce risk, we have conducted our inspections differently.

This inspection was carried out in a way which enabled us to spend a minimum amount of time on site. This was with consent from the provider and in line with all data protection and information governance requirements.

We carried out an announced comprehensive inspection at132 Harley Street Limited on 20 September 2023. Our inspection team was led by a CQC Lead Inspector. Before visiting, we looked at a range of information that we hold about the service. We reviewed information submitted by the service in response to our provider information request. During our visit we interviewed staff, observed practice and reviewed documents.

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:

We found that care and treatment were not always provided safely as not all staff were trained to the appropriate levels of safeguarding adults and children for their roles. The building management carried out safety assessments, however the provider could not demonstrate they effectively monitored these.

Safety systems and processes

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

- Although the service had conducted their own internal health and safety risk assessments, there were some risks that were not well managed, related to safety risks in the building managed by another organisation.
- The building management carried out safety assessments, however the provider could not demonstrate they effectively monitored this. There was no evidence of regular attempts to get assurances about the status of any remedial actions to control risks. At the time of our inspection, staff told us that the building's management had undertaken a fire risk assessment of the premises, but this was not available to look at. The provider was not aware whether actions identified by the external fire assessor had been implemented to reduce the risk. This meant that patients and staff members' health and wellbeing was at risk.
- Although the provider had carried out their own internal fire safety risk assessment in June 2023, there was limited evidence that fire risks were adequately controlled. For example, the fire safety risk assessment template used by service staff needed to be updated. There were no review dates recorded against actions identified. Following our inspection, the provider sent us confirmation that a fire risk assessment was booked with an external fire safety assessor, to inspect the premises, on 31 October 2023.
- The provider told us that the building landlord was responsible for installing and maintaining the fire alarm system. However, the service did not keep an up-to-date log of weekly fire alarm checks and it was not clear whether any faults with the fire detection system had been identified, investigated and remedial action taken.
- Staff told us the fire alarm service was completed annually. However, the service was not able to show us a copy of the last fire alarm service or copy of any recommendations or actions by the assessor.
- The provider had a fire evacuation procedure and sent us evidence of their own fire evacuation drills. The last fire drill was on 5 September 2023. The service sent us evidence of fire extinguisher inspection completed in October 2022.
- Fire action signage – when we inspected the premises, there was insufficient fire action signage. For example, there were no signs directing patients or visitors to evacuation exit on the ground floor. Following our inspection, the service told us that they had reviewed fire action signage and ensured signs were appropriately displayed.
- The provider did not have appropriate safety policies and activities to ensure safety. There was an infection control and decontamination policy. However, arrangements to prevent, detect and control the spread of infections, including those that were health care associated, were not effective. For example, there was no legionella risk assessment available when we inspected the service. Staff were not able to obtain information about any issues identified by the external legionella risk assessment, which may have required action by the building landlord. Following our inspection, the provider told us they had arranged for a legionella risk assessment to be carried out independently on 24 October 2023. (Legionella is a term for a particular bacterium which can contaminate water systems in buildings).
- The service did not have a system of monthly checks of hot water outlets to ensure that all temperature readings are above 55°C. Following our inspection, the provider sent us a legionella management policy which included guidance on appropriate measures to control bacterial growth.
- Following our inspection, the provider took action to develop a comprehensive risk assessment log to improve management of safety and environmental risks. We saw evidence that fire safety and legionella checks had been added to the risk assessment log.

Requires Improvement

Are services safe?

- There were safety policies and staff received safety information on the service as part of their induction and training. They outlined clearly who to go to for further guidance.
- The service had systems to safeguard children and vulnerable adults from abuse. Although we found not all staff had received up to date safeguarding training appropriate to their role. The practice had a safeguarding policy and there was information of how safeguarding concerns should be managed within the practice. The provider did not consult with children or patients aged under 18 although there was no restriction on children entering the premises whilst accompanying adults attending appointments. We checked 3 staff files and found 2 non-clinical staff had not completed adult and children safeguarding training to the appropriate level for their role. (It is a requirement set out in the Intercollegiate Guidelines for non-clinical staff to be trained in safeguarding children to level two). Following our inspection, the service sent us evidence that staff identified had completed appropriate safeguarding training, as was necessary to carry out their duties.
- 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).
- Not all staff who acted as chaperones had completed chaperone training. Two members of non-clinical staff had not done chaperone training. There was no effective system to monitor training to ensure staff had up-to-date skills and knowledge. However, staff who acted as chaperones had received a DBS check. Following our inspection, the service sent us evidence of completed chaperone training for the non-clinical members of staff.
- There were systems to ensure cleaning of medical equipment between testing and diagnostic procedures.
- There were appropriate systems for safely managing healthcare waste.
- The provider did not have effective policies to manage environmental risks. We saw examples of risk associated with the surrounding environment that had not been identified and acted upon effectively.
- The provider had not always ensured that facilities and equipment were safe, and that equipment was maintained according to manufacturers' instructions. There was no evidence of a recent fixed wiring check. We asked for a copy of the electrical installation condition report (EICR), but this was not available. Staff told us a fixed wiring check had been due to be done in January 2021, but this had been delayed due to the COVID-19 pandemic.
- The service had carried out their own internal electricity risk assessment which included listing risks which were not adequately controlled and the actions needed. We saw one control listed which said 'All power sockets to be observed for any deterioration". However, in the clinical room on the ground floor, we observed a plug socket on the wall and saw that the face of the socket was not fastened to the wall securely. We raised this with the clinic manager at the time who told us they would arrange for their maintenance person to repair the socket.
- Following our inspection, the registered manager told us they had arranged for an engineer to carry out a fixed wiring check on 6 October 2023. Staff sent us a copy of the electrical Installation Condition Report (EICR) which listed some remedial actions to ensure safety compliance. We saw evidence that staff had arranged for remedial work to be carried out and the remedial actions were added to the risk assessment log, which staff were monitoring.
- Equipment calibration – at the time of our inspection, there was no evidence that the digital weighing scales, colposcopes or blood pressure machines had been calibrated. Following our inspection, the service told us they had arranged for a biomedical engineer from Medical Store Ltd to conduct calibration checks.
- Medical equipment – at the time of our inspection, there was no evidence of regular maintenance and calibration checks of diagnostic equipment, for example the urodynamic testing machine. (Urodynamics are tests to for finding out how your bladder and urethra are working). Following our inspection, the service sent us evidence that they had arranged for a biomedical engineer to complete service checks of diagnostic equipment and conduct calibration checks where relevant.

Risks to patients

Requires Improvement

Are services safe?

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

- Two non-clinical members of staff had not received appropriate training in basic life support for their roles
- There were arrangements for planning and monitoring the number and mix of staff needed. When there were changes to services or staff the service assessed and monitored the impact on safety.
- At the time of our inspection, the service did not have a business continuity plan in place. Following our inspection, the provider sent us a copy of a business continuity plan which included a business impact analysis of threats to the continuity of business at 132 Harley Street.
- 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. They knew how to identify and manage patients with severe infections, for example sepsis.
- 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.
- When there were changes to services or staff the service assessed and monitored the impact on safety.
- There were appropriate indemnity arrangements in place.

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.
- Clinicians made appropriate and timely referrals in line with protocols and up to date evidence-based guidance. The provider told us that patients can be referred back to their GP if needed, or referred onward privately to another consultant for specialist treatment, when needed.

Safe and appropriate use of medicines

The service systems for appropriate and safe handling of medicines were not always effective.

- The systems and arrangements for managing medicines, including vaccines, controlled drugs, emergency medicines and equipment minimised risks. Although the service did not see patients who were acutely unwell, clinicians did administer Gardasil vaccinations and had appropriate emergency medicines and equipment to resuscitate somebody who has had a cardiac arrest and also resuscitate somebody with anaphylaxis.

- The service monitored prescription stationery however it did not keep prescription stationery securely. For example, we found blank letterhead prescription forms in a folder in a clinic room where the folders were accessible to anyone entering the clinic room. Staff told us the clinic rooms were kept locked and the prescription forms were stored in an A4 binder. However, we saw one binder left in the open, not securely locked away when the room was not in use. We raised this with managers and following our inspection, the service told us prescription stationery was stored in a locked cupboard.
- The service carried out regular medicines audit to ensure prescribing was in line with best practice guidelines for safe prescribing.

Requires Improvement

Are services safe?

- The service did not prescribe 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. The service had a prescribing policy which included guidance for gynaecologists treating recurrent lower urinary tract infections and an antibiotic prescribing policy.
- 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.
- We asked the provider how they verified the identity of the patients they treated. Staff told us that identity is established by the secretary at the time of booking the appointment for all patients who attend 132 Harley Street Ltd. The provider told us that patients registered at reception by completing a paper form which is then scanned into the system. Every time they attended, patients were required to update the information on the registration form where required. Also this registration form did not include the patient's medical history/medications/etc. The provider told us that each consultant had their own form for getting this medical information and they asked for this information during the consultation.
- The provider provided menopause management services which included providing Bioidentical Hormone Replacement Therapy. Some of the medicines this service prescribed are unlicensed. Treating patients with unlicensed medicines is higher risk than treating patients with licensed medicines, because unlicensed medicines may not have been assessed for safety, quality and efficacy. These medicines are not recommended by the National Institute for Health and Care Excellence (NICE) or the British Menopause Society. NICE Guidance NG23 states that clinicians must explain to women that the efficacy and safety of unregulated compounded bioidentical hormones are unknown.

Track record on safety and incidents

The service had a good safety record. However, improvement was required to ensure effective monitoring.

- There were risk assessments in relation to safety issues. These had been arranged by the building's management. However, the service did not always monitor and review this activity and therefore could not be assured that outstanding remedial actions had been implemented

Lessons learned and improvements made

The service learned and made improvements when things went wrong.

- There was a system for recording and acting on significant events. Staff understood their duty to raise concerns and report incidents and near misses. Leaders and managers supported them when they did so.
- There were adequate systems for reviewing and investigating when things went wrong. The service learned and shared lessons identified themes and took action to improve safety in the service.
- 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.
- 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.

Requires Improvement

Are services effective?

We rated effective as Requires improvement because:

There was no effective system to monitor essential staff training. We checked three staff files and found some gaps in staff mandatory training. Some staff had not received regular appraisal of their performance in their role from an appropriately skilled and experienced person.

Effective needs assessment, care and treatment

The provider had systems to keep clinicians up to date with current evidence based practice. We saw evidence that clinicians assessed needs and delivered care and treatment in line with current legislation, standards and guidance (relevant to their service).

- The provider assessed needs and delivered care in line with relevant and current evidence based guidance and standards such as the National Institute for Health and Care Excellence (NICE) best practice guidelines.
- The provider was a member of the British Society for Colposcopy and Cervical Pathology. (BSCCP) and on the Register of Accredited Colposcopists. Colposcopy is the investigation for patients presenting with abnormal cervical cytology (known previously as 'smears') or with other related cervical problems.
- 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. We reviewed a sample of consultation notes and identified no concerns. There was evidence of detailed medical history taking and information to make accurate diagnosis and treatment plans.
- We saw no evidence of discrimination when making care and treatment decisions.
- Staff assessed and managed patients' pain where appropriate.
- The service used technology and equipment to improve treatment and to support patients' independence. The service used advanced treatments for men or women who have urinary incontinence problems, for example an Emsella Chair. Staff told us the manufacturer provided the relevant safety guidance which they follow. The provider had completed clinical audits of patients receiving this treatment to improve outcomes for patients. We saw evidence that outcomes had been positive with no adverse effects.

Monitoring care and treatment

The service was actively involved in quality improvement activity.

- The service made improvements through the use of completed audits. Clinical audit had a positive impact on quality of care and outcomes for patients. There was clear evidence of action to resolve concerns and improve quality. The provider had carried out an audit of patients who had received Emsella Chair treatment for bladder weakness. Nine patients had undergone the Emsella Chair treatment since the start of this service in November 2022. Six completed all 6 treatments, 1 patient completed 4 treatments, 1 completed 3 treatments and 1 patient underwent 2 treatments. All of the 9 patients tolerated the treatments well at varying intensities. The average intensity being 95%. All patients were happy with the outcome.
- The provider audited cervical cytology laboratory results of patients screened for Primary human papillomavirus (HPV). (Human papillomavirus (HPV) is the major cause of cervical cancer).
- The provider followed National guidelines for the effective management of pelvic inflammatory disease (PID).

Effective staffing

Requires Improvement

Are services effective?

In the main, staff had the skills, knowledge and experience to carry out their roles. However, the arrangements for supporting and managing staff to deliver effective care and treatment, required improvement. There was no effective system of documenting staff appraisals.

- 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. (Revalidation is the process by which all licensed doctors are required to demonstrate on a regular basis that they are up-to-date and fit to practise in their chosen field and able to provide a good level of care). Fourteen NHS consultants provided outpatient consultations and were registered with the British Society for Colposcopy and Cervical Pathology.
- Staff whose files we reviewed had not completed all essential training including:

    basic life support safeguarding children, safeguarding vulnerable adults, chaperone training, fire safety, health and safety, infection control, equality and diversity, or information governance. Managers did not have a system to review all essential training to ensure staff remained up to date with mandatory training. There was no system to flag in an effective way when training was coming due for renewal.

- A member of non-clinical staff had been in post for 6 months but had not completed any essential training appropriate for their role. When we spoke with this member of staff they told us they had completed appropriate essential training in their previous job. We discussed this with managers who were not able to share evidence of recently completed training for this member of staff. Following our inspection, the provider sent us evidence showing that the member of staff had been booked on to a virtual course to complete outstanding essential training.
- Following our inspection, the provider implemented a spreadsheet of mandatory and additional training for staff to undertake. Managers used the spreadsheet to log when training was due and were responsible for keeping the spreadsheet updated. The service manager sent us evidence of mandatory training booked for 2 staff members who had not completed essential training.
- Staff had access to and made use of e-learning training modules, in-house training and external training. Staff were encouraged and given opportunities to develop.
- Staff had not received regular appraisal of their performance in their role from an appropriately skilled and experienced person. It was not clear how the learning needs of staff were identified because there was no effective system of appraisals. For example, when we checked staff files, we could not find any record of a formal appraisal for two non-clinical members of staff. Staff files did not contain information that demonstrated competency had been reviewed. We discussed this with the service manager who told us they were aware that some staff had not received an appraisal.
- We saw evidence that doctors' appraisals were up to date and all had been revalidated by the General Medical Council (GMC).
- 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. The provider was involved in multi-disciplinary team (MDT) meetings in conjunction with NHS services.
- 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. Staff told us that clinicians used a template form to record patient's

consent. The consent form also included checking PMH (past medical history) and contact details for a relative to be contacted, if needed. The consent forms were completed and saved in the notes. We were not able to see examples of completed consent forms as staff told us these forms were stored off site in the hospital files. We saw examples of patients being signposted to more suitable sources of treatment where this information was not available to ensure safe care and treatment.

- 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 told us that if a patient declined to share information with their GP, the clinic would provide a report that goes to the patient alone.
- 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, unlicensed medicines 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. The provider told us that if a patient was on high risk medicines which could interact with a prescription from the clinic, they would decline to prescribe, unless the patient's GP was also involved for safety.
- Patient information was shared appropriately (this included when patients moved to other professional services), and the information needed to plan and deliver 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. (Give examples).
- 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. The service had a consent policy and procedure in place, which covered gaining consent face to face or remotely when providing treatment to adults and people under 16 years of age. Best practice was followed in line with guidelines from the GMC. This meant that people were involved in the decision making and consent process, prior to receiving treatment and procedures.

Good

Are services caring?

We rated caring as Good because:

The service treated patients with kindness, respect and compassion.

Staff treated patients with kindness, respect and compassion.

- The service sought feedback on the quality of clinical care patients received.
- Feedback from patients was positive about the way staff treat people. Feedback from patients who completed the provider's internal feedback form was positive about the service and the way staff treated them.
- 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 were also told about multi-lingual staff who might be able to support them. Information leaflets were available in easy read formats, to help patients be involved in decisions about their care.
- Information about payment and prices of consultations and tests was sent to patients when their appointment was booked.
- Staff communicated with people in a way that they could understand, for example, communication aids and easy read materials were available.

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:

The service was providing responsive care. The service provided appointments to see doctors in short timescales, and appointment times met patient needs.

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.
- 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. The service's registration process identified any potential access needs of a new patient.
- The service's website contained a range of patient information relating to treatments and answers to general questions.

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. Staff told us that if a patient had an abnormal smear result, they would receive a letter instructing them to book follow-up. A copy of the letter would be saved in the patient's file and copied to their GP.
- 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. For example, where patients were referred to other services, referrals would always be followed up by phone, within days.

Listening and learning from concerns and complaints

The service took complaints and concerns seriously and responded 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. It acted as a result to improve the quality of care. Staff shared examples of responses made to complaints they had received. Team meetings were used to inform staff of incidents and to discuss complaints and ensure lessons were learnt.

Requires Improvement

Are services well-led?

We rated well-led as Requires improvement because:

Leadership and oversight had not been sufficient to ensure that safety was consistently managed. There were ineffective arrangements to follow up on some safety risk assessment actions and recommendations as well as an overall lack of clarity around processes for managing risks.

Leadership capacity and capability:

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

- Leaders had the clinical capacity and skills to deliver the service, however, safety aspects of the provider were not clearly known or prioritised to ensure high quality care was delivered. There was insufficient focus on adequate systems of governance and management of risks.
- Leaders were knowledgeable about issues and priorities relating to the quality and future of services. They understood the challenges and were addressing them.
- Leaders at all levels were visible and approachable. They worked closely with staff and others to make sure they prioritised compassionate and inclusive leadership.
- The provider had effective processes to develop leadership capacity and skills, including planning for the future leadership of the service.

Vision and strategy

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

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

Culture

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

- Staff felt respected, supported and valued. They were proud to work for the service.
- The service focused on the needs of patients.
- Leaders and managers acted on behaviour and performance inconsistent with the vision and values.
- The service had a culture which centred on the needs and experience of people who use services. 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.
- At this inspection we found there was a lack of formal processes for providing all staff with the development they needed. While there was an appraisal policy, there was no effective system of documenting staff appraisals. There was no record of discussions recorded. We checked the appraisal policy which stated that staff should have an appraisal

Requires Improvement

Are services well-led?

annually but we found some staff had not received an appraisal in the last year. The processes for providing all staff with the development they needed required improvement. Managers did not have effective oversight of the appraisal system and staff files did not contain information that demonstrated competency had been reviewed. We checked 3 staff files and there was no record of an appraisal in the last 12 months for 2 members of non-clinical staff.
- Staff were supported to meet the requirements of professional revalidation where necessary.
- The service licensed rooms to consultants who were specialists in their fields. Their appraisals and revalidation was monitored to ensure they kept up to date with mandatory training and other learning requirements. Clinical staff, including nurses, were considered valued members of the team. They were given protected time for professional time for professional development and evaluation of their clinical work.
- There was a strong emphasis on the safety and well-being of all staff.
- The service actively promoted equality and diversity. It identified and addressed the causes of any workforce inequality. Staff had received equality and diversity training. Staff felt they were treated equally.
- There were positive relationships between staff and teams.

Governance arrangements

The overall governance arrangements were ineffective. The overarching governance framework had not ensured that systems and processes were operating effectively.

- Structures, processes and systems to support good governance and management were not clearly set out, understood and effective. The provider did not have clear and effective processes for managing risks, issues and performance. Risks and issues were not always dealt with appropriately or quickly enough. For example, monitoring of assessor's recommendations from fire safety risk assessment.
- The governance and management of partnerships, joint working arrangements and shared services promoted interactive and co-ordinated person-centred care.
- The service had an appraisal policy, however, leaders had not followed the appraisal policy.

Managing risks, issues and performance

There was a lack of clarity around processes for managing risks, issues and performance.

- The service provider did not have an effective process to identify, understand, monitor and address current and future risks including risks to patient safety. There were some internal risk assessment processes, but these did not always function well and were inconsistent in their implementation and impact.
- There were insufficient control measures in place to manage safety risks and arrangements to monitor actions was ineffective. Although risk assessments relating to the building occupied by the service were arranged and managed by the building's management, the service did not monitor and review this activity and therefore could not be assured that outstanding actions had been implemented. For example, the provider had not checked that priority actions from the fire safety risk assessment were completed.
- The service had processes to manage current and future performance. Performance of clinical staff could be demonstrated through audit of their consultations, prescribing and referral decisions. However, there was no specific monitoring of the outcomes of consultants who were licensed to use the premises clinic rooms. Leaders lacked oversight as to whether intended outcomes were being achieved.
- Leaders had oversight of safety alerts, incidents, and complaints.

Requires Improvement

Are services well-led?

- Clinical audit had a positive impact on quality of care and outcomes for patients. There was clear evidence of action to change services to improve quality. We saw evidence that procedures to treat gynaecological and urological problems were audited to check outcomes for patients. We saw that outcomes were shared through email or discussed in clinical team meetings.
- The provider had plans in place and had trained staff for major incidents.

Appropriate and accurate information

The service acted on appropriate and accurate information.

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

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 encouraged and heard views and concerns from the public, patients, staff and external partners and acted on them to shape services and culture.
- Staff could describe to us the systems in place to give feedback. We saw evidence of feedback opportunities for staff and how the findings were fed back to staff. We also saw staff engagement in responding to these findings.
- The service was transparent, collaborative and open with stakeholders about performance.

Continuous improvement and innovation

There was evidence of systems and processes for learning, continuous improvement and innovation.

- There was a focus on continuous learning and improvement. The provider told us they consistently sought ways to improve the service.
- The service provided innovative laser treatments to treat health conditions following chemotherapy and other cancer treatments.
- The service made use of internal and external reviews of incidents and complaints. Learning was shared and used to make improvements.
- Leaders and managers encouraged staff to take time out to review individual and team objectives, processes and performance.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

The table below shows the legal requirements that were not being met. The provider must send CQC a report that says what action they are going to take to meet these requirements.

Regulated activity	Regulation
Diagnostic and screening procedures Treatment of disease, disorder or injury Family planning services	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment The provider had not ensured that care and treatment is provided in a safe way. In particular: • The provider had not done all that was reasonably practicable to mitigate risks to the health and safety of service users receiving care and treatment. In particular, management of fire safety, electrical wiring and infection prevention and control. This was in breach of Regulation 12(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Regulated activity	Regulation
Diagnostic and screening procedures Treatment of disease, disorder or injury Family planning services	Regulation 17 HSCA (RA) Regulations 2014 Good governance The overarching governance framework had not ensured that all systems and processes were operating effectively. In particular: • The provider did not ensure there were effective arrangements in place for identifying, managing and mitigating risks. In particular, ensuring that the areas of the premises they occupied were safe for use. • The provider was not able to provide evidence that safety risks in respect of infection control, electrical wiring and fire safety had been formally assessed, and the assessments documented. • Ensuring that the areas of the premises they occupied were safe for use. • Ensuring that staff appraisals were appropriately documented.

This section is primarily information for the provider

Requirement notices

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

Regulated activity	Regulation
Diagnostic and screening procedures Treatment of disease, disorder or injury Family planning services	Regulation 18 HSCA (RA) Regulations 2014 Staffing We found the members of staff employed by the registered provider did not receive such appropriate training as was necessary to enable them to carry out their duties. In particular: • Leaders had not followed their own training and development policy. • Non-clinical staff had not received formal training that included: basic life support safeguarding children, safeguarding vulnerable adults, chaperone training, fire safety, health and safety, infection control, equality and diversity, or information governance. This was in breach of regulation 18(2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.