# Independent Healthcare Inspection (Announced)

## London Women's Clinic Wales, Cardiff

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**Healthcare Inspectorate Wales (HIW) is the independent inspectorate and regulator of healthcare in Wales**

# Our purpose

**To check that people in Wales receive good quality healthcare**

# Our values

**We place patients at the heart of what we do. We are:**

- **Independent**
- **Objective**
- **Caring**
- **Collaborative**
- **Authoritative**

# Our priorities

**Through our work we aim to:**

| | |
|---|---|
| **Provide assurance:** | **Provide an independent view on the quality of care** |
| **Promote improvement:** | **Encourage improvement through reporting and sharing of good practice** |
| **Influence policy and standards:** | **Use what we find to influence policy, standards and practice** |

# 1. What we did

Healthcare Inspectorate Wales (HIW) completed an announced inspection of London Women's Clinic Wales, Cardiff on the 29 July 2019.

Our team, for the inspection comprised of one HIW inspector, acting as inspection lead, one clinical peer reviewer and one HIW inspector acting as the lay reviewer.

HIW explored how the service complied with the Care Standards Act 2000, requirements of the Independent Health Care (Wales) Regulations 2011 and met the National Minimum Standards for Independent Health Care Services in Wales.

Further details about how we conduct independent service inspections can be found in Section 5 and on our website.

# 2. Summary of our inspection

We found that the London Women's Clinic Wales, Cardiff had arrangements in place to promote the safety and wellbeing of patients attending the clinic.

We also noted a number of areas of good practice at the clinic, including being accredited as a training centre, study days and fertility fairs.

This is what we found the service did well:

- Patients provided positive comments about their experiences of using the clinic
- Health promotion material was readily available at the clinic
- Arrangements to promote and protect patients' privacy and dignity
- A number of ways for patients to provide feedback about their experiences
- Ensuring the clinic was clean and tidy to reduce cross infection
- Good medication management processes in place and effective processes for checking the equipment used
- A number of areas of innovation were noted
- Good management and leadership
- Up to date training and appraisals.

This is what we recommend the service could improve:

- Display outcomes and any changes made as a result of patient feedback
- The mental capacity assessment at the clinic.

There were no areas of non-compliance identified at this inspection.

# 3. What we found

## Background of the service

London Women's Clinic Wales, Cardiff (the clinic) is registered to provide an independent day patient fertility service for adults at 15 Windsor Place, Cardiff, CF10 3BY. London Women's Clinic Wales includes three sites at Swansea, Cardiff and Bristol. Treatment is carried out at the Cardiff clinic.

The service was first registered on 3 September 2012.

The service employs a staff team which includes:

- One Senior Fertility Consultant and Responsible Individual
- Four Fertility Consultants, who also cover Swansea and Bristol
- One Business & Quality Manager, Senior Embryologist
- One Senior Nurse and Registered Manager
- Four Nurses including theatre and fertility nurses
- One Lab Manager, Senior Embryologist[1]
- Two Clinical Embryologists
- Two Receptionists
- Two Administrators (one clinic, one laboratory).

A range of services are provided which include:

- Procurement, keeping, processing, distribution, use and storage of gametes

[1] Embryology is the branch of biology that studies the pre-implantation development of gametes (sex cells), fertilisation, and the development of embryos.

- Creation, procurement, keeping, processing, testing, distribution, use and storage of embryos
- Placing of any permitted embryos in a woman
- Using embryos in training
- Consultation and counselling
- Ovulation induction
- Cycle monitoring including the use of ultrasound
- Phlebotomy services

The service may only be provided in accordance with a valid license issued by the Human Fertilisation and Embryology Authority (HFEA)[2].

No overnight accommodation is provided.

[2] https://www.hfea.gov.uk/

## Quality of patient experience

*We spoke with patients, their relatives, representatives and/or advocates (where appropriate) to ensure that the patients' perspective is at the centre of our approach to inspection.*

Patients provided positive comments about their experiences of using the clinic. Patients could provide feedback about their experiences in a number of ways.

We saw that health promotion material was readily available at the clinic.

Arrangements were in place to promote and protect patients' privacy and dignity.

Prior to the inspection, we invited the service to distribute HIW questionnaires to patients to obtain views on the services provided. A total of 19 questionnaires were completed. We also spoke to two patients during the inspection. Overall, patient feedback was positive, and patients rated the care and treatment that they were provided with as excellent. Patient comments included the following:

> *"Reception staff always cheerful and welcoming. Nurses and doctors approachable and helpful, prompt response to emails or phone calls. Always take the time to address questions and concerns"*

> *"Excellent service, quick response time. Always keen to assist. All staff approachable, friendly, knowledgeable"*

### Health promotion, protection and improvement

There was information available for patients on how they can take responsibility for their own health and wellbeing. Leaflets were freely available in the waiting room relating to services offered at the clinic. The service also had a website detailing the services offered.

In addition we saw an example of a patient information pack that provided useful information for patients on their various options and chosen procedure.

### Dignity and respect

Patients were asked in the questionnaires whether they agreed or disagreed with a number of statements about the staff at the clinic. All patients agreed that staff were always polite and listened to them. Patients also told us that staff were kind and sensitive when carrying out their care and treatment.

During our visit, we noted that patients were arriving and being seen quickly. We saw reception staff welcoming patients in a friendly manner and being polite and courteous when speaking to them. One of the ground floor rooms would be used in the event of patients wishing to speak with staff in private.

We found that arrangements were in place to promote patients' privacy and dignity. We saw staff engaging with patients in a respectful and professional manner both during telephone conversations and face to face. Patients we spoke with stated that staff were respectful and kind and took time to get to know the patients. They felt their privacy and dignity was respected.

We saw that doors were closed during consultations. Privacy curtains were provided around examination couches to maintain patients' privacy and dignity during consultations or when they were receiving treatment.

Information was displayed informing patients of their right to have a chaperone present when being seen by healthcare staff. The use of chaperones aims to protect both the healthcare professional and patient when the patient is examined by the healthcare professional. However, the ultrasound consent forms being used included a section relating to “male surgeon / doctor”. General Medical Council (GMC) guidelines[3] no longer refer to any gender of the chaperone and the section should be changed accordingly. Additionally, we noted that evidence of the chaperone being offered was not always recorded on patient records on each occasion. We recommend that this be recorded on each occasion the patient receives treatment.

Improvement needed

The registered persons are required to provide HIW with details of the action taken to:

[3] https://www.gmc-uk.org/-/media/documents/maintaining-boundaries-intimate-examinations-and-chaperones_pdf-58835231.pdf

- Evidence the offer of chaperones on patient records on each occasion
- Change the ultrasound consent forms to delete references to specific genders when offering a chaperone.

## Patient information and consent

All but one of the patients who completed a questionnaire agreed that staff have provided them with enough information about their treatment, including information about the different treatment options available, any associated risks and information about the costs involved.

We noted from patient records that patients received good information about their care that was easy to understand and given at the right time so they could make the choice that was best for them.

Senior staff we spoke with said that a great emphasis was placed on providing patients with sufficient information to allow them to make an informed decision on their treatment. As described above, relevant written information for patients was readily available within the clinic. We also viewed the policy on the Welfare of the Child[4] that is described further below.

The registered persons had produced a Statement of Purpose and separate Patients' Guide as required by the regulations. These set out information about the clinic and included information about the services offered, how they could be accessed and the arrangements for consent to treatment. There was also an up to date written policy on obtaining valid patient consent.

## Communicating effectively

The majority of patients that completed a questionnaire told us that they would know how to make a complaint if they were unhappy with the service provided at the clinic.

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[4] A woman shall not be provided with treatment services unless account has been taken of the welfare of any child who may be born as a result of the treatment (including the need of that child for supportive parenting), and of any other child who may be affected by the birth.

Generally, information was provided in English only. Arrangements should be made to provide further information in Welsh and to help staff make an 'Active Offer'[5]. Language Line[6] was available to translate for patients whose first language was not English.

We saw pictorial signs were displayed to assist patients to find a suitable emergency escape route in the event of a fire.

## Care planning and provision

The arrangements for providing care and treatment were set out within the Statement of Purpose.

The patients we spoke with confirmed that they received assistance and information in a timely manner. Emails were responded to quickly and when promised a call back from clinical staff, this was usually within the hour.

Staff we spoke with stated that patients would be informed on arrival if there was a delay. During the inspection, patients in reception were seen promptly without having a wait.

The clinic also has the services of two counsellors who are available to discuss any issues or feelings that the patients may have prior to or as a result of their treatment. The counselling is compulsory for certain treatments.

## Equality, diversity and human rights

The Statement of Purpose and information posted on the clinic's website, clearly sets out that services were provided having due regard to patients' rights.

There was disabled parking available to the rear of the clinic and good, level access to the rear of the premises. Access to the first and second floors was by means of a stairway and/or a lift.

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[5] An 'Active Offer' means providing a service in Welsh without someone having to ask for it. http://gov.wales/topics/health/publications/health/guidance/words/?lang=en

[6] Language Line is a UK language translation service agency that provides a wide range of interpreting, translation and localisation agency services.

All staff had completed the equality and diversity training required by the clinic.

### Citizen engagement and feedback

Patients had opportunities to comment on their experiences of visiting the clinic through a variety of methods. These included; a message and link on all external emails asking for comments on the service; a questionnaire with the initial patient information; text message surveys; and regular surveys of patients. Additionally patients could write Facebook and Google reviews. The results of the surveys and feedback are discussed in the Quality Management Review meetings that were held quarterly.

We were also informed of an example where a trend in the surveys had identified a need for treatment plans to be improved. In order to demonstrate to all patients that the clinic listens and acts on their feedback we recommend that they display the outcomes or changes made as a result of patient feedback in the waiting areas.

Improvement needed

Outcomes and any changes made as a result of patient feedback to be displayed within the clinic.

## Delivery of safe and effective care

*We considered the extent to which services provide high quality, safe and reliable care centred on individual patients.*

We found that the staff team were committed to providing patients with safe and effective care.

The clinic was clean and tidy and arrangements were in place to reduce cross infection.

There were good medication management processes in place and effective processes for checking the equipment being used.

A number of areas of innovation were noted.

### Managing risk and health and safety

The clinic environment was well maintained and in a good state of repair. We saw that all areas were clean and tidy and free of trip hazards.

A written risk management policy was in place, which is the same policy for all sites run by London Women's Clinic. The policy stated it was based on the current advice from the Health and Safety Executive (HSE)[7] website in July 2010. Risk Assessments were based on the "5 steps to risk assessment"[8] as produced by the HSE. The risk register included sections on cryogenic storage (storage at very low temperatures), medicines management and infection control. Senior staff confirmed that environmental and procedural risk assessments (to identify potential hazards and risks) had been completed. We saw records demonstrating this process and saw that actions had been identified to reduce the risks identified. Risks were discussed regularly at management meetings.

[7] https://www.hse.gov.uk/

[8] http://www.hse.gov.uk/risk/controlling-risks.htm

We noted that there was adequate security within the location with a system of alarms to the inside and close circuit television to the outside of the premises and the lobby. There was discrete signage to the outside of the premises identifying the clinic.

## Infection prevention and control (IPC) and decontamination

There were no major concerns given by patients over the cleanliness of the clinic; all the patients that completed a questionnaire strongly agreed, in their opinion, the environment was both clean and tidy.

Written policies and procedures were available to help guide staff on infection prevention and control. There was evidence of regular infection control audits at the clinic. Clinical areas were cleaned daily and a deep clean was performed monthly; relevant cleaning records and schedules were provided to evidence these arrangements. All staff had received up to date training on this subject.

We saw that staff had access to personal protective equipment (PPE) to help prevent cross infection. Hand washing facilities were available; effective hand washing is important to promote infection prevention and control.

All of the instruments used during procedures were purchased sterilised and were single use only. This promoted effective infection prevention and control. We saw that medical sharps (such as needles) had been placed in appropriate containers for safe disposal. This helped reduce the risk of injury (to staff and patients) and cross infection from used sharps. Clinical waste, including medical sharps, was placed in colour coded bags/containers and stored safely prior to being collected by the waste contractor for safe disposal.

## Medicines management

There was a medicines management policy at the clinic that covered all aspects of medicines management at the clinic. Medicines were securely stored in three locations within the clinic to ensure that there was easy access to the medicines on each floor. Controlled drugs were kept securely in one location, with the controlled drug key kept in a safe box in a locked number coded room. Controlled drugs were checked by two staff at the beginning of the day and at the end of the theatre list.

Any medicines management significant events would be discussed at the monthly clinical governance meetings. Adverse reactions to drugs were reported via the Yellow Card[9] system.

Records were maintained of medicines administered to patients. These records showed that patients had been asked about known allergies to promote their safety and wellbeing prior to medication being prescribed/administered as part of their care and treatment.

### Safeguarding children and safeguarding vulnerable adults

Written policies and procedures were available to guide staff on the action to take should they suspect abuse of children or adults who become vulnerable or at risk. Additionally as described above there was also a policy that described the approach to be followed to take proper account of the welfare of any child who may be born as a result of treatment and any other child who may be affected by the birth.

Staff working at the clinic had completed safeguarding training to a level appropriate to their roles. The responsible individual (and lead consultant) assumed the lead role in safeguarding and staff were clear of their responsibilities in relation to reporting safeguarding issues.

### Medical devices, equipment and diagnostic systems

A range of equipment was available at the clinic to support the provision of care and treatment to patients. We saw evidence that this equipment was being tested/calibrated on a regular basis to ensure that they were safe to use and providing accurate readings.

Equipment and drugs for use in the event of a patient emergency were available and checked on a daily basis by the designated staff member. Furthermore, staff had received updated resuscitation training.

### Safe and clinically effective care

[9] http://www.wales.nhs.uk/ourservices/directory/NationalProgrammesandServices/372

From our discussions with staff and examination of patient care documentation, we found that patients were receiving safe and clinically effective care. There was evidence of good multi-disciplinary working between the nursing, medical staff and laboratory staff.

The service was consultant led and includes medical staff with additional specialist training specific to this area of work. There were also specially trained fertility nurses who had additional skills and could undertake some of the clinical procedures, including scans.

There were a number of different audits undertaken at the clinic that were reported to the clinical governance meetings monthly. Of particular note was the quality assurance programme of ongoing audits of all key performance indicators (KPIs) in the laboratory. Staff we spoke with stated that where there were outliers in KPIs, there would be an in depth review to identify recommendations that would improve performance. There would then be a re-audit of practice in order to demonstrate improved compliance with KPIs. We were informed of a particular example from last year, where there was a high complication rate with a particular procedure, that led to an audit of pipette[10] types. The high complication rate was linked to one pipette type and its use was discontinued.

### Participating in quality improvement activities

We were informed of a number of instances of good practice and development plans at the clinic. These included:

- EngagedMD, which is a web-based informed consent application used to educate patients and ensure all consent and in house forms are completed in a timely manner with no anomalies
- A reproductive study day for GPs with sessions on infertility, laboratory work, patient pathway and endometriosis[11].

[10] A disposable device consisting of a plastic core and a drinking-straw-like sheath, used to obtain endometrial biopsies through gentle suction.

[11] Endometriosis is a condition where tissue similar to the lining of the womb starts to grow in other places, such as the ovaries and fallopian tubes.

- Collaboration between AIVF, a company engaged in research, development and commercialisation of software based product and technology in the field of IVF[12] and LWC to share data

- Accreditation as a training centre for the National School of Healthcare Science[13] Work Based Training Provider (STP) in Reproductive Science

- Fertility Fairs, with access to fertility experts to answer questions on the fertility process, one to one mini consultations, seminars on treatment and fertility.

### Information management and communications technology

The records management system used is IDEAS (Infertility Database Embryology and Andrology System), which is an electronic medical record system for reproductive endocrinology[14]. Hard copy records were scanned onto the system and the original copies were then shredded, no paper copies were kept. The information was backed-up to the Cloud[15]. Access to patient records from all three sites covered by the clinic could be obtained from any of the sites. Additionally, some select staff had access from home and from the clinic headquarters in London.

### Records management

Good records are important to make sure patients receive the right care. We found the sample of records checked to be comprehensive. However, we did notice that there was not a patient ID included on forms for two patients that had been scanned into the patient record system. This could potentially result in an incorrect record being scanned or records being attributed to the wrong person.

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[12] https://www.nhs.uk/conditions/ivf/

[13] http://www.nshcs.hee.nhs.uk/

[14] Reproductive endocrinology is a branch of medicine that identifies and treats infertility in both men and women

[15] A strategy for backing up data that involves sending a copy of the data over a proprietary or public network to an off-site server.

The medical records checked showed that relevant information was given to patients about their condition, investigation and management options. This information was shown in the medical records as being given verbally, written and in the form of information leaflets. All patient records sampled had an individual history section completed at the start of the consultations.

Consultation letters included in the records described the treatment options available, including benefits and risks. We noted that there was a complete record of medication prescribed and also consent forms for patients given injections.

Whilst there was also evidence that counselling was offered on several occassions, there was no record of uptake. Only one of the five patient records sampled had evidence of counselling.

We noted that a checklist of consent forms required at each procedure had been created by the clinic. Staff we spoke with stated that there had been an audit of the consent forms used and the results were presented to the clinical governance meeting that had resulted in improved practice. Additionally, there was a checklist completed before any surgical procedure to ensure that all the relevant checks have been completed by the laboratory staff. Nursing staff also completed their own checklist.

Staff we spoke with, regarding mental capacity assessments[16], stated that if there were any concerns these were discussed with colleagues at the Clinical Governance meetings. The patient's GP would also then be contacted to check if there had been previous mental health issues and psychiatric / mental health sevrices involvement. Whilst mental health is a question on the patient medical history form there was not a formal assessment of mental capacity prior to treatment and GPs were not routinely copied into correspondence. We recommend that a formal mental capacity assessment is carried out and the clinic should consider using a system similar to the form[17] used in the NHS in Wales.

[16] http://www.wales.nhs.uk/sites3/home.cfm?orgid=744

[17] http://www.wales.nhs.uk/sites3/Documents/744/Mental%20Capacity%20Assessment%20Form.dot

Improvement needed

The clinic should carry out a formal mental capacity assessment and the clinic should consider using a system similar to the form used in the NHS in Wales.

Additional controls should be put in place to ensure that all forms have a patient ID added prior to scanning.

## Quality of management and leadership

*We considered how services are managed and led and whether the workplace and organisational culture supports the provision of safe and effective care. We also considered how the service review and monitor their own performance against the Independent Health Care Regulations and National Minimum Standards.*

We found good management and leadership at the clinic with staff commenting positively on the support that they received.

Staff told us that they were treated fairly at work and that an open and supportive culture existed. Staff also told us that they were aware of the management structure within the organisation and that the communication between management and staff was effective.

Staff were able to describe their individual roles and responsibilities and told us they had access to the training and guidance that they needed to undertake their duties.

### Governance and accountability framework

- There were clear lines of responsibility both within the clinic and to the head office of the clinic in London. A number of the Human Resources (HR) functions, such as personnel and training records were kept in the head office, but they were available at short notice to the clinic.

There was an up to date Statement of Purpose that included the requirements of Schedule 1 to The Independent Health Care (Wales) Regulations 2011[18]. The statement included the aims and objectives of the clinic, treatments provided and organisational structure of the clinic. The Patients' Guide had also been completed in accordance with the above regulations and included a summary of

[18] http://www.legislation.gov.uk/wsi/2011/734/made

the Statement of Purpose, the terms and conditions in respect of services to be provided for patients and the complaints procedure. The clinic were advised to forward any changes to this Statement of Purpose and Patients' Guide to HIW in a timely manner.

Staff we spoke with said that there were good informal, day to day staff supervision and support processes in place. They confirmed that they felt supported in their work by their manager and colleagues.

Both the registered manager and responsible individual were based at the clinic and were on hand to support staff and to monitor the quality of the services provided. Additionally, members of the main board in London attend the clinical governance monthly meetings.

There were regular meetings held, these included weekly management meetings, monthly clinical governance (CG) meetings and quarterly quality management review (QMR) meetings. The CG and QMR meetings included all staff across the three sites, Swansea, Cardiff and Bristol.

### Dealing with concerns and managing incidents

Staff we spoke with described the arrangements for reviewing significant incidents and sharing learning from these to promote patient safety and well-being. Serious adverse events (SAEs), non-conformances and near misses[19] from all sites were discussed at the Quality Management Review meetings and at Clinical Governance meetings. These meetings were also used to discuss complaints and challenging cases. Depending on the nature of any incidents and non-conformances they were also reported to head office and the HFEA.

Details of how patients could make a complaint were included within the Statement of Purpose, on the website and in leaflet form. A written complaints procedure was also available. These clearly set out the timescales for acknowledging and responding to complaints. In accordance with the regulations: the contact details of HIW were also included. However, the complaints policy was not clearly displayed in the clinic, to ensure that all patients were aware of the policy. We recommended that this should be rectified. We

[19] https://www.hfea.gov.uk/media/2793/2019-01-03-code-of-practice-9th-edition-v2.pdf

viewed the complaints register and found this to contain full information of the complaint, actions taken and outcome.

Improvement needed

The clinic is required to clearly display the complaints policy in the reception of the clinic.

## Workforce planning, training and organisational development

Staff we spoke with were able to describe their roles and how they contributed to the overall operation of the clinic. Medical, consulting and laboratory services were provided by doctors, nurses and technicians directly employed by the clinic. Anaesthetists were employed on a sessional basis by the clinic and the responsible individual had previously checked their qualifications, CVs and GMC records before granting them practising privileges. Suitable checks had been undertaken in relation to their registration with respective professional bodies of all staff.

There was a vacancy, at the time of our visit, for an embryologist at the clinic and this was being advertised. The clinic was able to arrange its staffing and rota in advance of requirements as they were aware of the treatments and consultations. Additionally, theatres were in operation on a Monday, Wednesday and Friday. Embryologists and consultants also operated an on call rota. Sufficient staff were seen on duty during the day of our inspection.

As previously stated staff records were kept centrally at the head office in London. The clinic were able to obtain information from London as required on personnel issues. This was noted during the inspection when samples of records were requested.

The HR function at head office inform the clinic of when any training, appraisals or Disclosure and Barring Service (DBS)[20] checks are required for members of staff. In addition, the clinic had recently instituted a process of appointing staff

[20] https://www.gov.uk/government/organisations/disclosure-and-barring-service

champions who will also take responsibility for ensuring that the necessary training and appraisals were carried out in a timely manner.

Information contained within the staff files inspected demonstrated that staff had attended mandatory training and other training relevant to their roles. We found that all staff had received an appraisal of their work performance within the last 12 months.

### Workforce recruitment and employment practices

Workforce recruitment practices and procedures were being followed in line with regulations and standards. Staff records we reviewed showed that the clinic had followed the appropriate procedures and undertaken relevant recruitment checks prior to their commencement in post. Additionally, we saw evidence to confirm that each member of staff had undertaken a DBS check as required by the regulations.

# What next?

Where we have identified improvements and immediate concerns during our inspection which require the service to take action, these are detailed in the following ways within the appendices of this report (where these apply):

- Appendix A: Includes a summary of any concerns regarding patient safety which were escalated and resolved during the inspection
- Appendix B: Includes any other improvements identified during the inspection where we require the service to complete an improvement plan telling us about the actions they are taking to address these areas.

Where we identify any serious regulatory breaches and concerns about the safety and wellbeing of patients using the service, the registered provider of the service will be notified via a non-compliance notice. The issuing of a non-compliance notice is a serious matter and is the first step in a process which may lead to civil or criminal proceedings.

The improvement plans should:

- Clearly state when and how the findings identified will be addressed, including timescales
- Ensure actions taken in response to the issues identified are specific, measurable, achievable, realistic and timed
- Include enough detail to provide HIW and the public with assurance that the findings identified will be sufficiently addressed.

As a result of the findings from this inspection the service should:

- Ensure that findings are not systemic across other areas within the wider organisation
- Provide HIW with updates where actions remain outstanding and/or in progress, to confirm when these have been addressed.

The improvement plan, once agreed, will be published on HIW's website.

# 4. How we inspect independent services

Our inspections of independent services may be announced or unannounced. We will always seek to conduct unannounced inspections because this allows us to see services in the way they usually operate. The service does not receive any advance warning of an unannounced inspection. In some circumstances, we will decide to undertake an announced inspection, meaning that the service will be given up to 12 weeks' notice of the inspection.

Feedback is made available to service representatives at the end of the inspection, in a way which supports learning, development and improvement at both operational and strategic levels.

HIW inspections of independent healthcare services will look at how services:

- Comply with the Care Standards Act 2000
- Comply with the Independent Health Care (Wales) Regulations 2011
- Meet the National Minimum Standards for Independent Health Care Services in Wales.

We also consider other professional standards and guidance as applicable.

These inspections capture a snapshot of the standards of care within independent services.

Further detail about how HIW inspects independent services can be found on our website.

## Appendix A – Summary of concerns resolved during the inspection

The table below summaries the concerns identified and escalated during our inspection. Due to the impact/potential impact on patient care and treatment these concerns needed to be addressed straight away, during the inspection.

| Immediate concerns identified | Impact/potential impact on patient care and treatment | How HIW escalated the concern | How the concern was resolved |
|---|---|---|---|
| No immediate concerns were identified on this inspections. | | | |

## Appendix B – Improvement plan

## Service: London Women's Clinic Wales, Cardiff

## Date of inspection: 29 July 2019

The table below includes any other improvements identified during the inspection where we require the service to complete an improvement plan telling us about the actions they are taking to address these areas.

| Improvement needed | Regulation / Standard | Service action | Responsible officer | Timescale |
|---|---|---|---|---|
| **Quality of the patient experience** | | | | |
| The registered persons are required to provide HIW with details of the action taken to:<br>• Evidence the offer of chaperones on patient records on each occasion<br>• Change the ultrasound consent forms to delete references to specific genders when offering a chaperone. | 10. Dignity and respect | 1. Email has been sent to all staff to record the offer of chaperone on each occasion which involves ultrasound scan and any intimate examination.<br>2. Notices will be displayed in procedure rooms to remind patients of availability of chaperone.<br>3. Audit will be conducted at the end of three months to check practice improvement<br>4. Ultrasound consent has been revised to delete references to specific genders when offering a chaperone | Dr Hemlata Thackare and Anne Fisher | 2. 29.08.2019<br>3. Audit to be completed by 01.12.2019<br>4. 14.09.2019 |

| Improvement needed | Regulation / Standard | Service action | Responsible officer | Timescale |
|---|---|---|---|---|
| Outcomes and any changes made as a result of patient feedback to be displayed within the clinic. | 5. Citizen engagement and feedback | Poster will be displayed within the clinic | Giles Palmer & S. Day | 30.09.2019 |
| **Delivery of safe and effective care** | | | | |
| The clinic should carry out a formal mental capacity assessment and the clinic should consider using a system similar to the form used in the NHS in Wales.<br><br>Additional controls should be put in place to ensure that all forms have a patient ID added prior to scanning. | 20. Records management | 1. All healthcare professionals working at the clinic are registered with their professional bodies and are aware of their duty to assess capacity to consent to treatment or investigation. The clinic has always worked on the premise "All adults are presumed to have sufficient capacity to decide on their own medical treatment, unless there's significant evidence to suggest otherwise"<br><br>Consultants recommending treatment or investigations and involved in carrying out the treatment have always assessed capacity to consent but going forwards, will document this formally in patient records. The treatment discussion now has a check box to document 'capacity to consent has been assessed' All staff were sent an email to inform them of the change | Dr Hemlata Thackare | Audit to be completed by 10.12.2019 |

| Improvement needed | Regulation / Standard | Service action | Responsible officer | Timescale |
|---|---|---|---|---|
| | | in practice and signpost them to Treatment discussion record.<br><br>We will audit the change in practice after three months<br><br>From 1st May 2019, GPs of all new patients registered at the clinic have been sent a letter to ask of any Safeguarding concerns.<br><br>We have not treated any patient who has lacked capacity to consent. We will use the NHS Mental Capacity assessment Form if such an occasion arises in the future.<br><br>2. A random audit will be performed after three months to check whether all scanned documents have patient ID. Staff have been reminded of this previously and once again by email | | |
| **Quality of management and leadership** | | | | |
| The clinic is required to clearly display the complaints policy in the reception of the clinic. | 23 Dealing with concerns and | Complaints policy is now displayed on a stand in Reception | Dr Thackare & Mr Giles Palmer | 31.07.2019 |

| Improvement needed | Regulation / Standard | Service action | Responsible officer | Timescale |
|---|---|---|---|---|
| | managing incidents | | | |

The following section must be completed by a representative of the service who has overall responsibility and accountability for ensuring the improvement plan is actioned.

## Service representative

**Name (print):** Dr Hemlata Thackare

**Job role:** Consultant Gynaecologist, PR to HFEA & Responsible Individual to HIW

**Date:** 09.09.2019