

Inspection Report

6 July 2026



Marble Arch Clinic

Type of service: IC-Private Doctor Services

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Assurance, Challenge and Improvement in Health and Social Care

Information on legislation and standards underpinning inspections can be found on our website <https://www.rqia.org.uk/> [The Independent Health Care Regulations \(Northern Ireland\) 2005](#) and [Minimum Care Standards for Independent Healthcare Establishments \(July 2014\)](#)

1.0 Service information

Organisation/Registered Provider: Marble Arch Health Ltd	Registered Manager: Ms Lisa Gallagher
Responsible Individual: Dr Orla Conlon	Date registered: 16 September 2024
Person in charge at the time of inspection: Dr Orla Conlon	
Brief description of the accommodation/how the service operates: Marble Arch Clinic is registered with the Regulation and Quality Improvement Authority (RQIA) as an independent clinic (IC) with a private doctor (PD) category of care. A private doctor is a General Medical Council registered doctor who does not have a prescribed connection to a Responsible Officer within the Health and Social Care (HSC) sector in Northern Ireland. A multidisciplinary team at Marble Arch Clinic offers a range of gynaecological health services to adolescent and adult females on an outpatient basis. This inspection focused solely on the arrangements for providing private doctor services that fall within regulated activity and the category of care for which the establishment is registered with RQIA. Prior to the inspection, a variation to the registration application was submitted to RQIA, regarding the expansion of clinical areas within the establishment. This application is still awaiting approval and is discussed further in section 5.2.6.	

2.0 Inspection summary

This was an announced inspection, undertaken by a care inspector on 6 July 2026 from 11 am to 2.30 pm.

It focused on the themes for the 2026/27 inspection year. The purpose of the inspection was to assess progress with areas for improvement identified during the last care inspection and to assess compliance with the legislation and minimum standards.

There was evidence of good practice concerning patient safety in respect of staffing; recruitment and selection of staff; staff training; safeguarding; management of medical emergencies; infection prevention and control (IPC); the environment; records management. Other examples included the management of the patients' care pathway; client confidentiality; communication; governance arrangements and ensuring the core values of privacy and dignity were upheld.

No immediate concerns were identified regarding the delivery of patient care.

3.0 How we inspect

RQIA is required to inspect registered services in accordance with legislation. To do this, we gather and review the information we hold about the service, examine a variety of relevant records, meet and talk with staff and management and observe practices on the day of the inspection.

The inspection was facilitated by Dr Conlon and Ms Gallagher.

The information obtained is then considered before a determination is made on whether the clinic is operating in accordance with the relevant legislation and minimum standards.

Examples of good practice are acknowledged and any areas for improvement are discussed with the person in charge and detailed in the quality improvement plan (QIP).

4.0 What people told us about the service

We issued posters to the registered provider prior to the inspection inviting clients and members of staff to complete an electronic questionnaire.

Four patients submitted responses. Responses indicated that they felt their care was safe and effective, that they were treated with compassion and that the service was well led. All clients indicated that they were either satisfied or very satisfied with each of these areas of their care. Four patient responses included comments. They commented on the dedication, support and professionalism of staff.

No staff submitted questionnaire responses.

5.0 The inspection

5.1 What has this service done to meet any areas for improvement identified at or since last inspection?

Areas for improvement from the last inspection on 15 July 2024		
Action required to ensure compliance with The Independent Health Care Regulations (Northern Ireland) 2005		Validation of compliance
Area for improvement 1 Ref: Regulation 25(4)(a) Stated: First time	The applicant responsible individual shall ensure the fire risk assessment action plan recommendations are implemented in accordance with the risk assessor's instructions.	Met
	The applicant responsible individual shall inform the aligned inspector upon completion of the work.	
	Action taken as confirmed during the inspection: This area for improvement has been assessed as met. Further detail is provided in section 5.2.6	

5.2 Inspection outcome

5.2.1 How does this service ensure that staffing levels are safe to meet the needs of clients and that staff are suitably trained?

The staffing arrangements in respect of Marble Arch Clinic were reviewed. As previously stated a private doctor is a General Medical Council registered doctor who does not have a prescribed connection to a Responsible Officer within the Health and Social Care (HSC) sector in Northern Ireland. Dr Conlon confirmed that she is the only private doctor working in Marble Arch Clinic.

A review of Dr Conlon's records evidenced the following:

- confirmation of identity
- current General Medical Council (GMC) registration
- professional indemnity insurance
- qualifications in line with services provided
- ongoing professional development and continued medical education that meets the requirements of the Royal Colleges and GMC
- ongoing annual appraisal by a trained medical appraiser

- an appointed responsible officer
- arrangements for revalidation

Dr Conlon confirmed that she is aware of her responsibilities under GMC Good Medical Practice.

A review of training records evidenced that Dr Conlon had completed basic life support, IPC, fire safety awareness and safeguarding adults at risk of harm training in keeping with RQIA training guidance.

There were systems in place to monitor GMC registration and professional indemnity of PDs.

Evidence was available that staff who have a professional registration undertake continuing professional development (CPD) in accordance with their professional body's recommendations.

It was demonstrated that staffing levels are safe and staff are appropriately trained to meet the needs of clients.

5.2.2 How does the service ensure that recruitment and selection procedures are safe?

There were recruitment and selection policies and procedures in place that adhered to legislation and best practice guidance.

Dr Conlon oversees recruitment and selection and approves staff appointments with the support of Ms Gallagher and a company director. Both Dr Conlon and Ms Gallagher confirmed they had a clear understanding of the legislation and best practice guidance.

Ms Gallagher gave assurances that should any PDs be recruited in the future, all recruitment documentation as outlined in Schedule 2 of The Independent Health Care Regulations (Northern Ireland) 2005 would be sought and retained for inspection.

There was evidence of job descriptions and induction checklists for the different staff roles within the multi-disciplinary team. Ms Gallagher confirmed that if a professional qualification is a requirement of the post, a registration check is made with the appropriate professional regulatory body.

Discussion with Ms Gallagher confirmed staff will be provided with a job description, contract of employment/agreement and received induction training when they commenced work in the clinic.

There were robust recruitment and selection procedures in place that adhered to the legislation and best practice guidance to ensure suitably skilled and qualified staff work in the clinic.

5.2.3 How does the service ensure that it is equipped to manage a safeguarding issue should it arise?

Policies and procedures were in place for the safeguarding and protection of adults and children at risk of harm. The policies included the types and indicators of abuse and distinct referral pathways in the event of a safeguarding issue arising with an adult or child. The relevant contact details were included for onward referral to the local Health and Social Care Trust should a safeguarding issue arise.

Discussion with Dr Conlon confirmed that she was aware of the types and indicators of abuse and the actions to be taken in the event of a safeguarding issue being identified.

Review of records demonstrated that Dr Conlon, as the safeguarding lead, has completed formal level two training in safeguarding adults in keeping with the Northern Ireland Adult Safeguarding Partnership (NIASP) training strategy (revised 2016) and minimum standards.

It was confirmed that copies of the regional policy entitled Co-operating to Safeguard Children and Young People in Northern Ireland (November 2024) and the regional guidance document entitled Adult Safeguarding Prevention and Protection in Partnership (July 2015) were available for reference.

It was determined that the service had appropriate arrangements in place to manage a safeguarding issue should it arise.

5.2.4 How does the service ensure that medical emergency procedures are safe?

Emergency oxygen and an automated external defibrillator (AED) were in place, as outlined in the clinic's resuscitation policy. A robust system was in place to ensure that emergency equipment did not exceed expiry dates and was ready for immediate use in the event of a medical emergency.

Dr Conlon confirmed that all staff working in the clinic have training in basic life support. Discussion with Dr Conlon and Ms Gallagher demonstrated both had a good understanding of the actions to be taken in the event of a medical emergency. As mentioned previously, Dr Conlon had completed refresher training in basic life support in keeping with RQIA training guidance.

It was determined that the service had appropriate arrangements in place to manage a medical emergency should it arise.

5.2.5 How does the service ensure that it adheres to infection prevention and control and decontamination procedures?

The IPC arrangements were reviewed throughout the establishment to evidence that the risk of infection transmission to clients, visitors and staff was minimised.

There was an overarching IPC policy and associated procedures in place. A review of these documents demonstrated that they were comprehensive and reflected legislation and best practice guidance.

The consultation treatment room was clean and clutter free. Discussion with Dr Conlon evidenced that appropriate procedures were in place for the decontamination of equipment between use. Cleaning schedules for the clinic were in place.

Hand washing facilities were available and adequate supplies of personal protective equipment (PPE) were provided. It was noted that hand detergent and paper towels required to be wall mounted above or adjacent to the sink and this was discussed with Dr Conlon. She was receptive to this advice and gave assurances that this matter would be addressed.

As discussed previously, Dr Conlon had up to date training in IPC and is aware that the Department of Health (DOH) and Public Health Agency (PHA) websites provide advisory information, guidance and alerts with regards to IPC.

It was confirmed in conversation with Dr Conlon that gynaecological specimens are collected at Marble Arch Clinic. It was confirmed that the Clinic has a contract in place with an external pathology laboratory service. A procedure was in place for the collection, labelling, storage, preservation, transport and administration of specimens. Dr Conlon clearly described the procedure for reporting results to the clinician and nursing team.

Dr Conlon confirmed that no reusable medical devices are used in the clinic. It was confirmed that there was equipment in place for the decontamination of ultrasound probes. The decontamination process is documented clearly in a written policy and procedure and staff training records are retained.

As a result of the assurances given at the time of inspection, it was determined that the service would have appropriate arrangements in place in relation to IPC and decontamination.

5.2.6 How does the service ensure the environment is safe?

As discussed in section 1.0, Marble Arch Clinic submitted an application to vary its registration in April 2026 with the intention to develop the premises.

The onsite inspection confirmed that the development had commenced and further advice and guidance was provided to Dr Conlon in this regard.

The areas of the premises, currently used in relation to the patient pathway, were maintained to a good standard of maintenance and décor.

A tour of the premises confirmed that the fire risk assessment recommendation, concerning the means of escape from the first floor, had been implemented. It was determined that area for improvement 1, made against the regulations and outlined in section 5.1, has been met.

Ms Gallagher confirmed that a new fire risk assessment will be undertaken due to the redevelopment of the premises. This will be followed up separately by an RQIA estates inspector.

Appropriate arrangements are in place to maintain the environment.

5.2.7 Are records being effectively managed?

The arrangements for the management of records were reviewed to ensure that records are managed in keeping with legislation and best practice guidance.

Review of documentation confirmed that the establishment had a policy and procedure in place for the management of records. The policy reviewed included the arrangements for the creation; use; storage; transfer; disposal of and access to records in keeping with best practice guidance and legislative requirements.

Dr Conlon confirmed she was aware of the importance of effective records management and that records are held in line with best practice guidance and legislative requirements.

The patient pathway was discussed with Dr Conlon who stated that the clinical records were accessible on an electronic software system. It was demonstrated that robust IT systems were in place to ensure that all patients' clinical records were held securely and that appropriate access controls were in place.

It was confirmed that Dr Conlon is responsible for maintaining clinical records in accordance with GMC guidance and Good Medical Practice.

The establishment is registered with the Information Commissioner's Office (ICO).

Discussion with Dr Conlon and review of the management of records policy confirmed that clients have the right to apply for access to their clinical records in accordance with the General Data Protection Regulations, which came into effect in May 2018, and where appropriate ICO regulations and Freedom of Information legislation.

It was determined that clinical records are managed in accordance with legislation and best practice guidance.

5.2.8 How does the service ensure that clients are treated with dignity and respect and are involved in the decision-making process?

Discussion with Dr Conlon regarding the consultation and treatment process confirmed that clients are treated with dignity and respect.

The consultations and treatments are provided in private consultation rooms. If required, information is provided to the client in verbal and written form during their consultation to allow clients to make choices about their care and treatment and provide informed consent.

It was confirmed that there was a policy and procedure in place with respect to consent for patients under 18 years of age.

Ms Gallagher told us that clients are provided with the opportunity to complete a satisfaction survey via QR code when their treatment is complete.

Results are collated to provide an anonymised summary report which is made available to clients and other interested parties. We reviewed the most recent annual report, dated March 2026, which indicated a high level of patient satisfaction with the areas surveyed.

Ms Gallagher confirmed that an action plan would be developed to inform and improve services provided, if appropriate.

Appropriate measures are in place to treat clients with dignity and respect and to ensure they have enough information to make informed decisions.

5.2.9 Are robust arrangements in place regarding organisational and medical governance?

Organisational Governance

Where the business entity operating the service is a corporate body or partnership or an individual owner who is not in day to day management of the clinic, unannounced quality monitoring visits by the registered provider must be undertaken and documented every six months; as required by Regulation 26 of The Independent Health Care Regulations (Northern Ireland) 2005.

Dr Conlon was in day to day management of the clinic, therefore the unannounced quality monitoring visits by the registered provider are not applicable.

Medical Governance and Practising Privileges

The only mechanism for a clinician to work in a registered independent clinic is either under a practising privileges agreement or through direct employment by the establishment. Practising privileges can only be granted or renewed when full and satisfactory information has been sought and retained in respect of each of the records specified in regulation 19 of The Independent Health Care Regulations (Northern Ireland) 2005.

It was confirmed that Dr Conlon, as owner and director of Marble Arch Health Ltd, and therefore is directly employed, does not require a practising privileges agreement.

As mentioned previously, Dr Conlon is the only PD providing services at Marble Arch Clinic. As discussed in section 5.2.3 above, Dr Conlon has a responsible officer and is affiliated with a designated body. Dr Conlon practices in other private health care facilities and if necessary can seek support from peers.

Discussion with Dr Conlon and review of records evidenced that there are regular management meetings involving Ms Gallagher and the Clinic's directorship. The Clinic introduced a multidisciplinary committee meeting in December 2025. A review of meeting minutes confirmed that the committee focuses on clinical governance matters, discusses service developments, and shares learning. Dr Conlon described her active participation in professional communities to maintain her expertise and keep abreast of developments in gynaecological medicine.

Complaints Management

The arrangements for the management of complaints and incidents were reviewed to ensure that they were being managed in keeping with legislation and best practice guidance.

The complaints policy and procedure required further development to provided clear instructions for patients and staff to follow. This was discussed with Ms Gallagher who agreed to address this matter following the inspection. Patients were made aware of how to make a complaint by way of the client's guide.

Arrangements were in place to record any complaint received in a complaint register and retain all relevant records including details of any investigation undertaken, all communication with complainants, the outcome of the complaint and the complainant's level of satisfaction.

A review of records concerning complaints evidenced that complaints had been managed in accordance with best practice guidance.

Notifiable Events/Incidents

Discussion with Ms Gallagher confirmed that an incident policy and procedure was in place which includes the reporting arrangements to RQIA. Ms Gallagher confirmed that incidents are effectively documented and investigated in line with legislation. All relevant incidents are reported to RQIA and other relevant organisations in accordance with legislation and RQIA Statutory Notification of Incidents and Deaths. Arrangements are in place to audit adverse incidents to identify trends and improve service provided.

Quality Assurance

Policies and procedures were available outlining the arrangements associated with the Marble Arch Clinic. Observations made confirmed that policies and procedures were indexed, dated and systematically reviewed on a three yearly basis or more frequently if required.

Dr Conlon and Ms Gallagher both demonstrated a clear understanding of their roles and responsibilities in accordance with legislation.

Dr Conlon and Ms Gallagher confirmed that the statement of purpose and client's guide are kept under review, revised and updated when necessary and available on request.

The RQIA certificate of registration was displayed in a prominent place.

Observation of insurance documentation confirmed that current insurance policies were in place.

It was determined that suitable arrangements are in place to enable Dr Conlon and Ms Gallagher to assure themselves of the quality of the services provided.

5.2.10 Does the service have suitable arrangements in place to record equality data?

The arrangements in place in relation to the equality of opportunity for clients and the importance of staff being aware of equality legislation and recognising and responding to the diverse needs of clients was discussed with Dr Conlon.

6.0 Quality Improvement Plan/Areas for Improvement

This inspection resulted in no areas for improvement being identified. Findings of the inspection were discussed with Dr Conlon, Responsible Individual, and Ms Gallagher, Registered Manager, as part of the inspection process and can be found in the main body of the report.



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