Isokinetica Ltd

Isokinetic Medical Group

Inspection report

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Overall summary

We carried out an announced comprehensive inspection on 3 May 2018 to ask the service the following key questions; Are services safe, effective, caring, responsive and well-led?

Our findings were:

Are services safe?

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

Are services effective?

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

Are services caring?

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

Are services responsive?

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

Are services well-led?

We found that this service was providing well-led care in accordance with the relevant regulations.

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the service was meeting the legal requirements and regulations associated with the Health and Social Care Act 2008.

Isokinetic Medical Group is an independent clinic in the central London, which provides a sports and exercise medicine related healthcare service. The service offers services for adults and children.

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. Therefore we were only able to inspect the services provided by the doctors which included screening, assessment, diagnosis, follow-ups and referrals but not the osteopathy, physiotherapy, hydrotherapy and on-field rehabilitation services.

The managing director 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.

Twenty patients provided feedback about the service. Patients said they were satisfied with the excellent standard of person-centred care received and said the staff was approachable, committed and caring.

Our key findings were:

Summary of findings

- Staff understood and fulfilled their responsibilities to raise concerns, and to report incidents and near misses. There was a system in place for acting on significant events.
- There were arrangements in place to protect children and vulnerable adults from abuse.
- Most risks were generally well managed though improvements were needed in relation to calibration of clinical equipment, business continuity planning and fire safety risk assessment.
- Safety systems and processes were in place although no infection control audits had been carried out.
- The service was unable to provide documentary evidence to demonstrate that all staff had received training relevant to their role.
- The service routinely reviewed the effectiveness and appropriateness of the care it provided. It ensured that care and treatment was delivered according to evidence-based guidelines.
- Consent procedures were in place and these were in line with legal requirements.
- Systems were in place to protect personal information about patients.
- Appointments were available on a pre-bookable basis. The service provided only face to face consultations.
- Information about services and how to complain was available.
- The provider was aware of and complied with the requirements of the Duty of Candour.
- There was a clear leadership structure and staff felt supported by management. The service proactively sought feedback from staff and patients, which it acted on.
- There was a clear vision and strategy and staff spoke of an open and supportive culture.

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

- Ensure care and treatment is provided in a safe way to patients.

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

There were areas where the provider could make improvements and **should**:

- Ensure all necessary recruitment checks are in place and records kept in staff files including evidence of satisfactory conduct in previous employment in the form of references and health checks.
- Review the fire safety risk assessment.
- Ensure persons employed in the provision of the regulated activity receive the appropriate training and appraisal necessary to enable them to carry out the duties.
- Review systems to verify a patient's identity on registering with the service.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?

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

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

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 full details of this action in the Requirement Notices at the end of this report).

This was because:

- The service was unable to provide documentary evidence of calibration of clinical equipment had been carried out in line with manufacturers' guidance.
- The provider did not have a formal documented business continuity plan in place.
- The fire safety risk assessment was out of date.
- The provider had not carried out an infection control audit. A spill kit was not available in the premises.
- There were gaps in the staff recruitment checks undertaken prior to employment.
- There was a system for the reporting of significant events and incidents.
- There were systems and processes in place to keep patients safe and safeguarded from abuse.
- There were systems in place to protect all patient information and records were stored securely.
- The provider was aware of and complied with the requirements of the Duty of Candour and encouraged a culture of openness and honesty.

Are services effective?

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

- We observed that the doctors assessed patients' needs and delivered care in line with relevant and current evidence based guidance and standards.
- There was an appropriate system for recording and updating patient care and treatment information.
- The practice carried out quality improvement activity including audit and reflective practice.
- Individual prescribing decisions and consultation records were monitored by the medical director.
- There were gaps identified in the staff training and the service was unable to provide documentary evidence to demonstrate that all staff had received training relevant to their role.
- The service was unable to provide documentary evidence to demonstrate that all administrative staff had received a formal appraisal within the last 12 months.
- The service had arrangements in place to coordinate care and share information appropriately for example when patients were referred to other services or to their own GP.

Are services caring?

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

- Systems were in place to ensure that all patient information was stored and kept confidential.
- According to patient feedback, services were delivered with compassion, dignity and respect and they were involved in decisions about their care and treatment.

Summary of findings

- Information for patients about the services was available.
- Translation services were available for patients who did not have English as a first language.
- The service provided a hearing induction loop for patients with a hearing loss.

Are services responsive to people's needs?

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

- The facilities and premises were appropriate for the services being provided.
- There was information available to patients to demonstrate how the service operated.
- There was timely access to appointments once requested. Appointments were available on a pre-bookable basis. The consultation appointment was only offered face to face.
- Patients were able to request consultations early morning or late evening.
- There was a complaints policy which provided information about handling complaints from patients. The service monitored complaints, compliments and suggestions to ensure that the services offered to meet the needs of their patients.

Are services well-led?

We found that this service was providing well-led care in accordance with the relevant regulations.

- The provider had a clear vision and strategy.
- There was a clear ethos of patient centred care.
- Governance arrangements were in place and enabled the day to day running of the service. However, some improvements were required to ensure safety and support good governance.
- There were arrangements for identifying, recording and managing risks, issues and implementing mitigating actions. However, some improvements were required.
- Service specific policies were available.
- Patient and staff feedback was encouraged and considered in the running of the service.
- Staff we spoke with felt confident to carry out their role and described an open and supportive culture.

Isokinetic Medical Group

Detailed findings

Background to this inspection

Isokinetica Ltd provides a private, non NHS service. Isokinetic Medical Group started in May 2012 and has two directors who run the service. The service employs three doctors. All doctors are UK based, on the General Medical Council (GMC) register, and have an indemnity insurance to cover their work.

The team consists of a managing director, a medical director and two doctors, head of rehabilitation, head of administration, head of the front office, physiotherapists, osteopaths, a team of administrative staff and head of maintenance.

Services are provided from: Isokinetic Medical Group, 11 Harley Street, Marylebone, London, W1G 9PF. We visited this location as part of the inspection on 3 May 2018.

Online services can be accessed from the practice website: www.isokinetic.com.

The provider had specialised in offering the person-centred sports and exercise medicine related healthcare service. The service offers services for adults and children. There are approximately 350 active patients. On average the service offers 200 consultations per week with the doctors.

The service has core opening hours from 8am to 7pm Monday to Friday and 9am to 1pm Saturday. The service offers extended hours if required for working patients who could not attend during normal opening hours.

The service is registered with the Care Quality Commission to provide the regulated activities of diagnostic and screening procedures, treatment of disease, disorder and injury, and surgical procedures. 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 because other services are out of the scope of CQC registration.

On 3 May 2018, our inspection team was led by a CQC Lead Inspector. The team included a GP specialist advisor.

Pre-inspection information was gathered and reviewed before the inspection. We spoke with the managing director, the medical director and a doctor and administrative staff. We collected written feedback from three members of staff. We looked at records related to patient assessments and the provision of care and treatment. We also reviewed documentation related to the management of the service. We reviewed patient feedback received by the service.

To get to the heart of patients' experiences of care and treatment, we always ask the following five questions:

- Is it safe?
- Is it effective?
- Is it caring?
- Is it responsive to people's needs?
- Is it well-led?

These questions therefore formed the framework for the areas we looked at during the inspection.

Are services safe?

Our findings

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

Safety systems and processes

The provider had systems to keep people safe and safeguarded from abuse. However, some improvements were required.

- The provider had systems to safeguard children and vulnerable adults from abuse. Policies were regularly reviewed and were accessible. Staff we spoke with understood their responsibilities to protect patients from abuse, neglect, harassment, discrimination and breaches of their dignity and respect.
- All the doctors at the service had received training in safeguarding and knew the signs of abuse. All the doctors had received adult and level three child safeguarding training. However, the provider was unable to provide documentary evidence that administrative staff had received child safeguarding training in line with intercollegiate guidance for all staff working in healthcare settings.
- The service treated children (aged five years and over) and had a system in place to ensure that children were protected. The service had processes in place to ensure that all children under the age of 16 years old attended the appointment with parent or guardian who had parental responsibility for them and they must be accompanied at all times during consultation and treatment. The service offered consultations on a one to one basis to patients aged 16-18 unless they requested to be accompanied by a chaperone. The service did not have a policy in place which required evidence of parental responsibility to be provided before a child could be seen by the doctor. However, the doctors asked the children verbally during the consultation to confirm their relationship with parent or guardian.
- A notice in the waiting room advised patients that chaperones were available if required. All administrative staff who acted as chaperones were trained for their role.
- 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). The provider had the policy to renew DBS checks every two years.
- The service carried out staff checks, including checks of professional registration where relevant, on recruitment and on an ongoing basis. The three staff files we reviewed showed that appropriate recruitment checks had been undertaken prior to employment with the exception of evidence of satisfactory conduct in previous employment in the form of references and health checks (satisfactory information about any physical or mental health conditions) were not available.
- There was an effective system to manage infection prevention and control. The contractor was responsible for cleaning the premises. We observed that appropriate standards of cleanliness and hygiene were followed. However, the provider had not carried out an infection control audit. A spill kit was not available in the premises. The provider was unable to provide documentary evidence that all doctors and administrative staff had completed infection control training.
- There were systems for safely managing healthcare waste. There was a contract for the removal of clinical waste and we saw that clinical waste and sharps bins were appropriately managed.
- On registering with the service patient's identity was not verified. Patients were able to register with the service by verbally providing a date of birth and address. They were able to pay by the bank account, debit or credit card and cash. Patients could choose to provide their debit or credit card details during the registration process.
- At each consultation, patients confirmed their identity face to face and the doctors had access to the patient's previous records held by the service.
- The service had excellent facilities. However, the provider had not always ensured that equipment was safe and that equipment was maintained according to manufacturers' instructions. For example, calibration of clinical equipment had not been carried out in line with manufacturers' guidance which included blood pressure monitors, digital thermometers and weighing scales. The service was unable to provide documentary evidence to ensure clinical equipment was safe to use and was in good working order.

Are services safe?

- We noted that the safety of electrical portable equipment was assessed in September 2017 at the premises to ensure they were safe to use.
- The service had not carried out Disabled Access Audit or Disability Discrimination Act (DDA) Audit.
- The provider did not have a formal documented business continuity plan in place. However, they informed us they had considered some plans but did not document them.

Risks to patients

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

- There were arrangements for planning and monitoring the number and mix of staff needed. Staff told us there were usually enough staff to maintain the smooth running of the service and there were always enough staff on duty to keep patients safe.
- The staff understood their responsibilities to manage emergencies on the premises and to recognise those in need of urgent medical attention. The staff knew how to identify and manage patients with severe infections, for example, sepsis.
- The service had a formal documented comprehensive medical emergency plan in place.
- When there were changes to services the service assessed and monitored the impact on safety.
- The doctors had a professional indemnity insurance that covered the scope of their practice.

Information to deliver safe care and treatment

- Individual care records were written and managed in a way that kept patients safe. Patient records (with the exception of consultation notes) were stored securely using an electronic record system. Staff used their login details to log into the operating system, which was a secure programme. Consultation notes were held in paper format and the doctors had access to the patient's previous records held by the service. Patient consultation notes were stored securely in the locked room in the locked cabinets.
- The care records we saw showed that information needed to deliver safe care and treatment was available to relevant staff in an accessible way.
- Risks related to patients' diagnoses and other health and wellbeing risks were recorded in patients' records.
- Referral letters included all of the necessary information.

Safe and appropriate use of medicines

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

- The systems for managing medicines, including medical gases, and emergency medicines and equipment minimised risks.
- The private prescriptions were handwritten on the letterhead which included a company name and other necessary information. These paper prescriptions were prescribed and signed by the doctor. There was a record of what was prescribed in the patient consultation notes.
- The service mostly prescribed exercise and rehabilitation for the treatment of sports related or other injuries.
- The service very occasionally prescribed antibiotics for the treatment of wound infections, joint injections and anti-inflammatory medicines used to relieve pain. In total, the service had prescribed 30 prescriptions in the last three months.
- Once the doctor prescribed the medicine and dosage of choice, relevant instructions were given to the patient regarding when and how to take the medicine, the purpose of the medicine and any likely side effects and what they should do if they became unwell.
- The provider did not have a repeat prescribing policy.
- The service did not prescribe any controlled drugs or any high risk medicines which required regular monitoring.

Track record on safety

The practice had a track record on safety. However, improvements were required.

- The provider conducted safety risk assessments, however they were not always regularly reviewed. For example, a fire safety risk assessment had been carried out by an external contractor on 10 August 2016. According to this fire safety risk assessment it was required to undertake a review after 12 months, however this action had not been carried out.
- The service informed us few days after the inspection that they were going to undertake a new fire safety risk assessment of the premises in May 2018.

Are services safe?

- The service had carried out the last fire drill on 21 February 2018 and fire extinguishers were serviced on 1 October 2017. Smoke alarm checks had been carried out on 30 April 2018.
- The fixed electrical installation checks of the premises had been carried out in August 2014 and of the swimming pool in November 2015.
- The service had a variety of other risk assessments to monitor the safety of the premises such as control of substances hazardous to health (COSHH), gas safety checks and an asbestos survey was carried out in March 2013. This helped it to understand risks and gave a clear, accurate and current picture of safety that led to safety improvements.
- A legionella (a bacterium which can contaminate water systems in buildings) risk assessment was carried out by an external contractor on 27 August 2015. This risk assessment had not been reviewed but the service had effective processes in place to manage the risk in the premises. The provider informed us few days after the inspection that they were going to review the legionella risk assessment in May 2018.

Lessons learned and improvements made

- There was an incident reporting policy for staff to follow and there were procedures in place for the reporting of incidents and significant events.
- The medical director had signed up to receive patient and medicine safety alerts. They provided examples of alerts they had received but there were no examples of alerts being acted on as none had been relevant.
- 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.
- They kept written records of verbal interactions as well as written correspondence.

Are services effective?

(for example, treatment is effective)

Our findings

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

Effective needs assessment, care and treatment

The service had systems to keep the doctors up to date with current evidence-based practice. We saw that the doctor assessed needs and delivered care and treatment in line with current legislation, standards and guidance such as the National Institute for Health and Care Excellence (NICE) and Faculty of Sport and Exercise Medicine (FSEM) best practice guidelines.

- The provider had specialised in offering sports and exercise medicine. On average they offered 200 doctor consultations per week.
- The service offered physiotherapy, hydrotherapy and osteopathy (the treatment of medical disorders through the manipulation and massage of the skeleton and musculature) services, and on-field rehabilitation sessions but these services were out of the scope of this inspection.
- The service ensured that all patients were seen face to face for their consultation. The service offered a 40 to 60 minute initial consultation with a doctor. Patients were assigned a case manager (a doctor) after an initial consultation with a doctor.
- All patients' completed a medical questionnaire at their first visit which included information about their past medical history, personal details, date of birth, drug allergies and NHS GP details (plus consent to update NHS GP of all consultations details).
- The service used a comprehensive assessment process including a full life history account and necessary examinations such as blood tests or scans to ensure greater accuracy in the diagnosis process. The assessments were tailored according to information on each patient and included their clinical needs and their mental and physical wellbeing.
- The outcomes of each assessment were clearly recorded and presented with explanations to make their meaning clear, which included a discussion on the treatment options.
- We reviewed examples of medical records which demonstrated that patients' needs were fully assessed and they received care and treatment supported by clear clinical pathways and protocols.
- Staff used appropriate tools to assess the level of pain in patients.

Monitoring care and treatment

We saw the service had an effective system to assess and monitor the quality and appropriateness of the care provided.

- The doctors were not responsible for managing patients with long-term conditions and they were referred to their NHS GP or other private consultants with their consent.
- Patients' health was monitored to ensure sports medicines and exercises were being used safely and followed up on appropriately. Patients were required to attend regular progress reviews to monitor and adjust the treatment according to a patient's symptoms and needs, without which the doctor would not prescribe further treatment. The doctor had access to all previous notes.
- The doctor advised patients what to do if their condition got worse and where to seek further help and support. Patients were given a business card with a doctor mobile telephone number and they were able to contact the doctor to discuss any concerns.
- The service had an out of hours arrangement to provide an out of hours service after 7pm and at weekends when the service was closed.
- After the initial consultation, the service sent a follow-up email to offer help and support to answer any queries or book a follow-up appointment.

Specimens were not managed in the premises and patients were advised to attend the appointment at the laboratory. We found the service was following up on pathology results and had an effective monitoring system in place to ensure that all abnormal results were managed in a timely manner and saved in the patient's records. A patient we spoke with on the day of inspection informed us that the service was very pro-active to follow up and discuss the scan or blood test results.

The provider had carried out quality improvement activity and routinely reviewed the effectiveness and appropriateness of the care and treatment provided.

- Findings were used by the provider to improve services. For example, the provider had carried out an audit of 25 random clinical records to check the accuracy and record keeping of planned treatment, consent obtained,

medical history and referrals to other consultants. The audit results demonstrated that consent was not obtained in one clinical record and evidence of referral was not kept in three out of 25 clinical records checked. The provider had shared the learning with all clinical staff and reminded to follow the protocol correctly.

- We saw evidence of an audit cycle of joint injections given to patients. The aim of the audit was to monitor the rate of success of joint injections given to patients. This audit had found 100% satisfactory results with no case of infection reported after joint injections given to patients at the service.
- There were no prescribing audits to monitor the individual prescribing decisions to monitor the quality of the prescriptions issued, but individual patients on prescribed medicines were monitored to identify the appropriateness of their medicines. Overall clinical outcomes for patients were monitored.
- The service had carried out regular audits to identify why patients had cancelled or missed the pre-book appointments. The service had undertaken regular audits of all patients who required further treatment but did not return after their initial consultation to understand the reasons and improve their service.

Effective staffing

Staff had the skills, knowledge and experience to carry out their roles. However, some improvements were required.

- The service had employed three doctors. A managing director and a medical director were supported by the head of rehabilitation, the head of administration, the head of front office and a team of administrative staff to deal with telephone, email and face to face queries and book appointments.
- The doctors were registered with the General Medical Council (GMC) the medical professionals' regulatory body with a licence to practice.
- The doctors were registered with the Independent Doctors Federation (IDF) the independent medical practitioner organisation in Great Britain. (IDF is recognised as the nationwide voice of independent doctors in all matters relating to private medicine, their education and revalidation).
- The doctors had a current responsible officer. (All doctors working in the United Kingdom are required to have a responsible officer in place and required to follow a process of appraisal and revalidation to ensure their fitness to practice). The doctor was following the required appraisal and revalidation processes.
- The provider had a very comprehensive recruitment and selection process. After the initial interview, all staff was required to complete a work internship period which was six days for an administrative staff, eight days for a doctor and one month for a physio. After the successful completion of this internship period, all staff was offered comprehensive role-specific induction training.
- The provider had an internal education department within the organisation. All staff was given training handbooks at the start of their induction training programme.
- All staff had attended a comprehensive role-specific induction training programme which included three months (for administrative staff) or six months (for doctors) placement at the headquarters in Italy. All staff was required to pass a written examination at the end of this training programme. We were told that doctors did not start consulting with patients until they had successfully met the relevant criteria.
- The service was unable to provide documentary evidence to demonstrate that all staff had received ongoing training relevant to their role. Some staff had not received training that included: safeguarding children and adults, fire safety, basic life support and health and safety. All staff had not received infection control and equality and diversity training.
- We saw the managing director had received an appraisal at the headquarters in Italy. However, the service was unable to provide evidence that all administrative staff had received a formal appraisal within the last 12 months. Staff we spoke with informed us they received regular coaching, mentoring and support through one-to-one meetings but minutes of these meetings were not documented.

Coordinating patient care and information sharing

- Patients received coordinated and person-centred care.
- If a patient needed further examination they were directed to an appropriate agency; we noted examples of patients being signposted to their own GP as well as referral letters to private consultants.
- When a patient contacted the service, they were asked if the details of their consultation could be shared with their NHS GP. If the patient did not agree to the service

sharing information with their GP, then in case of an emergency the provider discussed this again with the patient to seek their consent. We saw an example of consultation notes having been shared with the GP with the appropriate patient consent.
- Correspondence was shared with external professionals in a way that ensured data was protected. Information required passwords in order to access any data shared with external providers.

Supporting patients to live healthier lives

The doctors were consistent and proactive in helping patients to live healthier lives.

- They encouraged and supported patients to be involved in monitoring and managing their health.
- They discussed changes to care or treatment with patients as necessary.
- Nutritional supplements and exercise programmes had been recommended to provide support and promote the healthy lifestyle.

Consent to care and treatment

- The doctors understood and sought patients' consent to care and treatment in line with legislation and guidance. If a patient's mental capacity to consent to care or treatment was unclear we were told the doctor would assess the patient's capacity and record the outcome of the assessment.
- The service had a consent policy in place and the doctors had received training on consent.
- We were told that any treatment including fees was fully explained to the patient prior to the procedure and that people then made informed decisions about their care.

Are services caring?

Our findings

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

Kindness, respect and compassion

- The staff we spoke with was aware of their responsibility to respect people's diversity and human rights.
- Staff understood patients' personal, cultural, social and religious needs. For example, the service offered female only swimming pool sessions two to three times per week.
- The service gave patients timely support and information.
- We obtained the views of patients who used the service. We spoke with a patient and received 19 patient Care Quality Commission comment cards. All of the comment cards we received were positive about the service.
- Patients said they felt the provider offered an excellent service and the staff was helpful, caring and treated them with dignity and respect. They told us they were satisfied with the care provided by the provider and said their dignity and privacy was respected. They said the doctor responded compassionately when they needed help and provided support when required.

Involvement in decisions about care and treatment

- The service gave patients clear information to help them make informed choices including details of the scope of services offered and information on fees.
- We saw that treatment plans were personalised and patient specific which indicated patient were involved in decisions about care and treatment.
- Patients told us they felt listened to and supported by the doctor and had sufficient time during consultations to make an informed decision about the choice of treatment available to them.
- Feedback suggested that patients felt diagnosis and treatment options were explained clearly to them.
- We found that interpretation services were available for patients who did not have English as a first language. Patients were also told about the multi-lingual staff who might be able to support them.
- The service had provided a hearing induction loop for those patients who were hard of hearing.

Privacy and Dignity

The service respected and promoted patients' privacy and dignity.

- Staff recognised the importance of patients' dignity and respect.
- The service complied with the Data Protection Act 1998.
- The service had a confidentiality policy in place and systems were in place to ensure that all patient information was stored and kept confidential. Staff were mindful and adherent to the provider's confidentiality policy when discussing patients' treatments.
- Staff knew that if patients wanted to discuss sensitive issues or appeared distressed they could offer them a private room to discuss their needs.
- We noted that consultation room doors were closed during consultations and that conversations taking place in these rooms could not be overheard.
- The service had arrangements in place to provide a chaperone to patients who needed one during consultations.
- The service waiting area was a separate room from the reception space. This meant that conversations in the reception area, as patients arrived for their appointments or after consultations, could not be overheard.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

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

Responding to and meeting people's needs

- Patient's individual needs and preferences were central to the planning and delivery of tailored services. Services were flexible, provided choice and ensured continuity of care, for example, early morning and late evening appointments were available for patients who were unable to attend the practice during normal working hours.
- The provider offered consultations to anyone who requested and paid the appropriate fee, and did not discriminate against anyone.
- The provider offered services to patients who were aged five years and over.
- They provided services to patients with an ethos of providing individualised care and treatment, considering and respecting the wishes of its patients.
- The facilities and premises were appropriate for the services delivered.
- An ultrasound scan service was offered onsite. An ultrasound scan is a procedure that used high-frequency sound waves to create an image of part of the inside of the body.
- The practice made reasonable adjustments when patients found it hard to access services. There were steps going up to the premises main entrance door. They had a portable ramp that could be used to wheelchair or pushchairs users access the premises.
- There was a patients' leaflet which included arrangements for dealing with complaints, information regarding access to the service, consultation and treatment fees, terms and conditions, and a cancellation policy.
- The service website was well designed, clear and simple to use featuring regularly updated information.
- The service sent text message reminders of appointments.

Timely access to the service

Patients were able to access care and treatment from the service within an acceptable timescale for their needs.

- Patients had timely access to initial assessment, test results, diagnosis and treatment. Patients were offered various appointment dates to help them arrange for suitable times to attend.
- The provider aimed to provide an appointment for their patients to undertake an assessment as soon as possible and informed us that assessments were usually undertaken within one week of any request.
- The appointment system was easy to use. Appointments were available on a pre-bookable basis. The service only offered face to face consultations.
- Consultations were available between 8am to 7pm Monday to Friday and 9am to 1pm Saturday. The provider was flexible to accommodate consultations between 7.20am to 9pm Monday to Friday if required for working patients who could not attend during normal opening hours.
- Patients could access the service in a timely way by making their appointment over the telephone, in person or online.
- This service was not an emergency service. Patients who had a medical emergency were advised to ask for immediate medical help via 999 or if more appropriate to contact their own GP or NHS 111.
- The patient feedback we received confirmed they had flexibility and choice to arrange appointments in line with other commitments.

Listening and learning from concerns and complaints

The service had a system in place for handling complaints and concerns.

- The service had a complaints policy and there were procedures in place for handling complaints. The policy contained appropriate timescales for dealing with the complaint. There was a designated responsible person to handle all complaints.
- The complaints policy included information of the complainant's right to escalate the complaint to the Centre for Effective Dispute Resolution (CEDR), the General Medical Council (GMC), the Nursing and Midwifery Council (NMC) and the Care Quality Commission (CQC) if dissatisfied with the response.
- Information about how to make a complaint was available on the service's website and on the patients

Are services responsive to people's needs?

(for example, to feedback?)

leaflet. We saw this information included the complainant's right to escalate the complaint to the Care Quality Commission (CQC) if dissatisfied with the response.

- However, it did not include information of the complainant's right to escalate the complaint to the Independent Doctors Federation (IDF) and Independent Healthcare Sector Complaints Adjudication Service (ISCAS) if dissatisfied with the response.
- We looked at three complaints received in the last 12 months and found that all complaints had been addressed in a timely manner and patients received a satisfactory response. The service had been open in offering complainants the opportunity to meet with the managing director. There was evidence that the service had provided an apology and used the information provided by the patient to review the service. For example, the provider informed us they had increased the number of towels available in stock. The provider had organised a customer service skills training to improve staff skills.

Are services well-led?

(for example, are they well-managed and do senior leaders listen, learn and take appropriate action?)

Our findings

We found that this service was providing well-led care in accordance with the relevant regulations.

Leadership capacity and capability

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

- Leaders were knowledgeable about issues and priorities relating to the quality and future of services. They understood the challenges to run the service and ensure patients accessing service received high-quality assessment and care.
- 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 service had effective processes to develop leadership capacity and skills.
- The service was run by a managing director and a medical director. The medical director, who was a UK based GMC registered doctor, had overall responsibility for any medical issues arising.

Vision and strategy

- The provider had a clear vision to provide a high-quality person-centred service.
- The service's stated aims and objectives were to provide the highest professional patient-centred healthcare service which meets and exceeds patients' expectations and provide an excellent patient experience. This included working in partnership with staff and maintaining a highly motivated skilled workforce, in order to provide a consistently high standard of health care.

Culture

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

- The service had an open and transparent culture. We were told that if there were unexpected or unintended safety incidents, the service would give affected patients reasonable support, truthful information and a verbal and written apology.
- The provider was aware of and had systems to ensure compliance with the requirements of the duty of candour. (The duty of candour is a set of specific legal requirements that providers of services must follow when things go wrong with care and treatment).
- The service focused on the needs of patients.
- Staff we spoke with told us they were able to raise concerns and were encouraged to do so. They had confidence that these would be addressed.
- There were positive relationships between staff and the leaders.
- There were processes for providing all staff with the development they need. They were given protected time for professional development. All clinical staff and a managing director received regular annual appraisals in the last year.
- There was a strong emphasis on the safety and well-being of all staff. The provider was offering private family medical insurance, fully funded GP access and psychological support to all staff.
- The provider was organising four team social events per year. In addition, the team was going out for meal every two months.

Governance arrangements

There were clear responsibilities, roles and systems of accountability to support good governance and management.

- The service had a governance framework which supported the delivery of the strategy and good quality care. However, some improvements were required to ensure safety and support good governance.
- Staff were clear on their roles and accountabilities including in respect of safeguarding and health and safety.
- There was a range of service specific policies which were accessible.

Managing risks, issues and performance

- There was an effective, process to identify, understand, monitor and address current and future risks including risks to patient safety.
- The service identified, assessed and managed clinical and environmental risks related to the service provided.
- Service leaders had oversight of MHRA alerts, incidents, and complaints.

Are services well-led?

(for example, are they well-managed and do senior leaders listen, learn and take appropriate action?)

- The service had processes to manage current and future performance. Performance of employed clinical staff could be demonstrated through the audit of their consultations, prescribing and referral decisions. The information from these checks was used to produce a clinical report that was discussed at weekly clinical team meetings.
- There were regular reviews of service performance and progress towards strategic goals. Both directors closely reviewed the data and performance of the service and actions were taken to address concerns when they arose. Quarterly performance management reports were produced and shared with the central management board based at the headquarters in Italy. This ensured a comprehensive understanding of the overall performance of the service was maintained.
- There was no specific prescribing audit activity, but overall clinical outcomes for patients were monitored.
- The service had plans in place and had trained staff for major incidents. However, the service did not have a formal documented business continuity plan in place.

Appropriate and accurate information

The service acted on the appropriate and accurate information.

- Patient assessments, treatments and medications were recorded in a paper format. We reviewed anonymised assessment reports where a diagnosis was made. We found that the assessments included clear information and recommendations. The doctor responsible for monitoring patients' care was able to access notes from all previous consultations.
- Care and treatment records were complete, legible and accurate, and securely kept.
- Quality and operational information was used to ensure and improve performance. Performance information was combined with the views of patients.
- The service used information technology systems to monitor and improve the quality of care.
- The provider had protocols for safe sharing and storage of sensitive information.

Engagement with patients, the public, staff and external partners

The service encouraged and valued feedback from patients and staff.

- Comments and feedback were encouraged and reviewed. The provider had implemented changes to improve the service following the feedback from the patients. For example, the water fountain had been installed in the gymnasium area and water bottles provided in response to the feedback from the patients.
- There were many examples of compliments received by the service. For example, we saw several compliments related to the caring and professional nature of staff and the clear explanations around proposed treatments, risks and outcomes.
- The service was offering 'patient of the month' award based on their individual recovery, positive contribution to the atmosphere and friendly attitude towards the staff team.
- The service was collecting patient feedback via electronic tablets regarding the support and care provided. This was highly positive about the quality of service patients received.
- The doctors walk around in the premises and engaged informally with patients in the treatment areas. The service had set a target for every doctor to walk 10,000 steps per day in the premises.
- The managing director was collecting verbal feedback from random patients once a month.
- The service had initiated an 'email of the week' to communicate with all staff members. This was used to share information, staffing matters, monitor the resources and included a theme of the week and a motivational quote.
- Staff meetings were held regularly which provided an opportunity for staff to learn about the performance of the practice.
- Plenary meetings were held three times per year which provided an opportunity for staff to share ideas.
- The service was transparent, collaborative and open with stakeholders about performance.
- Leaders were regularly attending an annual international conference (attended by 3000 delegates from 95 countries) organised by the organisation.

Continuous improvement and innovation

- The service consistently sought ways to improve. There was a focus on continuous learning and improvement at all levels within the service.

Are services well-led?

(for example, are they well-managed and do senior leaders listen, learn and take appropriate action?)

- The doctors were engaged in continuous professional development. They participated in three weekends training courses per year for peer support and professional development at the headquarters in Italy.
- The provider informed us they were planning to switch to bespoke cloud based secure electronic record system in December 2018.
- We saw the head of front staff and head of administration had started their employment in the service as a receptionist and was supported to grow, develop and secure promotions.

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 Surgical procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment **How the regulation was not being met:** 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: The service was unable to provide documentary evidence to ensure calibration of clinical equipment had been carried out in line with manufacturers' guidance. The provider did not have a formal documented business continuity plan in place. The provider had not carried out an infection control audit. The service was unable to provide documentary evidence to demonstrate that all staff had received training suitable to their role, that included: safeguarding children and adults, basic life support and infection control. **Regulation 12(1)(2)**