The Regenerative Clinic

Inspection report

18-22
Queen Anne Street
London
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www.theregenerativeclinic.co.uk

Date of inspection visit: 23 September 2019
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This report describes our judgement of the quality of care at this service. It is based on a combination of what we found when we inspected, information from our ongoing monitoring of data about services and information given to us from the provider, patients, the public and other organisations.

Ratings

Overall rating for this location	Good
Are services safe?	**Good**
Are services effective?	**Good**
Are services caring?	**Good**
Are services responsive?	**Good**
Are services well-led?	**Good**

Overall summary

This service is rated as Good overall. This service registered with the Care Quality Commission in 2018 and this inspection on 23 September 2019 was the service's first inspection.

Are services safe? – Good

Are services effective? – Good

Are services caring? – Good

Are services responsive? – Good

Are services well-led? – Good

We carried out an announced comprehensive inspection at The Regenerative Clinic as part of our inspection programme and in response to concerns we received. The service was registered by the CQC on 17 July 2018 and had not yet been inspected.

The Regenerative Clinic is an independent health service which provides treatment for orthopaedic injuries, sports injuries, arthritis and other degenerative conditions. Although it also offers conventional surgery, its main focus is on regenerative treatments such as Lipogems and Platelet Rich Plasma (PRP) therapy.

Our key findings were:

•The service had systems to assess, monitor and manage risks to patient safety. However, the service did not ensure all staff, in particular non-clinical staff had undergone the necessary training to underpin the safety systems and processes in place. The service learned from, and made changes as a result of, incidents and complaints.

•The service assessed need and delivered care in line with current legislation, standards and evidence-based guidance. There was a programme of regular audits in place through which it reviewed the effectiveness and appropriateness of the care provided.

•The service treated patients with kindness, respect and compassion.

•The service organised and delivered services to meet patients' needs. Patients were able to access services within an appropriate timescale and complaints were managed appropriately.

•There was a clear leadership structure in place, and staff told us that they felt able to raise concerns and were confident that these would be addressed.

•Responsibilities, roles and systems of accountability supported good governance and management.

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

•Ensure the provider and Registered Persons are aware of their obligation to inform the Care Quality Commission of certain notifiable incidents that occur whilst a regulated activity is being carried out as set out in the Care Quality Commission (Registration) Regulations 2009.

Dr Rosie Benneyworth BM BS BMedSci MRCGP

Chief Inspector of Primary Medical Services and Integrated Care

Our inspection team

The inspection team included a CQC lead inspector and a GP specialist adviser.

Background to The Regenerative Clinic

The Regenerative Clinic is an independent health service which offers a range of joint treatment services for sports injuries and osteoarthritis. It specialises in Lipogems and Platelet Rich Plasma (PRP) treatment. These are minimally invasive treatments which use the patient's own cells to treat pain and inflammation. The service also offers a range of other treatments such as pain-relieving injections and rejuvenation treatments. More information can be found at https://www.theregenerativeclinic.co.uk/.

The service is situated within Queen Anne Street Medical Centre, 18 – 22 Queen Anne Street, Marylebone, London W1G 8HU. It is a distinct service from the Medical Centre although various medical services are contracted from it including pharmacy services, resuscitation, clinical governance including practising privileged and revalidation, infection control and theatre services. The Provider operates another similar service in Birmingham which is separately registered and therefore was not visited as part of this inspection.

The leadership team at the service consists of two Consultant physicians and the Chief Executive who was also the registered manager of the service. The chief executive is also nominated individual. 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. A nominated individual is a person who has overall responsibility for supervising the management of the regulated activity and ensuring the quality of the services provided.

There is also an operations manager who had oversight of the day to day running of the service. Clinical services were provided by a number of specialists, consultants and professors in various medical fields including orthopaedics, maxillofacial, plastic and reconstructive surgeons, consultant physiotherapists, anaesthetists, spinal surgeons, radiologists, obstetricians and gynaecologists providing clinical care at various times. All clinicians were substantively employed within the NHS and worked at the service under practising privileges, (this is where a medical practitioner is granted permission to work in a private hospital or clinic in independent private practice). Non-clinical services were provided by a number of medical secretaries and researchers.

The service opens from 8am to 6pm Monday to Friday although they could be flexible to meet patient requirements.

The service is registered with the CQC to provide the following regulated activities: Diagnostic and screening procedures, Surgical procedures, Treatment of disease, disorder or injury

How we inspected this service

We carried out this inspection as a part of our comprehensive inspection programme of independent health providers and in response to concerns which were reported to us. Our inspection team was led by a CQC lead inspector, who was supported by a GP specialist advisor. The inspection was carried out on 23 September 2019. During the visit we:

• Spoke with two of the lead consultants and non-clinical members of the leadership team.

• Reviewed a sample of patient care and treatment records.

We did not speak to any patients as part of this inspection.

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.

Good

Are services safe?

We rated safe as Good because:

The service had systems to assess, monitor and manage risks to patient safety. Staff had the information they needed to deliver safe care and treatment to patients. The service learned from, and made changes as a result of, incidents and complaints. The service had reliable systems for appropriate and safe handling of medicines. The service had a good safety record and learned and made improvements when things went wrong.

Safety systems and processes

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

• The service had systems to safeguard children and vulnerable adults from abuse. The provider had appropriate safety policies, which were regularly reviewed and communicated to staff. We saw registers signed by staff to confirm they had read the policies. They outlined clearly who to go to for further guidance. The service had a designated safeguarding lead whose role included drafting and reviewing the safeguarding policy, being the first port of call for staff for any safeguarding related matters and making safeguarding referrals.

• Staff received safety information from the service as part of their induction and refresher training.

• The service did not treat children however they were aware that children could attend with parents who were patients. They knew how to identify and report concerns. Staff we spoke with were aware of the types and signs of abuse and what action to take if they had any concerns about their safety.

• The provider carried out staff checks at the time of recruitment and on an ongoing basis where appropriate. This included identity, references and employment history. The service's policy was for all staff to undergo Disclosure and Barring Service (DBS) checks. (DBS checks identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable).

• All clinical staff at the service were required to provide practising privileges requests which were approved and vetted by Queen Ann Street Medical Centre's medical director. This was done to ensure all Consultants were qualified and suitable to work for the service. This included ensuring they were up to date with safeguarding training. (Practising privileges are where a medical practitioner is granted permission to work in a private hospital or clinic in independent private practice). We were told this training was shared with non-clinical staff in meetings however, records/minutes of this training were not kept. The provider told us they intended to source online training for staff directly employed by the service to access and undertake necessary training. The healthcare assistant, who worked full-time, was the only member of staff who acted as chaperone and was trained for the role.

• There was an effective system to manage infection prevention and control. All cleaning and waste removal services were provided by and were the responsibility of the medical centre. A contract with a specialist company was in place for the removal of waste including clinical waste. We saw that all areas of the service were visibly clean and hand hygiene and personal protective equipment (PPE) such as gloves and gowns were available.

• The provider ensured that facilities and equipment were safe and that equipment was maintained according to manufacturers' instructions.

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.

• Non-medical staff who provided administrative and secretarial support were not based at the location but off-site. They had no direct contact with patients and therefore the service had assessed their training needs and concluded they did not require safety related training such as basic life support and safeguarding. However, the provider was in the process of compiling a training schedule to record any training that had been carried out and to demonstrate the assessment of each staff member's training needs.

• There were suitable medicines and equipment to deal with medical emergencies which were stored appropriately and checked regularly. These were held and managed by the medical centre and included defibrillators, nebulisers, anaphylaxis medication and oxygen, all of which were maintained and available for the service to use.

Good

Are services safe?

• When there were changes to services or staff the service assessed and monitored the impact on safety.

• There were appropriate indemnity arrangements in place. Each clinician had their own indemnity arrangement. We saw the service had its own appropriate policy and the medical centre in which it was housed also had a separate policy in place.

Information to deliver safe care and treatment

Staff had the information they needed to deliver safe care and treatment to patients.

• Individual care records were written and managed in a way that kept patients safe. The care records we saw showed that information needed to deliver safe care and treatment was available to relevant staff in an accessible way.

• The service had systems for sharing information with staff and other agencies to enable them to deliver safe care and treatment.

Safe and appropriate use of medicines

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

• The service did not hold any medicines itself. All medicines were sourced from the medical centre's in-house pharmacy with whom they had a contract for supply. The systems and arrangements for managing medicines and equipment minimised risks. The service kept prescription stationery securely and monitored its use.

• Consultant's wrote individual prescriptions for the medicines and they were dispensed by the in-house pharmacy. The Medical Centre were responsible for maintaining stock levels and ensuring all medicines were regularly checked and safely stored. In the event that medicines required were not available at the in-house pharmacy, the same prescription could be used to obtain the medicine from any external pharmacy.

• In relation to pain relief following the procedure, the provider told us their protocol was to prescribe all patients 14 days' supply of pain relief and a laxative following discharge. All dispensing was carried out by a qualified pharmacist and all medicines were labelled according to regulatory requirements.

• Staff prescribed, administered or supplied medicines to patients and gave advice on medicines in line with legal requirements and current national guidance.

Track record on safety and incidents

The service had a good safety record.

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

• The service monitored and reviewed activity. This helped it to understand risks and gave a clear, accurate and current picture that led to safety improvements.

• Safety incidents were investigated, reviewed and discussed at weekly meetings and learning was shared with all staff.

Lessons learned and improvements made

The service learned and made improvements when things went wrong.

• There was a system for recording and acting on significant events. Staff understood their duty to raise concerns and report incidents and near misses. Leaders and managers supported them when they did so.

• There were adequate systems for reviewing and investigating when things went wrong. The service learned and shared lessons identified themes and acted to improve safety in the service.

• For example, in response to information received by the CQC in relation to a notifiable incident which had occurred at the service, we reviewed safety records held by the practice and interviewed relevant staff. We found the incident referred to had been investigated and reflected upon by the clinicians. Records showed emergency action had been taken immediately and the incident had been managed effectively. The patient involved had been offered the appropriate ongoing support although they had not made an official complaint to the service. Following the incident and internal investigation the service had altered its technique in relation to the specific procedure to avoid repetition. The provider accepted they had not notified the CQC of this incident in accordance with Regulation 18 of The Care Quality Commission (Registration) Regulations 2009 and said this was an oversight on their part. Following our inspection, we were advised a system had been implemented to ensure any notifiable incidents were reported to CQC.

Good

Are services safe?

• The service acted on and learned from external safety events. The service manager received patient and medicine safety alerts although these were not disseminated to other staff members. This was mitigated by the fact that the clinicians were all employed substantively by the NHS and so would receive these alerts themselves, however the provider undertook to ensure alerts received were circulated to relevant individuals by the service as well.

Good

Are services effective?

We rated effective as Good because:

The service assessed need and delivered care in line with current legislation, standards and evidence-based guidance. There was a programme of quality improvement, including regular audits through which the effectiveness and appropriateness of the care provided was reviewed.

At the time of our inspection training needs for non-clinical staff had not been assessed and adequately provided for. However, this was in progress at the time of our inspection and we received confirmation following the inspection that training had been arranged.

Effective needs assessment, care and treatment

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

• The provider was aware of, and followed, current NICE guidance and standards in relation to the type of conditions they treated. We saw examples of NICE guidelines such as those for platelet-rich plasma injections (PRP) for knee osteoarthritis and routine preoperative tests for elective surgery.

• Lipogem and PRP treatments, the service's main areas of expertise, are relatively new and we saw examples of ongoing studies into how use of the treatment could be expanded. The provider told us they had carried out their own research and due diligence to ensure consultants who worked with them were experienced and had the required expertise in their respective fields to provide the best standards of care.

•The provider told us the clinical efficacy of their treatment was assessed by the service's research team who were responsible for following up patients at set intervals following treatment, collating and reviewing the data to ensure the claims made by the service in terms of effectiveness were supported evidentially.

•Patients' immediate and ongoing needs were fully assessed. Where appropriate this included their clinical needs and their mental and physical wellbeing.

•Clinicians had enough information to make or confirm a diagnosis.

•We saw no evidence of discrimination when making care and treatment decisions.

•Staff assessed and managed patients' pain where appropriate.

•The provider told us the treatment they used helped patients avoid or delay the need for more invasive surgery and/or joint replacement, meaning patients mobility could be preserved for longer and healing optimised. The provider showed us examples of audits and reviews they had carried out to demonstrate this.

Monitoring care and treatment

The service was actively involved in quality improvement activity.

•The service used information about care and treatment to make improvements. The research team routinely monitored clinical outcomes for patients who had received treatment for up to a year following treatment. We saw examples of studies into the long-term efficacy of the procedure in the treatment of hip and knee arthritis.

•The service made improvements through the use of completed audits. Clinical audit had a positive impact on quality of care and outcomes for patients. There was clear evidence of action to improve quality and safety.

•For example, we saw the service conducted clinical audits monitoring the effectiveness of the treatment it offered (hip joint treatment) three and six months after the procedure. Their results showed 17 out of 26 patients had a "dramatic response" (determined by levels of pain measured before and after the procedure), nine did not respond to the treatment. In those patients that did respond they found that six months after treatment, their average pain scale fell. The service also measured the functional outcome of their treatment using the Oxford Hip Score (OHS), a joint-specific, patient-reported outcome measure tool designed to assess disability in patients undergoing total hip replacement. Through their audit the service found the OHS also improved for the patients who responded to the treatment from 28 to 43, a normal level of function for the majority of people.

Effective staffing

Good

Are services effective?

Staff had the skills, knowledge and experience to carry out their roles.

•Clinical staff were appropriately qualified. All clinicians were substantively employed within the NHS and we were told they had undergone all required training. All Consultants had to submit practising privilege requests which were vetted and approved by the Medical Centre's Medical Director. Their files were maintained and checked by the Medical Centre and an approved list of practising doctors was issued weekly.

•The provider had an induction programme for all newly appointed staff. All staff had an annual appraisal and an informal quarterly performance review within their teams.

•We looked at two Consultant's files and saw evidence they were registered with the General Medical Council (GMC) and were up to date with revalidation. The service did not routinely check and keep these records for all the Consultants who worked there.

•The provider had not assessed the learning needs of non-clinical staff and designed a training programme to ensure their training needs were met. On the day of our inspection we found the provider had started to design a staff training record, however this was not complete. We were told that training including safeguarding and mental capacity was delivered by clinicians to non-clinical staff, however the training materials used were not available for inspection and minutes were not taken. The provider undertook to assess the learning needs of all staff member and provide non-clinical staff with access to an on-line course provider to ensure their training needs were met. Following our inspection, the provider confirmed training had been arranged.

Coordinating patient care and information sharing

Staff worked together, and worked well with other organisations, to deliver effective care and treatment.

•Patients received coordinated and person-centred care. Staff referred to, and communicated effectively with, other services when appropriate. For example, with the patient's GP.

•Before providing treatment, doctors at the service ensured they had adequate knowledge of the patient's health, any relevant test results and their medicines history. We saw examples of patients being signposted to more suitable sources of treatment where this information was not available to ensure safe care and treatment.

•All patients were asked for consent to share details of their consultation and any medicines prescribed with their registered GP on each occasion they used the service.

•The provider had risk assessed the treatments they offered. They were clear the treatment they offered may not be suitable for all patients with joint degeneration and such patients were advised appropriately about alternative treatments. The service did not prescribe medicine that required ongoing monitoring, those liable to abuse or misuse and those for the treatment of long-term conditions such as asthma.

•Patient information was shared appropriately (this included when patients moved to other professional services), and the information needed to plan and deliver care and treatment was available to relevant staff in a timely and accessible way. There were clear and effective arrangements for following up on people who had been referred to other services.

•The service did not offer blood or screening tests.

Supporting patients to live healthier lives

Staff were consistent and proactive in empowering patients and supporting them to manage their own health and maximise their independence.

•Where appropriate, staff gave people advice so they could self-care. Patients were provided with literature giving them information about the treatment, procedure and aftercare. Patients also had ongoing support from the service who followed up on all patients at set intervals following treatment.

•Risk factors were identified, highlighted to patients and where appropriate highlighted to their normal care provider for additional support. All patients were assessed for suitability to undergo the treatment offered by the service. For example, patients with advanced joint degeneration were advised they may not be suitable for the treatment and that their only alternative treatment may be joint replacement.

Good

Are services effective?

•Where patients needs could not be met by the service, staff redirected them to the appropriate service for their needs.

Consent to care and treatment

The service obtained consent to care and treatment in line with legislation and guidance.

•Staff understood the requirements of legislation and guidance when considering consent and decision making.

•Staff supported patients to make decisions. Where appropriate, they assessed and recorded a patient's mental capacity to make a decision.

•The service monitored the process for seeking consent appropriately.

Good

Are services caring?

We rated caring as Good because:

The service treated patients with kindness, respect and compassion. Staff helped patients to be involved in decisions about care and treatment and respected patients' privacy and dignity.

Kindness, respect and compassion

Staff treated patients with kindness, respect and compassion.

•The service sought feedback on the quality of clinical care patients received. The service carried out audits of all patients six and twelve months after treatment to monitor clinical effectiveness and patient satisfaction.

•Feedback from patients was positive about the way staff treat people

•Staff understood patients' personal, cultural, social and religious needs. They displayed an understanding and non-judgmental attitude to all patients.

•The service gave patients timely support and information.

Involvement in decisions about care and treatment

Staff helped patients to be involved in decisions about care and treatment.

•Interpreting services were available for patients who did not have English as a first language. The service had multi-lingual staff who might be able to support them and was able to obtain translation/interpreting services where necessary.

•Due to the nature of the service provided they had not experienced patients with complex additional support needs. However, they were aware that older patients may display signs of dementia and that the principles of the Mental Capacity Act (MCA) 2005 may apply. The provider believed clinical staff would have undergone MCA training in their substantive role but had not provided this training for the non-clinical staff. They told us additional support could be sought from the medical centre if required.

•Staff communicated with people in a way that they could understand. Communication aids were available. Staff ensured patients were given the time and information they required to make informed decisions about their treatment. This began with an extensive initial telephone consultation to understand their needs and carry out an initial assessment, followed by a consultation with a consultant at the clinic. This was followed up by a further consultation with support staff to ensure any remaining queries were answered. The service allocated each patient a point of contact within the service and supplied patients with that person's direct phone number to ensure continuity of care.

•Patients were advised to take two weeks between their initial consultation and having the procedure done in order to allow them time to reflect and decide if the treatment was suitable for them. They were provided with information to review in their own time and direct contact details of their allocated team member to answer any queries they may have.

Privacy and Dignity

The service respected patients' privacy and dignity.

•Staff recognised the importance of people's dignity and respect.

•Staff knew that if patients wanted to discuss sensitive issues or appeared distressed they could offer them a private room to discuss their needs.

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Are services responsive to people's needs?

We rated responsive as Good because:

The service organised and delivered services to meet patients' needs. Patients were able to access services within an appropriate timescale and complaints were managed appropriately.

Responding to and meeting people's needs

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

•The provider understood the needs of their patients and improved services in response to those needs. For example, the service understood that flexibility was important to their patients. Therefore, they designed their service to in such a way as to meet those needs, for example weekend, early or late appointments, shorter or longer appointments and consultations over the phone and by video conferencing where appropriate.

•For male patients aged over 65 years, ECG and blood count tests were routinely carried out and they were assessed by a senior anaesthetist straightaway for the patient's convenience and to save them time.

•The facilities and premises were appropriate for the services delivered.

•Reasonable adjustments had been made so that people requiring extra support could access and use services on an equal basis to others. For example, the lift, corridors and hallway were wide enough to accommodate wheelchairs and mobility scooters.

Timely access to the service

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

•Patients had timely access to initial assessment, test results, diagnosis and treatment. Patients who required same day appointments could be accommodated. The service's normal opening hours were 8am to 6pm Monday to Friday, however clinics could run later between 7pm and 8pm on Saturdays if required.

•Waiting times, delays and cancellations were minimal and managed appropriately.

•Patients with the most urgent needs had their care and treatment prioritised. Patients reported that the appointment system was easy to use.

•The service did not routinely carry out referrals, although it did receive referrals from GPs occasionally and ongoing communication with the referring GP was supported.

Listening and learning from concerns and complaints

The service took complaints and concerns seriously and responded to them appropriately to improve the quality of care.

•Information about how to make a complaint or raise concerns was available. Staff treated patients who made complaints compassionately.

•The service had an allocated phone number for complaints. Patients could be put through directly to their allocated point of contact or to the manager or Chief Executive. Patients could also raise any complaints by email. Information was provided to patients and was available on the service's website.

•The service had received nine complaints within the previous year. We reviewed these complaints and saw they were handled appropriately and in a timely manner.

•The service had a complaints policy and procedures in place. Complaints were discussed at patient pathway meetings. The service learned lessons from individual concerns, complaints and from analysis of trends. It acted as a result to improve the quality of care.

•For example, the service had received a complaint from a patient who felt they had not been shown sufficient aftercare by the service following their procedure. As a result, the service had changed their processes and now routinely booked in a follow up appointment for six weeks after the procedure at the time of their procedure. Patients were contacted three days prior to their follow up appointment to remind them and answer any queries they may have.

Good

Are services well-led?

We rated well-led as Good because:

There was a clear leadership structure in place, and staff told us that they felt able to raise concerns and were confident that these would be addressed.

Responsibilities, roles and systems of accountability supported good governance and management.

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 and were addressing them.

• Leaders at all levels were visible and approachable. They worked closely with staff and others to make sure they prioritised compassionate and inclusive leadership.

Vision and strategy

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

• There was a clear vision and set of values. The service had a realistic strategy and supporting business plans to achieve priorities.

• The provider had advanced plans to expand the service both nationally and internationally and to broaden the medical fields in which the treatment it specialised in could be used. For example, into women's health and aesthetics.

• The service developed its vision, values and strategy jointly with staff. Staff told us they were able to share ideas with the leaders about how to improve the service.

• Staff were aware of and understood the vision, values and strategy and their role in achieving them.

• The service monitored progress against delivery of the strategy.

Culture

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

• Staff felt respected, supported and valued. They were proud to work for the service.

• The service focused on the needs of patients.

• Leaders and managers acted on behaviour and performance inconsistent with the vision and values.

• Openness, honesty and transparency were demonstrated when responding to incidents and complaints. The provider was aware of and had systems to ensure compliance with the requirements of the duty of candour.

• Staff told us they could raise concerns and were encouraged to do so. They had confidence that these would be addressed.

• Clinical staff were supported in their learning and development through their substantive employment. All were experienced consultants in the relevant field of medicine. However, the learning and development needs of non-clinical staff was not fully assessed and provided for. All staff received regular annual appraisals in the last year.

• There was a strong emphasis on the safety and well-being of all staff.

• The service actively promoted equality and diversity. It identified and addressed the causes of any workforce inequality. Staff felt they were treated equally.

• There were positive relationships between staff and teams.

Governance arrangements

Responsibilities, roles and systems of accountability supported good governance and management.

• Structures, processes and systems in place did not always support good governance.

• Staff were largely clear on their roles and accountabilities. We found the provider was not clear about its roles and accountabilities, particularly in relation to the requirement to notify the CQC of certain incidents under Regulation 18 of the Care Quality Commission (Registration) Regulations 2009. Following our inspection, we were advised a system had been implemented to ensure any notifiable incidents were reported to CQC.

• The provider maintained appropriate records in relation to staff. Multiple clinicians worked at the clinic under a practising privilege arrangement. All clinicians submitted practising privilege requests which were vetted and approved by the Medical Centre's Clinical Director and

Good

Are services well-led?

independent chairman of their Medical Advisory Committee. An approved list of practising doctors was issued weekly and their files were maintained and checked by the Medical Centre.

• Leaders had established proper policies, procedures and activities to ensure safety and assured themselves that they were operating as intended.

Managing risks, issues and performance

There were clear and effective processes for managing risks, issues and performance.

• There was a process to identify, understand, monitor and address current and future risks including risks to patient safety.

• The service had processes to manage current and future performance. Performance of clinical staff could be demonstrated through audit of their consultations and clinical outcomes for patients. Leaders had oversight of safety alerts, incidents, and complaints.

• Clinical audit had a positive impact on quality of care and outcomes for patients. There was clear evidence of action to change services to improve quality.

• The provider had plans in place and had trained staff for major incidents.

Appropriate and accurate information

The service acted on appropriate and accurate information.

• Quality and operational information was used to ensure and improve performance. Performance information was combined with the views of patients.

• Quality and sustainability were discussed in relevant meetings where all staff had sufficient access to information.

• The service used performance information which was reported and monitored and management and staff were held to account

• The information used to monitor performance and the delivery of quality care was accurate and useful. There were plans to address any identified weaknesses.

• There were robust arrangements in line with data security standards for the availability, integrity and confidentiality of patient identifiable data, records and data management systems.

Engagement with patients, the public, staff and external partners

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

• The service encouraged and heard views and concerns from the public, patients, staff and external partners and acted on them to shape services and culture. For example, the service had responded to feedback from staff and patients and allocated each patient a single point of contact who stayed with that patient throughout the process of their treatment to support continuity and patient care. They had also responded to patient feedback and results of internal reviews by streamlining the initial assessment process, for example by reducing the amount of paperwork and forms patients received.

• Staff could describe to us the systems in place to give feedback. They described an open culture where they felt free to give feedback and share their opinions. For example, non-clinical staff were able to feed into the ongoing restructure of the service in terms of supporting better communication with patients and felt free to share learning from previous employment to improve the service. We saw evidence of feedback opportunities for staff and how the findings were fed back to staff, for example through team meetings and appraisals. We also saw staff engagement in responding to these findings.

Continuous improvement and innovation

There were systems and processes for learning, continuous improvement and innovation.

• There was a focus on continuous learning and improvement. The service had plans to extend and expand the range and locations of its services and continued to research and design new procedures and techniques within its field of practice.

• Learning was shared between clinicians at patient pathway meetings and the leaders attended various conferences and event internationally where learning and innovation was shared.

Good

Are services well-led?

• The service made use of internal reviews of incidents and complaints. Learning was shared and used to make improvements.

• There were systems to support improvement and innovation work. The provider told us they were constantly reviewing the clinical efficacy of their treatment and looking at how use of the treatment could be expanded and how they could partner with other organisations internationally to improve access to the treatment.