Anglo Japanese Management Services Limited

London Iryo Centre

Inspection report

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Overall summary

We carried out an announced comprehensive inspection on 12 October 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 not 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.

Our key findings were:

- Systems and processes were in place to keep patients safe. However, we identified some shortfalls in relation to safeguarding, incident analysis, managing and acting on medicines safety alerts.
- There were no medicine audits carried out to monitor the effectiveness of prescribing.
- Governance arrangements required improvements; there was no program of continuous clinical and internal audit to cover the range of services offered. The sharing of learning from complaints and significant events was not always shared with staff in a consistent way.
- Patients reported being treated with compassion, dignity and respect and they were involved in their care and decisions about their treatment.
- Patients said they found it easy to make appointments, and were happy with the 24-hour service provided at the practice.
- The clinic had good facilities and was well equipped to treat patients and meet their needs. The service could not evidence how they kept clinicians up to date with current evidence based practice.

Summary of findings

- There were no clear arrangements relating to the leadership of the service.

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

- Ensure effective systems and processes to ensure good governance in accordance with the fundamental standards of care.

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:

- Monitor fire exits so that they remain clear of any obstruction.
- Develop quality assurance processes to include two cycle clinical audits for the different specialisms offered at the service to drive improvement.
- Develop a system to monitor prescription stationery.

Professor Steve Field CBE FRCP FFPH FRCGPChief Inspector of General Practice

London Iryo Centre

Detailed findings

Background to this inspection

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.

London Iryo Centre is registered with the Care Quality Commission to provide Diagnostic and Screening procedures and Treatment of Disease, Disorder, Injury (TDDI).

London Iryo Centre provides a range of healthcare services for Japanese patients living in the United Kingdom. The clinic is recommended by the Japan Consulate for Japanese expatriates in the UK. The centre offers private consultations with doctors in a range of specialties ranging from doctors consulting services, medical emergency care, health checks, ultrasound, gynaecology paediatrician care, gastroenterology investigations and orthopaedics. Due to the wide range services offered at the service this inspection only focused on the primary care part of the service.

The provider explained that due to arrangements between the Japan Consulate and the General Medical Council, the doctors working at the service are granted temporary registration with the GMC. Therefore, the service is only allowed to be accessed by Japanese expatriates. The service has other visiting doctors who work within the NHS specialising in a variety of care settings.

The service is open 24 hours a day, seven days per week. Between 8pm and 9am the service is accessible to patients via the on-call system which is accessed by calling the service and being connected to the doctors on duty who offer patients an option to attend the service if this is deemed necessary.

The service undertakes 10, 000 consultations per year. We were told by the provider that most patients are registered with them for a period of up to five years before they return to Japan or move to other countries with work commitments. The service provides services to adults and children.

The service was offered to patients would could afford the fees which were explained prior to treatment and were also available on patient leaflets. We were told that the majority of patients accessing the service did not qualify for NHS care and as such where not registered with local GPs.

The service employs four full time doctors and two part time doctors, two visiting radiologists, one gastroenterologist, and a visiting psychiatrist, who also works within the NHS.

The service employs one full time nurse, who is registered with the Nursing and Midwifery Council (NMC). The nurse is employed to assist the doctors and undertake some clinical administration work and does not deliver patient care. Other staff at the service are health care assistants undertaking phlebotomy roles, two pharmacists, a practice manager and a number of clerical and administrative staff.

The service has a principle doctor who is the organisations Chief operating officer as well as the CQC 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.

Detailed findings

The principle doctor splits their time between the London Iryo Centre and one of their other services. During their absence the service is run by the assistant manager, who is a doctor at the service and the practice manager.

We obtained feedback about the service from eight patients from Care Quality Commission comment cards. All patient's comments were positive about the service experienced. Patients said they felt the service offered an excellent service as they could access it seven days per week and 24 hours a day. Patients reported that staff were helpful, caring and treated them with dignity and respect.

Our inspection team was led by a CQC Inspector and was supported by GP specialist advisor.

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

- The service conducted safety risk assessments. It had appropriate safety policies, which were regularly reviewed and communicated to staff. Staff received safety information from the service as part of their induction and refresher training. However, the systems to safeguard children and vulnerable adults from abuse required improvements. Policies were regularly reviewed and were accessible to all staff. All doctors were trained to Safeguarding children level 3 and all other administrative staff, the nurse and health care assistants to level 2. Adult safeguarding training had been completed to level 2 by all staff. Information about raising concerns was contained in the polices and the practice manager was aware of the process. However clinical staff we spoke with could not clearly outline the process they would follow if they had a safeguarding concern.
- The provider carried out staff checks at the time of recruitment and on an ongoing basis where appropriate. Disclosure and Barring Service (DBS) checks were undertaken where required. (DBS checks identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable).
- The clinic had a chaperone policy in place. The nurse acted as a chaperone and was trained for the role and had received a DBS check.
- We observed the premises to be clean and tidy and there were cleaning schedules in place. There were infection control policies in place and records confirmed that staff had received up to date training. A professional company was contracted to remove clinical waste.
- We saw evidence that an infection control audit had been undertaken to monitor infection control risks with follow up actions identified and action being taken.
- We saw evidence that some equipment had been calibrated and were checked for safety. However, some weighing scales and blood pressure monitors did not have stickers to confirm they had been checked. Following our inspection, the service sent records to confirm that all equipment was calibrated and that there was a service agreement with an external company who undertook the checks.
- There was a health and safety policy available. The service had an up to date fire risk assessment and a fire evacuation plan and fire drills were undertaken on a regular basis. However, we saw that one of the fire exits located in the staff room was blocked with packaging boxes. Following our inspection, the service sent information to advise they were in the process of improving the emergency exits as learnt from a previous fire drill and all the fire exits were clear of obstruction.
- The clinic had a variety of other risk assessments to monitor safety of the premises such as control of substances hazardous to health and legionella (Legionella is a term for a bacterium which can contaminate water systems in buildings).

Risks to patients

There were some systems to assess, monitor and manage risks to patient safety. However, some improvements are required.

- There were arrangements for planning and monitoring the number and mix of staff needed. However, there was no evidence to demonstrate that when there were changes to services the service assessed and monitored the impact on safety. There were no formal business continuity plans in place. However following our inspection the service sent us a copy of their business continuity plan. We reviewed this and judged that it still needed to contain information about staffing changes.
- Staff understood their responsibilities to manage emergencies and to recognise those in need of urgent medical attention. However, it was not clear if clinical staff had received sepsis training and awareness. Following our inspection, the practice manager sent evidence that the clinicians had in fact received this training prior to our inspection as an internal education seminar. An educational leaflet had also been created by one of the doctors and shared within the service.
- All staff received annual basic life support training and there were emergency medicines available in the treatment room. The service had a defibrillator available

on the premises and oxygen with adult and children's masks. A first aid kit and accident book were available. Emergency medicines were easily accessible to staff in a secure area of the service and all staff knew of their location. All the medicines we checked were in date and fit for use.

- There were appropriate indemnity arrangements in place to cover all potential liabilities.

Information to deliver safe care and treatment

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

- Individual care records were written and managed in a way that kept patients safe. The care records we saw showed that information needed to deliver safe care and treatment was available to relevant staff in an accessible way.
- The service had systems for sharing information with staff and other agencies to enable them to deliver safe care and treatment.
- The service had a system in place to retain medical records in line with the Department of Health and Social Care (DHSC) guidance.
- Clinicians made appropriate and timely referrals in line with protocols and up to date evidence-based guidance.
- We also saw that the documentation in the notes requested patients to return to the service without a formal recall system in place.

Safe and appropriate use of medicines

The system for the safe handling of medicines required improvements.

- We saw that prescriptions were kept in the pharmacy, though the prescriptions were not locked away, patients did not have access to this area. However, we saw no system in place to ensure the prescriptions were logged to monitor their use.
- We saw no evidence of the service carrying out regular medicines audit to ensure prescribing was in line with best practice guidelines for safe prescribing. The service had not conducted any searches relating to the use of Sodium Valproate by women of child bearing age. They advised us that this medication was held in the pharmacy and it was during any dispensing that the required action was carried out. However, this was not acceptable as the prescribing clinician was responsible for checking the appropriate use of medicines and not the pharmacist.
- Pharmacy clinicians we spoke with were aware of the need of monitoring the use of sodium valproate within this group.
- Investigations requested or performed were based on Japanese medical guidelines.
- Processes were in place for checking medicines and staff kept accurate records of medicines.
- There were effective protocols for verifying the identity of patients during telephone consultations. For example, when patients accessed the service during the out of hours service.

Lessons learned and improvements made

The service did not consistently learn and make 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.
- The systems for reviewing and investigating when things went wrong required some improvement. We saw some evidence that the service learned and shared lessons identified themes and acted to improve safety in the service. However not all incidents were fully investigated and shared. We saw an example of an incident that involved incorrectly labelled blood samples. The service had been advised by the Laboratory that the samples taken for analysis had possibly been miss- labelled. The laboratory had requested that the samples were re-taken. However, the service felt confident that the samples had been correctly labelled and took no further action. The practice manager and assistant manager told us that, no action was taken as they were confident the samples were for the correct patients. They further explained they had sent an email to the staff responsible for taking samples to ensure samples were correctly labelled. We saw no in- depth analysis of this incident and shared learning with the rest of the team.
- Pathology results were received from the laboratory and the nurse had the role to follow up results with the doctors. We saw no evidence of outstanding pathology results.

Are services safe?

- The service had systems in place for knowing about notifiable safety incidents

When there were unexpected or unintended safety incidents:

- The service gave affected people reasonable support, truthful information and a verbal and written apology.
- The service had a system of receiving medicines alerts. However, we saw no mechanism in place to disseminate alerts to all members of the clinical team and it was not clear whose role it was on acting on the alerts and making a follow up to ensure appropriate action had been taken.

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 only provided care to Japanese nationals and the GMC created temporary licences to the doctors to specifically treat Japanese patients in line with Japanese regulations and guidance. For example, we were told that in Japan cervical smears were offered from the age of 20 years. We also noted that patients aged 40 and above were offered further gastro investigations yearly in accordance to Japanese guidance.
- We saw evidence of further training for the visiting doctors. However, the service could not evidence any further training for the rest of the doctors apart from the routine mandatory training and the sepsis seminar held at the service. The principal GP advised that it was their role to deliver in house training to the rest of the doctors. However, this could not be evidenced further.

Monitoring care and treatment

- The service had largely conducted audits relating to specialist care that was offered at the clinic in areas such as endoscopy and radiation. No other clinical audits had been completed relating to primary care services. Following our inspection, we were provided with a cervical smear audit that had been completed at the service. The audit demonstrated that the service had a very low inadequate rate for smears.

Effective staffing

- The nurse was registered with the NMC and we saw evidence of ongoing training. Health care assistants conducting phlebotomy roles had received appropriate training.
- The learning needs of all other non-clinical staff were identified through a system of appraisals, meetings and reviews of practice development needs. Staff had access to appropriate training to meet these learning needs and to cover the scope of their work. This included on-going support during sessions, one-to-one meetings, and appraisals, coaching and mentoring. All staff had had an appraisal within the last 12 months.
- Staff received training that included: safeguarding, fire procedures, and basic life support and information governance awareness. Staff had access to and made use of e-learning training modules. However, clinical staff could not demonstrate the actions they would take should any safeguarding concerns arise.

Coordinating patient care and information sharing

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

Supporting patients to live healthier lives

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

- Where appropriate, staff gave people advice so they could self-care.
- Where patients need 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 decide.
- The service monitored the process for seeking consent appropriately. All patients registering with the service

Are services effective?

(for example, treatment is effective)

were required to bring proof of identity. Additional checks were undertaken for children attending to ensure the adults attending with them had the authority to give parental consent.

Are services caring?

Our findings

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

Kindness, respect and compassion

Staff treated patients with kindness, respect and compassion.

- 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.

- The service offers interpretation services when required.
- Patients told us through comment cards, that they felt listened to and supported by staff and had sufficient time during consultations to make an informed decision about the choice of treatment available to them.

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.

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

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

- The facilities and premises were appropriate for the services delivered.
- Reasonable adjustments had been made so that people in vulnerable circumstances could access and use services on an equal basis to others.
- We saw that the service made provisions to visit very ill patients despite there being a distance to travel.

Timely access to the service

Patients could 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.
- Waiting times, delays and cancellations were minimal and managed appropriately.
- Patients with the most urgent needs had their care and treatment prioritised.

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 complaint policy and procedures in place. The service learned lessons from individual concerns and complaints and from analysis of trends. It acted as a result to improve the quality of care. However, the service did not have further information for patients of any further action that may be available to them should they not be satisfied with the response to their complaint. We saw that the practice manager amended the leaflet prior to the end of our inspection to ensure it included all relevant information.
- We looked at two complaints received in the last 12 months and found they were satisfactorily handled and dealt with in a timely way. The service demonstrated an open and transparent approach in dealing with complaints. Lessons were learnt from concerns and complaints and action was taken to as a result to improve the quality of care.

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 not providing well led care in accordance with the relevant regulations.

Leadership capacity and capability;

- The director of the service who was also the principal GP was based at another clinic most of the time. It was not clear to us who was responsible for leading the service during the absence of the principal GP. The principal GP explained that the practice manager was on site all the time and the deputy manager who was also a doctor was on site to provide clinical and managerial oversight. However, the deputy manager spent most of their time undertaking clinical work and therefore we could not be assured they had sufficient time to undertake both the clinical and the leadership role within the clinic.
- We raised these concerns on the day of the inspection and the principal GP advised us that they supported the service in their absence and this was facilitated by modern technology. They told us they held daily video meetings with staff in London making contact as required should there be concerns.

Vision and strategy

- 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

- Staff felt respected, supported and valued. They were proud to work for the service.
- The service focused on the needs of patients.
- The provider was aware of and had systems to ensure compliance with the requirements of the duty of candour.
- Staff we spoke with told us they could raise concerns and were encouraged to do so. They had confidence that these would be addressed.
- All staff had received regular annual appraisals in the last year. Staff were supported to meet the requirements of professional revalidation where necessary.
- There was emphasis on the safety and well-being of all staff.

Governance arrangements

- The service had an overarching governance framework in place to support the delivery of good care. However, there were gaps in some areas of governance:
- There was a clear staffing structure and staff were aware of their own roles and responsibilities. However, the leadership of the service did not have the same structure. The principal GP had overall responsibility. However, in their absence the leadership role was assigned to the deputy who had clinical responsibility and worked as clinician. Therefore, they could not evidence they had sufficient time to enable them to run the service fully.
- The principal GP had key roles in areas such as safeguarding though they were not based at the service. Clinicians we spoke with were not clear in the processes they would follow.
- Service specific policies were implemented and were available to all staff. These were reviewed on a regular basis.
- Though regular meetings took place at the service. The sharing of significant incidents was not consistent.

Managing risks, issues and performance

There was no clarity around processes for managing risks, issues and performance.

- There were no effective, processes to identify, understand, monitor and address current and future risks including risks to patient safety. For example, the lack of an effective medicines alert system or safeguarding system to raise concerns.
- Performance of clinical staff could not be demonstrated as audits of their consultations, prescribing and referral decisions were not carried out.
- There was no continuous system for quality monitoring in place.
- The service did not have plans in place to deal with major disruptions.

Engagement with patients, the public, staff and external partners

Are services well-led?

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

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

- The public's, patients', staff and external partners' views and concerns were encouraged, heard and acted on to shape services and culture.
- Regular patient surveys were carried out with appropriate action being taken following such feedback.
- Staff could describe to us the systems in place to give feedback.
- We saw evidence of feedback opportunities for staff and how the findings were fed back to staff. We also saw staff engagement in responding to these findings.
- The service was transparent, collaborative and open with stakeholders about performance.

Continuous improvement and innovation

- The service made use of internal and external reviews of incidents and complaints. However, learning was not consistently shared to make improvements.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance The registered person had systems and processes in place that were operating ineffectively in that they failed to enable the registered person to assess, monitor and improve the quality and safety of the services being provided. There were no medicine audits to monitor the quality of prescribing. There was no effective system for managing and acting on medicines safety alerts. Clinical staff could not clearly outline the process they would follow if they had a safeguarding concern. There was no consistent system for investigation or sharing learning significant events. The service could not evidence how they kept clinicians up to date with current evidence based practice. There were no clear arrangements relating to the leadership of the service. This is in breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

This section is primarily information for the provider

Requirement notices