Knightsbridge Doctors

Knightsbridge Doctors - Bentinck Mansions

Inspection report

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Overall summary

We carried out an announced comprehensive inspection on 2 November 2017 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.

Background

Knightsbridge Doctors - Bentinck Mansions (trading under the name of Visa Medicals) is a private facility providing 'third party' medical examinations to individuals who require medicals for visa applications to visit the United States of America and Canada. The services are provided from a location at 4 Bentinck Mansions, London, W1U 2ER.

The provider employs a practice manager, three nurses, three radiographers and three reception/administrative staff. There are 10 immigration doctors and one lead immigration doctor who work under practising privileges (the granting of practising privileges is a well-established process within independent healthcare whereby a medical practitioner is granted permission to work in an independent hospital or clinic, in independent private practice, or within the provision of community services).

Services provided as part of a visa medical include chest X-rays; blood pressure checks, blood sampling and assessment of vaccination status and provision of vaccinations for immigration purposes. The practice is open 8.30am to 5pm Monday to Friday and 9am to 1pm on occasional Saturdays. Patients are asked to call to book an appointment by telephone between 9am and

Summary of findings

5pm. They are invited to state their preferred appointment times (at least five working days before their visa interview date for applicants for the USA) and are usually able to get an appointment of their choice within two working days. Visa medicals usually last an hour and a half with the first appointment starting at 8.50am and the last at 3.30pm.

The provider is registered with the Care Quality Commission (CQC) to carry on at the practice location, Bentinck Mansions, the regulated activities of Treatment of Disease Disorder or Injury and Diagnostic & Screening Procedures. The provider, Knightsbridge Doctors, has applied to remove Bentinck Mansions as a location as it is now trading as a separate company, Visa Medicals. After the inspection we informed the provider that in the provision of services as described to us, Visa Medicals was carrying on the regulated activities of Treatment of Disease Disorder or Injury and Diagnostic & Screening Procedures. We therefore advised Visa Medicals that they were required to apply to register with the CQC as a new provider and location alongside Knightsbridge Doctors' application to remove Bentinck Mansions as a registered location. At the time of writing no new provider and location application had been made. However, the provider has been in contact with our Registration team about progressing this.

The currently registered manager of Knightsbridge Doctors - Bentinck Mansions, resigned from the practice in 2016. We were told that the current practice manager of Visa Medicals would be applying for registration as the registered manager of Visa Medicals. This would need to be linked to the new provider and location application. A registered manager is a person who is registered with the CQC 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.

We received 47 completed CQC comment cards which were all very positive about the service provided. We spoke to one patient directly at the inspection who was also very positive about the service they had received.

Our key findings were:

- There was a system in place for the reporting and investigation of incidents and significant events. However, there was limited documentation in relation to the investigation of incidents and lessons learnt were not shared widely with staff within the practice.
- Systems and processes were in place to keep people safe. However, these systems were not effectively operated to ensure care and treatment to patients was provided in a safe way in relation to Health & Safety and Legionella risk assessment, safeguarding, infection control, equipment safety, medicines management and medical emergency provisions, business continuity planning and compliance with Ionising Radiation (Medical Exposure) Regulations 2000 (amended 2006 and 2011) [IR(ME)R] and Ionising Radiations Regulations [IRR] 1999 requirements, confirmation of professional indemnity insurance and patient safety alerts.
- Staff were aware of current evidence based guidance. Non-clinical staff had been trained to provide them with the skills and knowledge to deliver effective care and treatment. However, at the time of the inspection the practice was unable to provide confirmation of training in all areas undertaken by staff.
- Quality improvement and monitoring was exercised through ongoing quality assurance of visa medical reports by the two directors.
- There were formal processes for employed staff to receive an appraisal. However, these processes had only recently been reinstated after a period in abeyance.
- Staff we spoke with were aware of their responsibility to respect people's diversity and human rights.
- Patients were able to access services from the practice within an appropriate timescale for their needs.
- There was a complaints procedure in place, however there was no evidence of the communication within the practice of lessons learned from complaints.
- Clinical leadership and oversight was not formally stated in a strategy or development programme but was exercised mainly by the directors in quality assuring visa medical reports and regular written correspondence and updates with doctors.
- There were potential risks to the security of patient identifiable information.

Summary of findings

- The practice did not maintain accurate up to date information about all staff it employed, in particular in relation to training completed by radiographers and doctors employed with practising privileges.

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

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

In addition the provider should:

- Review the system for knowing about notifiable safety incidents to raise staff awareness of the notification requirements under the duty of candour.
- Review recruitment processes to ensure all pre-employment checks are completed in accordance with practice policy, particularly with regard to references.
- Review the induction processes to consider consistency in induction between directly employed staff and those employed with practising privileges.
- Review the facilities for those patients who are hard of hearing.
- Review the need for an emergency pull cord in the patients' toilet.
- Arrange for lessons learnt from complaints to be shared with all staff.

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).

- Systems and processes were in place to keep people safe. However, these systems were not operated effectively in respect of safeguarding, infection control, safety of premises and equipment, medicines management, compliance with Ionising Radiation (Medical Exposure) Regulations 2000 (amended 2006 and 2011) [IR(ME)R] and Ionising Radiations Regulations [IRR] 1999 requirements, confirmation of professional indemnity insurance and patient safety alerts.
- There was a system in place for the reporting and investigation of incidents and significant events. However, lessons learnt were not shared widely with staff within the practice and documentation, although recently improved, was limited.
- There were arrangements in place to deal with emergencies and major incidents. However, these arrangements were not operated effectively in respect of emergency equipment and medicines and business continuity planning.

Are services effective?

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

- Staff were aware of current evidence based guidance.
- Non-clinical staff had been trained to provide them with the skills and knowledge to deliver effective care and treatment. However, at the time of the inspection the practice was unable to provide equipment training records for radiographer staff for operating imaging equipment, and there were some gaps in information for these staff relating to safeguarding and infection control training. In addition the practice could not confirm details of mandatory training (including health and safety, infection control, safeguarding, basic life support, fire safety awareness, information governance and equality and diversity) for the majority of doctors working with practising privileges.
- Quality improvement and monitoring was exercised through ongoing quality assurance of visa medical reports by the two directors.
- There were formal processes for employed staff to receive an appraisal. However, these processes had only recently been reinstated and the majority of staff had not been appraised in the last two years. In addition, the practice was unable to provide confirmation of the date of the last appraisal for the majority of the doctors working with practising privileges.

Are services caring?

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

- Staff we spoke with were aware of their responsibility to respect people's diversity and human rights.
- We received 47 completed Care Quality Commission comment cards which were all very positive about the staff at the practice.

Summary of findings

- 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 responsive to people's needs?

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

- Patients were able to access services provided by the practice within an appropriate timescale for their needs.
- Access to the practice was available for people with mobility needs.
- Staff told us that they had access to translation services for those patients whose first language was not English.
- There was a complaints procedure in place.
- We found areas where improvements should be made relating to the safe provision of treatment. This was because the provider did not have an emergency pull cord in the patients' toilet; there was no hearing loop to aid those patients who were hard of hearing; and there was no evidence of the communication within the practice of lessons learned from complaints.

Are services well-led?

We found that this service was not providing well-led 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).

- Clinical leadership and oversight was not formally stated in a strategy or development programme but was exercised mainly by the directors in quality assuring visa medical reports and regular written correspondence and updates with doctors.
- Governance arrangements were in place. Quality improvement and monitoring was exercised through ongoing quality assurance of visa medical reports by the two directors. The meetings structure did not allow for the sharing of learning from complaints and significant events with all staff.
- There were limited arrangements for identifying, recording and managing risks, issues and implementing mitigating actions. Systems and processes were not operated effectively in relation to Health & Safety and Legionella risk assessment, safeguarding, infection control, equipment safety, medicines management and medical emergency provisions, business continuity planning and compliance with Ionising Radiation (Medical Exposure) Regulations 2000 (amended 2006 and 2011) [IR(ME)R] and Ionising Radiations Regulations [IRR] 1999 requirements.
- There were potential risks in security of patient identifiable data and records and data management systems, particularly in relation to the internal storage of X-ray images.
- The practice did not maintain accurate up to date information about all staff it employed. There were many gaps in information about the training completed, in particular by radiographers, and doctors employed with practising privileges.
- There was limited evidence of processes for seeking and acting on feedback from staff in order to evaluate and improve services. In particular, staff appraisal processes had only recently been reinstated after a period in abeyance.

Knightsbridge Doctors - Bentinck Mansions

Detailed findings

Background to this inspection

The inspection on 2 November 2017 was led by a CQC inspector and included a GP specialist advisor and an inspector from CQC's IRMER team.

Before the inspection we reviewed pre-inspection information submitted by the provider, requested by CQC.

During our visit we spoke with managers, administrative, radiography and clinical staff, reviewed personal care or treatment records of patients and also staff records.

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

Safety systems and processes

- Arrangements for safeguarding reflected relevant legislation and local requirements. Policies were accessible to all staff. There was information available to staff about who to contact for further guidance if staff had concerns about a patient's welfare. There was a lead member of staff for safeguarding.
- The majority of staff interviewed demonstrated they understood their responsibilities regarding safeguarding. We were told that staff directly employed by the practice had received training on safeguarding children and vulnerable adults, apart from one of the radiographers and a recently appointed member of the administrative team for whom training had been booked. However, the practice was unable to confirm details of the training received by another of the radiographers. We were told that doctors employed on practising privilege agreements were expected to arrange their own safeguarding training. However, the practice was unable to confirm details of the training received by some of those doctors. For staff for whom training details were confirmed, doctors and the safeguarding lead nurse were trained to child protection or child safeguarding level three and other nurses and administrative staff to level two. However, there was no information on the level for one of the radiographers and a newly started doctor was trained to level two. It is a requirement set out in the Intercollegiate Guidelines (ICG) for doctors working with children to be trained to child protection level three.
- The practice did not have a register in place of vulnerable adults and children as the majority of patients made one off visits for a visa medical and did not return. If any safeguarding concerns arose the practice would report them to the patient's GP. There were systems in place to check parental responsibility for minors. The practice policy required that all children must be accompanied by a parent or guardian and they identified who that was when an appointment for a medical was made. All applicants had to bring to the appointment their passport and for children their red book health record which enabled the practice to check the identity of parents or guardians.
- The practice had a chaperone policy in place. A notice was displayed in the waiting room and in consultation rooms to advise patients that chaperones were available if required. We saw records of patients being offered a chaperone during consultations including intimate examinations. A chaperone statement and consent form was signed by every patient which was given to them by the doctor prior to examination.
- Most chaperoning was undertaken by clinical staff. Some reception staff who occasionally acted as chaperones, had received chaperone training, understood the role, and they had received a Disclosure and Barring Service (DBS) check. (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).
- 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 apart from one radiographer the majority of directly employed staff had received or were booked to receive up to date training. However, the practice was unable to confirm details of the training received by the majority of doctors working with practising privileges. A professional company was contracted to remove clinical waste. We saw no evidence that regular infection control audits were undertaken to monitor infection control risks, apart from an audit of compliance with safety standards in the use of sharps containers carried out in 2013. The registered manager confirmed that annual infection control audits had not been carried out. The practice was unable to confirm whether a risk assessment of the premises had been completed for legionella (Legionella is a term for a particular bacterium which can contaminate water systems in buildings).
- All the doctors with practising privileges were registered with the General Medical Council (GMC) the medical professionals' regulatory body with a licence to practice. None of the doctors provided specialist care which required registration on the UK specialist register to provide this. We were told all the doctors had professional indemnity insurance that covered the scope of their practice. However, the practice was unable to provide confirmation of this in the case of four doctors.

Are services safe?

- All the doctors had a current responsible officer. (All doctors working in the United Kingdom are required to to follow a process of appraisal and revalidation to ensure their fitness to practice). We were told all the doctors were following the required appraisal and revalidation processes. However, the practice was unable to provide details to confirm this for the majority of doctors working with practising privileges.
- We reviewed the personnel files of the two most recently recruited staff including an administrator, and a doctor working with practising privileges. Appropriate recruitment checks had been undertaken prior to employment. For example, proof of identification, qualifications and appropriate checks through the DBS. We were told it was practice policy to request two references.The practice had only one written reference from previous employment for these staff. It was practice policy for all staff to receive a DBS check.
- All general electrical and clinical equipment was checked and calibrated to ensure it was safe to use and was in good working order. PAT testing of portable electrical appliances was up to date. There were up to date maintenance and testing records for X-ray equipment.
- In addition, an installation engineer had advised staff about what exposure factors to use for chest X-rays. However, this had not been optimised subsequently, resulting in albeit safe but higher patient doses that those typically seen for chest X-rays. Optimisation is the process where doses from X-rays (and other imaging examinations involving ionising radiation) are kept as low as reasonably practicable, in line with the intended purpose of the examination.
- There were other areas where the evidence did not demonstrate compliance with **Ionising Radiation (Medical Exposure) Regulations** 2000 (amended 2006 and 2011) [IR(ME)R] and Ionising Radiations Regulations [IRR] 1999 requirements. On the day of the inspection the practice was unable to provide:

IRMER

- Diagnostic reference levels (DRLs)
- IRMER Employer's procedures
- Radiographer equipment training records
- Records of Radiation Protection Adviser (RPA)/Medical Physics Expert (MPE) provision
- An equipment inventory

IRR

- Local rules

The practice submitted some of this information shortly after the inspection. However, not all of the employers procedures required under IRMER were provided. At the time of the inspection it was clear to inspectors that the employer and staff had very little awareness of the requirements of both IRMER and IRR. There was no evidence that staff operating the X-ray equipment had been adequately trained and the equipment settings used for chest X-rays were significantly higher than would commonly be used within hospital radiology departments. There were no local diagnostic reference levels (DRLs) in place at the practice and evidence seen after the inspection confirmed that typical doses at the practice were more than double the national DRL for chest X-rays. DRLs are used as a guide to help promote improvements in radiation protection practice.

- There were systems in place for the management and processing of pathology and X-ray results. Any abnormalities were referred to the doctor who completed the patient's medical. The doctor notified the patient and with their consent their regular GP.

Risks to patients

The practice had arrangements in place to respond to emergencies and major incidents but these arrangements were not operated effectively in all areas.

- The practice had a defibrillator available on the premises, although there were no children's pads for use with it. There was also oxygen with adult and children's masks. Emergency equipment was regularly checked to ensure it was operational and there were records for this. A first aid kit and accident book were available.
- We were told all staff received annual basic life support training and records for directly employed staff confirmed training had been completed or was booked. However, the practice was unable to provide details to confirm this for the majority of doctors working with practising privileges.
- Emergency medicines were easily available to staff in the nurse treatment room. The majority of staff knew of their location, although one doctor told us they were not told this on joining the practice. All the medicines

were in date and there were records of the checks of this. However, several medicines recommended in CQC guidance were not included in the kit and there was no written risk assessment of reasons for this. The medicines were stored in a secure area in the nurse's room. However, the room was not locked when the nurse left the room.

- We were told all clinical staff had professional indemnity insurance cover. However, the practice was unable to provide details to confirm this for four doctors.
- The practice did not have evidence to show they had risk assessed and put in place mitigating actions to ensure the continuity of services and patient and staff safety in the event of a major incident such as power failure or building damage.

There were procedures for assessing, monitoring and managing risks to patient and staff safety.

- There was a health and safety policy available. However, apart from completing visual checks on the premises there was no documented health and safety risk assessment carried out by the practice.
- The practice had an up to date fire risk assessment and a fire evacuation plan and carried out regular fire alarm tests and fire evacuation drills. There was also evidence of up to date checks of fire extinguishers.

Information to deliver safe care and treatment

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

- The doctors were responsible for recording results from medicals and procedures manually on paper for visa applicants to the USA and electronically for applicants to Canada. Copies of paper records were scanned into the clinical IT system and stored securely on computers that were password protected with restricted access. Paper medical records were stored securely at the practice. However, in the X-ray room we found CDs of X-ray images dating back over eight years which were not securely stored.
- In most instances patients' medical results were sent to the USA embassy five working days after their appointment, in time for their visa interview. This included CDs of X-ray images which were sent by special secure courier to the embassy. Medical results for applicants to Canada were sent securely via a Canadian government-operated online system, designed for submitting medical reports of immigration examinations, pathology reports and X-rays.

Safe and appropriate use of medicines

The practice had systems for appropriate and safe handling of medicines. However, we found systems for managing patient safety alerts and patient group directions were not effective.

- There was a medicines management policy in place. The provider held stocks of vaccines for all vaccinations required by the relevant embassy. For example, vaccination records would be reviewed to verify whether patients met the United States vaccination requirements, or if it was medically inappropriate for them to receive any of the vaccinations listed. If they did not have a vaccination record of any of the required vaccines, the practice was able to vaccinate them on the day of their medical examination. All stocks were monitored appropriately, stored securely and maintained at the correct temperature.
- There was some evidence that clinical staff received and acted on safety alerts. The nurses subscribed to Public Health England, MHRA safety and NaTHNac monthly travel vaccine alerts. However, the practice had no overarching system in place for receiving, disseminating and acting on patient safety alerts from these sources.
- All prescriptions were issued on a private basis by individual consultants. When a prescription had been issued the practice scanned a copy into the patient's medical notes on the clinical computer system.
- Patient Group Directions (PGDs) had been adopted by the practice to allow nurses to administer medicines in line with legislation. However, in checking PGDs for Hepatitis B vaccinations, the expiry date at the foot of the document was 2016, but on the front of the document the date had been changed manually to 2018. In addition, one of the PGDs had been signed by the staff member in 2016, but there was no doctor's signature to confirm the PGD.
- Nursing staff who administered immunisations and vaccinations had on line access to the Green Book (which has the latest information on vaccines and vaccination procedures, for vaccine preventable infectious diseases in the UK).

Are services safe?

- The practice did not hold stocks of any controlled drugs and the doctors did not prescribe any controlled drugs.

Reporting, learning and improvement from incidents

The practice had a good track record on safety. However, there was limited documentation relating to the investigation of incidents and the communication of lessons learned**.**

- 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 practice told us there had been four significant events reported in the last 12 months. Those we saw had been investigated and action taken to prevent recurrence. For example, the practice responded to a medical emergency outside of the practice but within the same building. It was realised during this incident that emergency equipment was not readily transportable and an emergency bag was purchased to aid portability in future incidents. Learning from this incident was discussed at a staff meeting attended by a small group of staff and placed in the practice incident folder available to all staff. However, the learning was not shared directly with all clinical staff.

More generally, there was limited documentation relating to the investigation of the majority of incidents in the last 12 months and the communication of lessons learned was not in all cases recorded in minutes of practice meetings. However, the completion of documentation had improved in the recording of the two most recent incidents and the practice manager was committed to sustained improvement in this respect.

The provider was aware of and complied with the requirements of the Duty of Candour. There were systems in place for knowing about notifiable safety incidents. However, not all staff we spoke with were familiar with the notification requirements.

When there were unexpected or unintended safety incidents:

- The service gave affected people reasonable support, truthful information and a verbal and written apology.
- However, we did not see written records of verbal interactions.

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment, care and treatment

The provider assessed needs and delivered care in line with relevant and current evidence based guidance and standards such as the National Institute for Health and Care Excellence (NICE) best practice guidelines.

Monitoring care and treatment

The practice collected and monitored information on care and treatment. Quality improvement and monitoring was exercised through ongoing quality assurance of visa medical reports by the two directors. Due to the nature of the service there was limited scope to undertake extensive clinical audit.

All medical reports were reviewed by the two clinical directors for quality and accuracy before being sent to the relevant embassy for visa interviews. Any issues were fed back to the doctor who had completed the medical.

Effective staffing

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

- There was a formal induction process for newly appointed administrative staff and we saw the completed checklist for the most recently appointed member of the administration team. This covered such topics as work processes and procedures, fire safety, health and safety and confidentiality. There was a formal induction process for doctors with practising privileges, including initial orientation to the practice, comprising one day shadowing a clinical colleague. Whilst there was no equivalent induction checklist, new clinical staff were provided with a link to a website, where they could access guidance for immigration medicals. This gave information on how to conduct a medical but no practice specific information.
- There was role-specific training and updating for relevant staff. For example, nursing staff had annual update training in the administration of vaccinations and immunisations. On the day of the inspection the practice was unable to provide evidence of equipment training records for radiographer staff for operating imaging equipment. This was subsequently provided some two weeks after the inspection.
- The learning needs of staff were identified on an individual basis. This was done previously through a system of appraisals for administrative, nursing and radiographer staff but none of these staff (apart from one radiographer) had received an appraisal in the past two years. However, the practice manager was in the process of updating the appraisal system and booking appraisal meetings for these staff.
- All the doctors with practising privileges had a prescribed link to a designated body with a 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). We were told the doctors were following the required appraisal and revalidation processes but the practice was unable to provide confirmation of the date of the last appraisal for the majority of the doctors.
- Staff directly employed by the practice received mandatory training that included: health and safety, infection control, safeguarding, basic life support, fire safety awareness, information governance and equality and diversity. Staff had received up to date training in these areas or were booked to receive such training. The practice was unable to provide details to confirm training in most of these areas for the majority of doctors working with practising privileges.

Coordinating patient care and information sharing

There was a limited need to work with other services.

- The provider told us that individual doctors shared information with patients' NHS GP if required and if patients consented to this. For example, for abnormal pathology or X-ray results.

Supporting patients to live healthier lives

It was not generally part of the visa medical process for doctors to help patients to live healthier lives. However, health promotion literature was available to patients at the practice and doctors and nurses provide health advice if required.

Consent to care and treatment

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

Are services effective?

(for example, treatment is effective)

- The practice had a consent policy in place and clinical staff we spoke with understood the relevant consent and decision-making requirements of legislation and guidance, including the Mental Capacity Act 2005.

Are services caring?

Our findings

Kindness, respect and compassion

- Staff we spoke with were aware of their responsibility to respect people's diversity and human rights.
- We received 47 completed Care Quality Commission comment cards which were all very positive about the staff at the practice. We spoke with one patient directly at the inspection who was also very positive about the staff.
- We reviewed patient feedback questionnaires and emails submitted to the practice over the three months before our inspection. Of the 17 submitted, 15 were very positive about the service provided, one was mixed and one patient was very unhappy about the service received. The latter related to the waiting time experienced when attending for a medical.

Involvement in decisions about care and treatment

- 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.
- Information was available to patients at the practice and on the practice's website about fees for medicals and associated treatments.

Privacy and Dignity

The practice respected and promoted patients' privacy and dignity

- The consultation and nurse treatment and X-ray rooms were set up to maintain patients' privacy and dignity during examinations, investigations and treatments.
- There was also a chaperone policy in place and on display. People were given gowns to wear when they had an X-ray and their dignity was respected.
- A private room was available if patients wanted to discuss sensitive issues or appeared distressed.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

The practice met patients' needs through the way it organised and delivered services. It took account of patient needs and preferences.

- Access to the practice was suitable for disabled patients. For example, a portable ramp was available for patients with mobility issues to access the main entrance, and gain entry to the practice. There were accessible toilet facilities, although there was no emergency pull cord in the toilet.
- Staff told us that they had access to translation services for those patients whose first language was not English, although the services were rarely needed as most patients spoke good English.
- There was no hearing loop available at reception to aid those patients who were hard of hearing.
- Information about the practice, including services offered, was on the practice's website and in the waiting room.

Timely access to the service

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

- The practice was open 8.30am to 5pm Monday to Friday and 9am to 1pm on occasional Saturdays. Patients were asked to call to book an appointment by telephone between 9am and 5pm. They were invited to state their preferred appointment times (at least five working days before their visa interview date for applicants for the USA) and were usually able to get an appointment of their choice within two working days. Visa medicals usually lasted an hour and a half with the first appointment starting at 8.50am and the last at 3.30pm.

Listening and learning from concerns and complaints

- There was a policy and procedures in place for handling complaints and concerns.
- The practice manager was the designated responsible person who handled all complaints in the practice. There was information on how to complain in the waiting room and in the patient leaflet but not on the practice website.
- The practice had received eight formal complaints in the last 12 months. There was limited documentation relating to these complaints but the practice manager was putting in place measures to address this. This was evident for the most recent complaint which had been dealt with appropriately. There was no evidence of the communication within the practice of lessons learned from complaints.

Are services well-led?

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

Our findings

Leadership capacity and capability

Leaders had the skills, knowledge and experience needed to manage the services provided by the practice. However, the capacity for leadership was not well articulated in the delivery of those services in understanding the challenges to quality or assessing the associated risks and identifying the actions needed to address them.

Staff told us leaders were visible and approachable. Clinical leadership and oversight was not formally stated in a strategy or development programme but was exercised mainly by the directors in quality assuring visa medical reports and regular written correspondence and updates with doctors. Following the inspection we were informed that the provider was in the process of amending the structure of their management programme with a view to the development of a new leadership strategy. The re-instatement of a staff appraisal system was part of this process.

Vision and strategy

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

- The practice's statement of purpose set out its vision and values. Given the nature of the service involving the delivery of a specific area of work, the provider saw no need for a formally stated strategy or business plan over and above that set out within statement of purpose for the practice.
- Staff we spoke with were not aware of the vision and values but understood the practice's aim to ensure patients had a good experience in attending for visa medicals.
- There was a mission statement set out in the practice's patient guide but the statement was not on display in the practice or on its website.

Culture

Staff told us that there was an open culture within the practice and they felt they could raise any issues or concerns with Management.

- Staff told us they felt respected, supported and valued. The practice focused on the needs of patients.
- Openness, honesty and transparency were the norm including with patients when responding to incidents and complaints.
- There were processes for providing staff with the development they needed. However, the appraisal process had not been in operation in the last one to two years, although the practice manager was already addressing this at the time of the inspection.

Governance arrangements

The provider had an overarching governance framework in place to support the delivery of good care.

- There was a clear staffing structure and staff were aware of their own roles and accountabilities. The director, practice manager and nursing staff had lead roles in key areas. For example, the director was the lead for quality assuring reports of visa medicals, the practice manager was the lead for handling complaints, and the senior nurse was the lead for safeguarding and infection control.
- Practice specific policies were implemented and available to all staff in hard copy or on the shared drive of the computer system.
- Bi-monthly staff meetings had recently been initiated by the practice manager but doctors and radiologists did not routinely attend these. There were no formal clinical governance meetings held involving all clinical staff. However, clinical oversight was exercised by the directors with daily review of visa assessments and regular written correspondence and updates with doctors.

Managing risks, issues and performance

The processes for managing risks, issues and performance were not operated effectively in all areas.

- There were limited arrangements for identifying, recording and managing risks, issues and implementing mitigating actions. Fire safety risk assessments were completed but there were none in place for wider Health & Safety or Legionella. We also identified shortfalls in safeguarding, infection control, equipment safety, medicines management and medical emergency provisions.
- Quality improvement and monitoring was exercised through ongoing quality assurance of visa medical

Are services well-led?

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

reports by the two directors. Due to the nature of the service there was limited scope to undertake extensive clinical audit. There were no infection control audits in place to monitor infection control standards.

Appropriate and accurate information

The management and processing of information within the practice was not operated effectively in all areas.

- There were potential risks in data security standards in relation to the availability, integrity and confidentiality of patient identifiable data, records and data management systems. CDs of X-ray images dating back over eight years were not stored securely.
- The practice did not maintain accurate up to date information about all staff it employed. There were many gaps in information about the training completed, in particular by radiographers, and doctors employed with practising privileges.

Engagement with patients, the public, staff and external partners

The practice had arrangements in place to engage and involve patients and staff in supporting quality sustainable services.

- The practice had a system in place to gather feedback from patients in the form of a feedback questionnaire available in the practice. Feedback was collected from patients on an on-going basis. We reviewed patient feedback questionnaires and emails submitted to the practice over the three months before our inspection. Of the 17 submitted, 15 were very positive about the service provided, one was mixed and one patient was very unhappy about the service received. The latter related to the waiting time experienced when attending for a medical.
- The provider engaged with staff through appraisal and staff meetings. However, appraisals for administrative, nursing staff and two of the three radiographers had not taken place in the past two years. We were told all the doctors with practising privileges were following the required appraisal and revalidation processes but the practice was unable to provide confirmation of the date of the last appraisal for the majority of the doctors.

Continuous improvement and innovation

There were arrangements in place for continuous learning and improvement, including ongoing monitoring of patient feedback and quality assurance of all medical reports by the clinical directors.

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 12 HSCA (RA) Regulations 2014 Safe care and treatment **How the regulation was not being met:** The provider did not have established and effectively operated systems to ensure care and treatment to patients was provided in a safe way in relation to: • Health & Safety and Legionella risk assessment • business continuity planning • infection control • equipment safety • medicines management • medical emergency provisions • compliance with Ionising Radiation (Medical Exposure) Regulations 2000 (amended 2006) [IR(ME)R] and Ionising Radiations Regulations [IRR] 1999 • patient safety alerts • confirming the suitability of staff in terms of their qualifications, competence, skills and experience to provide safe care and treatment This was in breach of regulation 12(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Regulated activity	Regulation
Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance **How the regulation was not being met:**

This section is primarily information for the provider

Requirement notices

The provider was not able to demonstrate good governance.

- There were limited arrangements for identifying, recording and managing risks, issues and implementing mitigating actions.
- There was no effective system for communicating or sharing learning from patient safety alerts, significant events, or complaints.
- The systems and processes in place were operating ineffectively in that they failed to enable the provider to maintain secure records of service users in respect of care and treatment provided, or of persons employed in carrying on regulated activities, in particular in relation to training undertaken.
- The processes for seeking and acting on feedback from staff in order to evaluate and improve services were not effective, in particular relating to staff appraisal.

This was in breach of regulation 17(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.