Docklands Healthcare

Quality Report

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This report describes our judgement of the quality of care at this location. It is based on a combination of what we found when we inspected and a review of all information available to CQC including information given to us from patients, the public and other organisations

Ratings

Overall rating for this location	Good
Are services safe?	Good
Are services effective?	Not sufficient evidence to rate
Are services caring?	Good
Are services responsive?	Good
Are services well-led?	Good

Mental Health Act responsibilities and Mental Capacity Act and Deprivation of Liberty Safeguards

We include our assessment of the provider's compliance with the Mental Capacity Act and, where relevant, Mental Health Act in our overall inspection of the service.

We do not give a rating for Mental Capacity Act or Mental Health Act, however we do use our findings to determine the overall rating for the service.

Further information about findings in relation to the Mental Capacity Act and Mental Health Act can be found later in this report.

Summary of findings

Overall summary

Docklands Healthcare is operated by HCA International Limited UK. Docklands Healthcare is one of five satellite sites that sits under the umbrella of the London Bridge Hospital campus. The centre provides fast access to magnetic resonance imaging (MRI), x-ray, ultrasound diagnostics and outpatient clinics in the following specialties: orthopaedics, neurology, gastroenterology and gynaecology.

The service has three consultation rooms, three changing cubicles, x-ray room, ultrasound room and MRI.

The service provides care and treatment to patients who self-pay or whose insurance company pays for their care.

We inspected this service using our comprehensive inspection methodology. We carried out an unannounced inspection on 7 March 2019.

To get to the heart of patients' experiences of care and treatment, we ask the same five questions of all services: are they safe, effective, caring, responsive to people's needs, and well-led? Where we have a legal duty to do so we rate services' performance against each key question as outstanding, good, requires improvement or inadequate.

Throughout the inspection, we took account of what people told us and how the provider understood and complied with the Mental Capacity Act 2005.

Services we rate

We have not previously rated this service. We rated it as **Good** overall.

We found good practice:

- The centre was clean and tidy and staff displayed a good understanding of infection prevention and control.
- The service disseminated learning from incidents through debriefing, incident newsletters, local risk registers, team meetings and emails.
- There were effective systems at the centre to ensure patient safety. All staff were aware of their roles and responsibilities in ensuring patients and their relatives were safe.
- Staff were positive about their working experience and felt supported to be part of a team.
- Patients comments and feedback about the service was positive.
- Staff demonstrated kindness and an understanding of how to meet patients' needs.
- The service continually acted on audits to continually identify opportunities for benchmarking and improvement.
- Medicines were managed appropriately by the service.
- The service did not have a waiting list and had no delayed or cancelled appointments for non-clinical reasons in the previous 12 months.
- Staff felt valued and described effective teamwork. Staff were confident to escalate concerns if needed.
- Docklands Healthcare was part of London Bridge Hospital campus governance structure. Each campus had their own local governance team who conducted regular visits whilst the governance facilitator was the site link.

However, we also found the following issues that the service provider needs to improve:

- Although the service completed a simulated emergency exercise in x-ray, the service did not practice the emergency evacuation procedure for patients and staff in MRI.

Nigel Acheson

Summary of findings

Deputy Chief Inspector of Hospitals (South and London)

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Diagnostic imaging	Good 	We rated diagnostic imaging as good. We rated this service as good because it was safe, effective, caring, responsive and well-led.

Summary of findings

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Good

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Summary of this inspection

Background to Docklands Healthcare

Docklands Healthcare is operated by HCA Healthcare UK. The service opened in October 2010. It offers private diagnostic tests and treatment and outpatient consultations for patients.

The centre was established to service the Canary Wharf living and working community with diagnostic and consultation facilities. The centre forms part of the wider London Bridge Hospital campus and as such falls under the same governance umbrella and is led by the same chief executive officer. Historically, the centre was just for diagnostic appointments. However, the location had created space for consulting rooms so that the service could work more closely with the private GP practice based within the same building. This means that patients were offered fast and convenient access to a wide range of services ensuring timely diagnosis and management. The centre offers rapid appointments for its diagnostic services; including MRI, x-ray and ultrasound.

The hospital has had a registered manager in post since June 2017.

Our inspection team

The team that inspected the service comprised a CQC lead inspector, CQC assistant inspector, and a specialist advisor with expertise in diagnostic imaging. The inspection team was overseen by Terri Salt, Interim Head of Hospital Inspection.

Information about Docklands Healthcare

Docklands Healthcare is one of five satellite sites that sits under the umbrella of the London Bridge Hospital campus. The service is a stand-alone purpose-built health care facility, with clinical consulting rooms and diagnostic and/ or screening facilities. Docklands Healthcare is located within walking distance of Canary Wharf DLR station. The location is convenient for London's city workers and residents. The location is also within easy reach of the main hospital campus should any patients need further onward care, such as day case or inpatient treatment. The centre provides fast access to magnetic resonance imaging (MRI), x-ray and ultrasound diagnostics and outpatient clinics in the following specialties: orthopaedics, neurology, gastroenterology and gynaecology.

The centre is situated in an office building with use of the ground floor. The centre's main entrance leads into the reception area. This area is also shared with a private GP practice which enables patients to have a streamlined service from primary to secondary care. Through a set of double doors is a corridor, there are three consulting rooms, a business office, dirty utility, clean utility, x-ray room, ultrasound room, treatment room and communication room. Through another set of double doors there is the MRI waiting area which has a toilet, phlebotomy room, business office and three changing rooms. Opposite the changing rooms is the MRI scanning control room and scanner itself. There was also a staff kitchen, toilet and the cleaners cupboard in this part of the building.

The service is registered to provide the following regulated activities:

The service is registered to provide the following regulated activities:

- Treatment of disease, disorder or injury
- Diagnostic and screening procedures

Summary of this inspection

During the inspection, we visited all areas in which care is provided. We spoke with 12 staff including registered nurses, reception staff, medical staff, radiographers and senior managers. We spoke with four patients. During our inspection, we reviewed nine sets of patient records.

There were no special reviews or investigations of the hospital ongoing by the CQC at any time during the 12 months before this inspection. The service was last inspected in March 2014 and found the service was meeting all five standards of quality and safety it was inspected against.

Activity (September 2017 to September 2018)

- Imaging scans: 3,041
- Outpatient appointments: 257

Staffing on the site included a superintendent radiographer, two radiographers, nurse, lead nurse and business office assistant and supervisor.

Track record on safety

- No Never events
- 11 clinical incidents of which, nine were no harm and two were low harm
- No serious injuries
- No incidences of hospital acquired Meticillin-resistant Staphylococcus aureus (MRSA),
- No incidences of hospital acquired Meticillin-sensitive staphylococcus aureus (MSSA)
- No incidences of hospital acquired Clostridium difficile (c.diff)
- No complaints

Services accredited by a national body:

- Our investors in People (Gold) – the London Bridge Campus was awarded a Gold originally in September 2014 and then again in October 2018.

Services provided at the hospital under service level agreement:

- Cleaning services
- Housekeeping and catering
- Clinical waste

Summary of this inspection

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?

Good

We rated it as **Good** because:

- Cleanliness and infection control policies and controls were in place, including for the environment.
- The service reported no never events or serious incidents in the reporting period.
- Staff we spoke with understood their responsibilities for reporting incidents and learning was shared across sites.
- Patient records were completed consistently and to a high standard.
- Safeguarding processes and training were in place and staff demonstrated good knowledge of these.
- All staff had up to date mandatory training.
- Medicines were managed appropriately by the service.
- The service had suitable premises and equipment and looked after them well.

However:

- The service did not carry out local practising of the emergency evacuation procedure for patients and staff in MRI.

Are services effective?

Not sufficient evidence to rate

We do not rate effective of these service types.

- The service demonstrated effective internal and external multidisciplinary (MDT) working.
- We saw procedures had been developed in line with national guidance and staff were aware of how to access them on the shared drive and intranet.
- All staff had completed their appraisals and performance development plans.
- Staff understood how and when to assess whether a patient had the capacity to make decisions about their care.
- Staff understood their roles and responsibilities under the Mental Health Act 1983 and the Mental Capacity Act 2005.

Are services caring?

Good

We rated it as **Good** because:

- All results from the ongoing patient feedback questionnaire indicated staff consistently involved patients in their care and treatment.

Summary of this inspection

- All staff including consultants demonstrated empathy and compassion with patients in the context of the sensitive nature of many of the procedures carried out and provided emotional support.
- Policies and training standards were in line with the National Institute for Health and Care Excellence (NICE) quality statement 15 in relation to dignity and kindness.
- Patients told us they felt listened to by health professionals, and felt informed and involved in their treatment and plans of care.

Are services responsive?

Good

We rated it as **Good** because:

- The service planned and provided services in a way that met the needs of local people.
- The service took account of patients' individual needs.
- Patients could access the service when they needed it and had the option to access services at the other satellite sites.
- The service treated concerns and complaints seriously, investigated them and learned lessons from the results, and shared these with all staff.
- Staff had access to language interpreter services via telephone.

Are services well-led?

Good

We rated it as **Good** because:

- The service had a clear vision and strategy and staff demonstrated awareness of the service's values.
- We found highly dedicated staff who were positive, knowledgeable and passionate about their work.
- Staff described the culture as open.
- There was a clear governance structure, which all members of staff knew.
- Staff were comfortable to raise concerns and were confident that they would be dealt with appropriately.
- The service demonstrated and confirmed that patient experience was the key factor for their service development.
- Staff described the senior leadership team as visible and engaged.

Detailed findings from this inspection

Overview of ratings

Our ratings for this location are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Diagnostic imaging	Good	Not rated	Good	Good	Good	Good
Overall	Good	Not rated	Good	Good	Good	Good

Good

Diagnostic imaging

Safe	Good
Effective	Not sufficient evidence to rate
Caring	Good
Responsive	Good
Well-led	Good

Are outpatients and diagnostic imaging services safe?

Good

We rated it as **good.**

Mandatory training

- **The service provided mandatory training in key skills to all staff and made sure everyone completed it.**
- Staff completed a programme of 11 mandatory training modules which included ethics and code of conduct, fire safety, health and safety, safeguarding children level two, infection control, safeguarding adults, HCA equality and diversity, mental capacity act, moving and handling, General Data Protection Regulation (GDPR) and basic life support. At the time of our inspection all staff were up to date with mandatory training with 100% compliance.
- The provider had an external learning academy where staff had the option to complete compliance modules as a day course or through an electronic learning program (e-learning) sessions. Staff told us they were encouraged to book the day courses.
- The learning academy produced a compliance report for managers which informed them of any mandatory training due for renewal. This enabled the management team to assign relevant time for staff to complete their training. Staff told us that additional training for example, human factors, root cause analysis (RCA) and managing conflicts could be done via the learning academy.
- Mandatory training was also incorporated into the appraisal system. Staff had to complete all their mandatory training to receive their pay reward.

Safeguarding

- **Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it.**
- The service had an up-to-date safeguarding policy which reflected national best practice and included human trafficking, Prevent and radicalisation. Prevent works to stop individuals from getting involved or supporting terrorism or extremist activity. The service had a separate female genital mutilation (FGM) policy.
- Staff demonstrated awareness of the safeguarding lead and told us they were accessible.
- Data provided by the service showed the overall staff compliance rates for safeguarding training for both and adults and children, levels one and two was 100%.
- The service provided victims of domestic violence with a bar code sticker which discreetly included a telephone number which victims could use to access support and advice.
- Staff also had a safeguarding handbook for quick reference which covered mental capacity, safeguarding flowchart, learning disability advice, domestic violence, Prevent, FGM and modern slavery. During the inspection, we saw the safeguarding flowcharts displayed in the staff room.
- We were informed there had been no safeguarding referrals in the reporting period.

Cleanliness, infection control and hygiene

Good

Diagnostic imaging

- **The service controlled infection risk well. Staff kept themselves, equipment and the premises clean. They used control measures to prevent the spread of infection.**
- All the areas we visited were visibly clean and tidy. Antibacterial hand gel was available at the entrance and reception staff encouraged people entering the building to use it. Alcohol gel dispensers were also located in the waiting room and in each clinical room.
- Each consultation room had a sink area with elbow operated sinks and displayed posters on 'Your 5 moments for hand hygiene'. During our inspection, we observed an ultrasound appointment and found consistent use of alcohol gel, hand hygiene practices and use of personal protective equipment (PPE).
- We observed all staff groups, including consultants, were bare below the elbow and actively washed and sanitised their hands before and after contact with patients in line with the National Institute of Clinical Excellence (NICE) Quality Statement 61 (Statement 3).
- Staff had adequate supplies of couch covers, disposable pillow cases and disposable paper for exam couches. Soiled linen was kept separated in the dirty utility for collection. The service changed the curtains every six months and during the inspection, we observed that all the curtains were in date.
- Procedures were in place for the safe management of hazardous waste, including storage and disposal. Each consultation room had bins for soiled waste, domestic waste and clinical infections waste. We checked the records for clinical waste disposal and sharps and found the records were up to date.
- The service had a dedicated infection control link nurse who ensured the infection control policies and staff training were up to date. The link nurse attended monthly infection prevention and control (IPC) meetings, shared learning across sites and completed monthly IPC audits including hand hygiene.
- Staff demonstrated good IPC awareness and told us the link nurse was accessible. Staff showed us the IPC policies on the intranet and told us audit results were discussed at team meetings. During the inspection, we saw IPC audit results displayed on the staff notice board.
- The service reported no incidences of healthcare acquired infections in the last 12 months. The waiting rooms displayed leaflets on Meticillin-resistant Staphylococcus aureus (MRSA).
- The IPC link nurse completed quarterly infection prevention and control audits. Data provided by the service for July to September 2018 showed the service achieved 100% in hand hygiene, general environment, medical devices/equipment, disposal of sharps and kitchen pantry. After the inspection, the service provided additional data for October to December 2018 which showed the service achieved 100% in hand hygiene, general environment, medical devices/equipment, disposal of sharps and 93% in kitchen pantry in December.
- The service had a three-step cleaning process for transvaginal ultrasound probes. During the inspection, we found the cleaning audit book was completed and up to date.
- An external auditor completed the annual sharps audit in July 2018. Results showed that although the service had good overall compliance in sharps awareness and practice, there was poor compliance with correct assembly of sharps bins. Out of a total of five bins, two were incorrectly assembled. The action plan included training for staff as well as compliance to be monitored which had been completed in September 2018. During our inspection, we checked three sharps bins and found they had been correctly assembled and were not overfilled.
- The service had a service level agreement with an external contractor to provide cleaning services. We found the cleaning schedules for equipment and the consultation rooms were up to date and fully completed. For example, the weekly erasing and cleaning for the computed radiography (CR) cassettes were up to date for January and February 2019.

Environment and equipment

- **The service had suitable premises and equipment and looked after them well.**
- The layout of the centre was compatible with health and building notification (HBN06) guidance. The reception area was bright and open with displayed notices on chaperone, hearing induction loop, data protection information and a television at a volume that was not intrusive to the waiting area. Patients had access to tea, coffee and fresh water facilities in the reception waiting area and in the additional waiting area along the

corridor. The service had sufficient fire extinguishers along the corridors. Access to all areas was restricted with secure digital key pad which prevented unauthorised access to the diagnostic imaging rooms.

- The service had three consultation rooms, three changing cubicles, x-ray room, ultrasound room and MRI. The service had sufficient supplies of dressing gowns and non-slip socks available. Patients had access to lockable cupboards for their personal belongings. The service displayed leaflets for patients on treatments and procedures and a health and safety work poster with contact details for the designated individual. The unisex toilet was suitable for disabled patients and had baby change facilities. The MRI waiting area displayed a poster on the music options during a MRI.
- Equipment was available in sufficient quantities throughout the centre and all equipment was safety tested and calibrated. For example, we checked the Hypobox and found all the items were within expiry. HypoBox is a one-stop care kit that provides a range of glucose products for use in cases of low blood sugar.
- Although the service directed bariatric patients to London Bridge Hospital for their diagnostic imaging, staff told us they had larger cuffs for blood pressure machines in event of obese patients attending the service to see a nurse.
- The service had light-up radiation signs to alert people when an x-ray was in progress. This was in line with Ionising Radiation Regulations (IRR) 2017. Signs in the diagnostic imaging department identified when x-rays were being taken, with a warning not to enter the room. There was controlled entry to the MRI suite, and signs and barriers to the scanner.
- We saw pregnancy warning signs throughout the centre to warn people that there was a risk of radiation and to advise patients to notify the radiographer if there was a chance they could be pregnant. The service used the corporate risk assessment forms for new and expectant employees.
- All clinical staff we observed had a valid in-date radiation monitoring badge. This ensured radiation dose monitoring for individual staff working in a controlled radiation environment.
- All equipment used within the MRI suite were MRI safe and were labelled as such. Records showed that staff were trained in MRI safety, and they understood their responsibility relating to the use of all equipment in an MRI environment. Daily quality assurance tests on the MRI machines were completed and documented by the radiographers. The tests assured staff that the MRI equipment was in good working order, safe to use and ensured that MRI images were of good quality.
- We reviewed the August 2018 annual audit results for radiation safety warning lights. The aim of audit was to ensure that the lights outside the x-ray room work when the x-ray machine is switched on, displaying the controlled room sign. The light displaying the 'do not enter' light should also work when making an exposure and the door should have the correct signage on it to warn of the potential danger. The service completed daily checks on the two different illuminated signs and collated the result on a daily log. The audit results showed the service achieved 100% compliance for both illuminated signs with signage in good working order.
- Staff doses were kept "as low as reasonably practicable" (ALARP) by use of in-room protective screens with adequate PPE provided. The service completed annual reviews of dose badges with the last one in October 2018. The x-ray room was locked when un-attended. During the inspection we saw an up to date set of local rules were in use. For example, in MRI the local rules had been recently reviewed in February 2019 and signed by relevant staff members.
- The service completed annual radiation safety PPE audit to ensure that the lead aprons in the x-ray room were in good working order. The service provided the audit results for August 2018 which found all the lead aprons were compliant except for one lead skirt which had last been screened in June 2017. The audit included a learning point for the site to remain vigilant that records were updated when lead aprons were sent off for screening. During the inspection, the service provided a log of x-ray screening which documented that the lead skirt had been decommissioned in June 2018 ensuring the service remained safe.
- Servicing and maintenance of premises and equipment was carried out using a planned preventative maintenance programme. Staff told us there were usually no problems or delays in getting repairs completed. During our inspection we checked the service dates for all equipment and found all the equipment was within service date. They all had portable appliance testing done on them and were all within the year of their test. For example, the auroscope had been tested in February 2019.

Good

Diagnostic imaging

- We checked the resuscitation equipment in the centre. Single-use items such as syringes and dressings were sealed and in date, and emergency equipment had been serviced. Resuscitation equipment check records indicated that resuscitation equipment had been checked daily by staff and was safe and ready for use in an emergency. The service completed monthly resuscitation crash trolley audits. Data provided by the service for January 2018 to June 2018 showed the service achieved 100% compliance each month. The first aid station had saline eye wash which we found in date.
- The service had a staff room with kitchenette facilities. Information displayed on the staff notice board included recent incidents across the campus, clinical audit results, "hot board hot topic", flowchart for safeguarding adults and children and upcoming training dates.

Assessing and responding to patient risk

- **Staff completed and updated risk assessments for each patient. They kept clear records and asked for support when necessary.**
- The centre had appropriate environmental measures and signage in place to identify areas where radiological exposure was present, in line with Ionising Radiation Medical Equipment Regulations (IR(ME)R). This ensured that staff and visitors did not accidentally enter a controlled zone.
- The service completed appropriate risk assessments prior to commencing MRI scans and x-rays. Staff completed patient safety questionnaires to ascertain if the patient had any metal objects in their body, so the clinician could assess whether it was safe for them to have the scan. Staff also asked patients verbally whether they had any metal objects in their body. The service also had a pregnancy risk assessment form.
- The service completed the six-point IR(ME)R check list prior to all imaging procedures. The service used 'Pause and Check' checklists for MRI and x-ray. 'Pause and Check' is a clinical imaging examination IR(ME)R Operator checklist that ensures the appropriate checks are carried out before an exposure is undertaken. 'Pause' stands for patient, anatomy, user checks, systems/settings, exposure and draw to a close. During the inspection, we saw the checklist displayed in the x-ray room and on the MRI notice board.
- The service completed six monthly x-ray referral form audits and incorporated pause and check. The audit aimed to improve the quality and legibility of x-ray request forms, ensure patient identification checks were completed and ensure adherence to IRMER guidelines. The August 2018 report showed the service scored 100% for the following areas: request form being issued by entitled referrer, sufficient clinical information, signature of entitled practitioner/operator, information to perform patient ID check, evidence of patient ID check, writing legible for radiographer and referrer and form was within date. The service scored 93% for dose data correctly recorded with date and with justification and authorisation, and scored 97% in previous imaging checked.
- After the inspection, the service provided additional data for October to December 2018 which showed the service had improved the score for dose data correctly recorded (achieving 100%) and image justified and authorised (achieving 97%). However, the score for previous image checked remained unchanged at 97%.
- Medical staff could access picture archiving and communication system (PACS) data from all HCA sites which ensured patients were not unnecessarily exposed to radiation.
- The service did not undertake any procedures under general anaesthesia/sedation and all procedures were done by qualified medical professionals.
- The service had appropriate emergency procedures to minimise any risk to patients, including benefitting from emergency response and/or emergency advice from the medical team in the adjacent general practice, as well as from the centre's medical team. Staff completed basic life support training (BLS) and intermediate life support (ILS) training once a year. The service displayed the cardiac arrest procedure in each consultation room. The service reported zero unplanned transfers of patients in the last 12 months.
- The service did not have a radiation protection supervisor (RPS) on site to provide radiation protection supervision oversight for x-ray as the individual was on long term sick. However, the service had access to the RPS at the London Bridge Hospital campus. Senior leads told us the service had relatively low numbers of x-rays carried out on site.

Good

Diagnostic imaging

- Each consultation room and changing cubicle had an emergency call bell. The service checked all the call bells throughout the service daily. During the inspection we saw the emergency call bell test log and observed the call bell checks taking place before clinics started.
- The service completed annual physics checks (Level B) on emergency stops in conjunction with more frequent and routine Level A checks. Although the service completed a simulated emergency exercise in x-ray in September 2018, the service did not practice the emergency evacuation procedure for staff and patients in MRI.
- The service completed annual x-ray dose reference level audits to ensure that medical doses received by the public were within acceptable limits. We reviewed the audit results for September 2018 which showed action points with a deadline and identified learning points.
- The service completed quarterly audits of the WHO checklist for the ultrasound guided injections. We reviewed quarter three audit results for 2018 which showed that out of a sample of 45 records, 38 (84%) had a checklist attached and 36 out of 38 (94%) were fully completed (against a target of 100% for both respectively). The action plan included required actions to be implemented with a designated name person and timeframe. The action plan indicated that a new WHO checklist had been developed and was in the process of being rolled out to all satellite sites with appropriate staff training.
- We reviewed the Control of Electromagnetic Fields at Work Regulations 2016 (CEMFAW) risk assessment and found that it did not clearly explain or mitigate risks to staff, patients and visitors. During the inspection, we discussed this with the Magnetic Safety Officer who assured us that documents would be updated, and staff would be informed accordingly. After the inspection, the service provided evidence that the departmental risk assessment for MRI had been updated.

Nurse staffing

- **The service had enough nursing staff, with the right mix of qualification and skills, to keep patients safe and provide the right care and treatment.**
- The staffing structure had recently changed. Staffing on the site included a superintendent radiographer, two radiographers, nurse, lead nurse, business office assistant and supervisor. Nursing staff were present on days when outpatient clinics were running.
- The superintendent radiographer and sister managed the daily running of the services. The business manager linked in with the estates team, resolved any issues with staffing and consultants but did not line manage any staff directly.
- Senior leads told us it was standard practice for staff to work across sites. This ensured staffing levels were maintained during holiday periods. The service occasionally used bank nurses and radiographers.

Medical staffing

- The site employed one superintendent radiographer and two radiographers of which one was rotational.
- Although there were no employed doctors on site, staff told us the service had arrangements with the adjacent private GP practice should a doctor be required.
- The centre operated consultant led care where each patient was under a consultant's care. All consultants who applied for practising privileges at the centre went through a robust application process where their medical expertise was checked and validated via the Medical Advisory Committee. The senior leads told us that although the service had expanded in 2016 to include consultation rooms for outpatient clinics, the service uptake required development.

Records

- **Staff kept detailed records of patients' care and treatment. Records were clear, up-to-date and easily available to all staff providing care.**
- Diagnostic imaging results were kept in the electronic picture archiving and communication system (PACS) system and available to the patient. The service did not store any paper records and staff told us the registration form was scanned onto the system and then disposed of. All patients who used the services were privately funded patients and all their data, medical records, and scan results were documented via the centre's patient electronic record system.
- All patient information was electronically available on the shared system which meant consultants working across the provider's sites, had access to the patient record.
- We reviewed nine records and found they were completed fully with details on examination requested, clinical details, MRI safety questionnaire completed,

referral form completed, allergies recorded, MRI pause checklist completed, registration form completed, and contrast details were recorded. We also found that chaperone details and consent had been included.
- The induction process for new staff included education and awareness on health records management.

Medicines

- Medicines were managed appropriately by the service.
- The service had a corporate medicines management policy which was up to date.
- Although the service did not have pharmacy support on site, the pharmacy team at the London Bridge Hospital provided the site with stock, anaphylaxis kits, emergency drugs and advice for medication related enquiries. The service did not store or administer controlled drugs as part of the services provided.
- The medicines were managed securely, all medicine which were randomly checked on inspection were within their expiry dates.
- We found the room temperature log in the clinical room and ultrasound room had been completed with no omissions for January, February and March 2019.
- The MRI control room had a fridge which stored point-of-care creatinine test sticks for radiology. We checked the fridge temperature log and found it had been completed with no omissions for January, February and March 2019.
- Emergency medicines were available in the event of an anaphylactic reaction. The MRI anaphylaxis box was checked and all items were within their manufacturer's expiry dates.
- Radiographers were authorised to work under patient group directions (PGDs) to administer contrast media, and other medicines required during diagnostic imaging processes. PGDs allow some registered health professionals (such as nurses) to give specified medicines to a predefined group of patients without them having to see a doctor. During the inspection, we checked the PGDs and found there were in date and the relevant staff members had read and understood the PGD and signed appropriately.
- The service had private patient prescription pads which were locked in drug cupboard. Although the service rarely used them, we checked the record sheet and found it was up to date with the last prescription number on the pad matching the record sheet.

Incidents

- **The service managed patient safety incidents well. Staff recognised incidents and reported them appropriately. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support.**
- Never Events are serious patient safety incidents that should not happen if healthcare providers follow national guidance on how to prevent them. Each never event type has the potential to cause serious patient harm or death but neither need have happened for an incident to be a never event. Although the service reported no never events or serious incidents between September 2017 and September 2018, the service provided three root cause analyses for previous serious incidents that took place within another service in the London Bridge Campus. We found the investigations were thorough with appropriate individuals involved and evidence of key learning points. Senior leads told us that staff received a one page learning summary after the root cause analysis was completed. We were told that outcomes from serious incidents that occurred at other sites was shared with staff across all locations to promote learning.
- Between September 2017 and September 2018, the service reported no patient deaths and no Ionising Radiation (Medical Exposure) Regulations (IR(ME)R) reportable incidents.
- The service reported 11 incidents which had been categorised as low or no harm between September 2017 and September 2018.
- The service used an electronic incident reporting system and staff we spoke with understood their responsibilities for reporting incidents and were confident in using the system. Incident reporting training was included in the new staff induction programme, which all staff attended when they commenced their employment at the centre.
- The service actively encouraged staff to report incidents and provided additional training if needed. Staff provided examples of learning from an incident. For example, a patient had fainted during a blood test and the call bell was pressed but it was not audible. The

service confirmed that no harm came to the patient but as a result, the service installed a new system with additional sounders and a television screen outside the MRI control room to show where the alarm was.

- Staff had good awareness of duty of candour requirements and told us it was part of mandatory training. Although there had been no duty of candour incidents in the past 12 months, staff explained that they would inform patients if an incident occurred which met the requirements of duty of candour and provide an apology.
- The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain notifiable safety incidents and provide reasonable support to that person.
- All incidents were reported and reviewed at the weekly CLIP (Complaints, Litigation, Incident and Patient Experience) Committee meetings together with the monthly Clinical Governance Committee. The meeting was led by the Medical Governance Lead and attended by the senior team which included the Business Manager and Head of Imaging, who would provide staff feedback.
- We reviewed the minutes for the last three CLIP meetings from mid-February to the first week of March. We found discussions took place on the action log, open and new complaints, closed complaints and learning, litigation, incidents trends and learning, root cause analysis tracker, patient experience and learning grid.
- The service disseminated learning from incidents across sites through incident debriefing, incident newsletters, local risk registers, team meetings and emails. During the inspection, we saw the staff notice board discussed incidents and shared learning across sites as a hot topic of the week.
- Staff received relevant patient safety alerts to ensure compliance with national best practice. Consultants received a newsletter from MAC that covered recent incidents, new appointments, new procedures, new strategies and new audits.

Are outpatients and diagnostic imaging services effective?

Not sufficient evidence to rate

We do not currently rate effective.

Evidence-based care and treatment

- **The service provided care and treatment based on national guidance and evidence of its effectiveness. Managers checked to make sure staff followed guidance.**
- Care and treatment was delivered to patients in line with National Institute for Health and Care Excellence (NICE), Royal Colleges guidelines and Society of Radiographers (SoR). Staff told us they followed national and local guidelines and standards to ensure effective and safe care. For example, the local rules for x-ray referenced the Ionising Radiation (Medical Exposure) Regulations 2017 (IR(ME)R 2017). The local rules were up to date and reflected both equipment usage and the services localised practice. The local rules were on display in each clinical room.
- The service had diagnostic reference levels available for all the examinations performed at the centre and all staff had access to the reference manual. Diagnostic reference levels (DRLs) are a practical tool to promote radiation dose optimisation.
- Staff were kept up-to-date with changes in policy and procedures, ensuring practice was evidence based. Staff told us that changes to practices and policies were highlighted by the Head of Imaging and they received emails and alerts from the Quality and Governance team.
- The service monitored any recommended changes in practice through a comprehensive programme of clinical audit. Staff were encouraged to participate in audit data collection and ensure that audit outcomes were disseminated across their areas.

Nutrition and hydration

- Staff offered patients a hot drink and biscuits post procedure.The waiting room and reception area had facilities for tea, coffee, hot chocolate and fresh drinking water.

Pain relief

Good

Diagnostic imaging

- **Staff assessed and monitored patients regularly to see if they were in pain.**
- Although the service did not use a formalised pain tool, staff told us they would check if the patient was in pain. The service could also access advice from the private doctors at the GP practice.

Patient outcomes

- **Managers monitored the effectiveness of care and treatment and used the findings to improve them. They compared local results with those of other services to learn from them.**
- The centre followed the HCA UK outpatient audit schedule, which included a range of quality audits and checks to ensure the effective delivery of service. Staff compared and audited key elements of the referral and scanning pathway and these were benchmarked with other HCA locations. KPI data indicated that the centre performed better than the HCA rate in regards to complaints, medication incidents, never events, information governance and patient satisfaction.
- An external company completed the Ionising Radiations Regulations 2017 (IRR17) and Ionising Radiation (Medical Exposure) Regulations 2017 (IR(ME)R 2017) audit for the service in October 2018. The service passed with a good standard of quality assurance performed at the site and had some minor recommendations.
- Staff said that all patients were seen promptly, and patients rarely had to wait for an appointment. None of the patients we spoke with during the inspection raised concerns about being able to access the centre in a timely manner.

Competent staff

- **The service made sure staff were competent for their roles. Managers appraised staff's work performance and held supervision meetings with them to provide support and monitor the effectiveness of the service.**
- All new employees received a corporate induction of three days for non-clinical staff and five days for clinical staff, as well as a local induction for one day. The service had a thorough local induction process for bank or agency staff to go through with a permanent staff member to ensure they were aware of local procedures and location of equipment and necessary items.
- New staff had to complete the mandatory training programme after induction and maintain compliance annually through the online learning management system.
- Data provided by the service showed that all employed staff had had an appraisal in the last 12 months. Staff reported to the relevant clinical lead and staff told us they received regular one to ones. For example, the business office manager supported the business support staff.
- The service encouraged staff to develop new skills through internal and external training. Staff told us they had equitable access to training regarding their professional development.
- Staff had the relevant qualifications and competence to keep patients safe. The Head of Imaging ensured the radiographers were compliant with their training and competencies and arranged supervision for them. The lead nurse checked the nurses' competencies were up to date. Nursing staff told us that competencies were reviewed every two years through the school of nursing.
- As part of the recruitment process, any new staff member was assessed for competencies and necessary qualification and documentation evidence was required from all new starters. Data provided by the service showed that relevant staff had had their professional registration checked in the last 12 months.
- All consultants who applied for practising privileges at the centre had their medical expertise checked and validated via the Medical Advisory Committee. Consultants told us the practising privileges process was managed well and they felt part of the organisation.

Multidisciplinary working

- Staff told us they had good working relationships with consultants which ensured staff could share necessary information about the patients and provide holistic care. For example, consultants and radiologist praised nursing staff and described them as supportive and efficient.
- Multidisciplinary team (MDT) meetings for each speciality took place at the London Bridge Hospital campus. Staff told us they were encouraged to attend.
- Staff told us they had good links with diagnostic imaging departments with the other campus sites, who they liaised with to make use of previous images of the same person requiring the test, if required.

Good

Diagnostic imaging

Seven-day services

- The centre had recently changed their opening hours to Monday to Friday 9am to 5pm with a walk-in service available for x-rays during opening hours.
- As the location was part of a cluster group, patients could easily access appointments across all the sites at times best suited to them, such as early mornings or evenings.

Health promotion

- As part of the London Bridge Hospital Campus, the site advertised the following support services for patients: physiotherapy, pilates, dietetic services and running and/or cycling.

Consent and Mental Capacity Act

- Staff were fully aware of their roles and responsibilities in relation to the requirement of consent. Patients were asked to complete a consent form during their pre-scanning checks before commencing their scan. The forms were filed in the patient record.
- Staff we spoke with told us they had not had any patients with a learning disability or mental health issues. Staff told us it was unlikely to have patients at the centre that were subject to DoLS or the MCA 2005 due to their acceptance criteria and available support. Patients would have been triaged to the main hospital site.
- Staff told us that training on the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS) was part of the mandatory training.
- Data provided by the service showed the staff training compliance rate for relevant staff was 100% for Mental Capacity Act 2005 (MCA) and DoLs.

Are outpatients and diagnostic imaging services caring?

Good

We rated it as **good.**

Compassionate care

- **Staff cared for patients with compassion. Feedback from patients confirmed that staff treated them well and with kindness.**
- Staff paid attention to maintaining patients' dignity, privacy and respect. Doors to patients' rooms were closed and privacy curtains were drawn when personal care or clinical examinations were carried out. We observed good interaction by all grades of staff including consultants with patients.
- Staff welcomed patients into the centre and directed them to free refreshments in the waiting area. We observed the reception staff answering patient enquiries and interacting with patients in a friendly manner. The following was representative of the feedback we received: "Staff are friendly and helpful", "I got my appointment without having to wait", "I am happy with the service" and "It has been a quick process from referral".
- The service displayed about the availability of chaperones and staff were readily available to act as chaperones when needed. All patients were offered the choice of having a chaperone during their diagnostic tests.
- Patients received a feedback form to complete and had the option to complete before leaving the centre or freepost back to an independent data analysis. The feedback form was easy to use, and staff told us patients usually completed the feedback forms while they waited for their scanned image(s) to saved onto a compact disc (CD).
- The service collated patient feedback on a monthly basis. The service provided data for the London Bridge campus outpatient departments for January and February 2019. Although the data was grouped together for the London Bridge Hospital campus, comments made by patients were separated by site. We reviewed the comments for Docklands Healthcare and found they were all positive.
- Between January 2018 and August 2018 patients rated the service's overall quality of care at an average of 95%. The percentage of patients who would recommend the service to others was 96%.

Emotional support

- **Staff provided emotional support to patients to minimise their distress.**
- Patients received diagnostic results on the same day as screening and clinical staff provided emotional support and guidance when results were upsetting or unexpected.

Good

Diagnostic imaging

- We observed an ultrasound consultation and saw good communication between the patient and consultant. The patient was provided with an explanation on the procedure and the next options. The consultant answered all the patient's questions and confirmed the results would be received on the same day. Staff members did not rush patients during appointments and engaged with patients providing reassurance when necessary.
- Staff understood the impact that patients' care, treatment and condition had on their wellbeing. Staff we spoke with stressed the importance of treating patients as individuals.
- The reception area had a sign to advise patients to let staff know if they wanted a private conversation. Staff told us consultation rooms were used for distressed or nervous patients. Patients were also invited to see the scanner beforehand to ease any nerves ahead of the appointment.

Understanding and involvement of patients and those close to them

- **Staff involved patients and those close to them in decisions about their care and treatment.**
- Staff communicated with patients so that they understood their care, treatment and condition. Patients reported that they were satisfied with the information they were provided by staff.
- Patients and their relatives were encouraged to participate in their treatment. The service encouraged patients and family members to feel welcomed and as important partners in the delivery of patient care.
- Staff, where possible, made extra effort to support patients. For example, a patient had got lost and called the centre. The staff member took a wheelchair to an agreed meeting point off site and brought them to the centre.

Are outpatients and diagnostic imaging services responsive?

Good

We rated it as **good.**

Service delivery to meet the needs of local people

- **The service planned and provided services in a way that met the needs of local people.**
- The service provided planned diagnostic treatment for patients at their convenience through the choice of appointment days and times to suit their needs. Patients were also able to access services at the other satellite sites within the London Bridge campus if needed.
- Staff told us that patients appreciated the accessibility of the service. The centre was an independent healthcare service located within a private GP Practice. Staff told us that most patients either walked to the centre or used public transport and local parking was available in a nearby shopping centre.
- The environment was appropriate, and patient centred. There was a comfortable waiting area with sufficient seating, cold water fountain, drinks machine for making hot drinks, and toilet facilities for patients and visitors.
  - However, signage directing patients to the centre was not clear. We were not able to find the centre initially. We discussed this with senior leads who told us the service was not able to have additional signage on the building or in the area due to the lease agreements. This was in line with Canary Wharf overarching community strategy whereby limitations had been placed on local business advertising. In response, the service provided patients with a map with contact details for the facility as part of the acknowledgement email for their appointment. Staff told us that on the infrequent occasions where a patient was unable to find the centre, staff would go out to find patients and bring them on site.
- During the inspection, we observed reception staff communicate with x-ray staff when a patient needed help or assistance with the doors in the corridor.

Meeting people's individual needs

- **The service took account of patients' individual needs.**
- The service provided individualised care based on the clinical need of the patient. The location was one of five satellite sites linked to the London Bridge Hospital's campus which enabled patients to have easy access to further care such as day case or inpatient treatment. Appointments with our consultants were arranged at a convenient time for the patients and onwards diagnostics could be arranged on the same day. This

included magnetic resonance imaging (MRI), x-ray and ultrasound. Staff told us patients did not have to wait for appointments and patients were able to see consultants on the same day across the campus sites.

- The centre was open from 09.00 am to 17.00 pm in order to cater for the city based patients who required appointments. The business manager and staff reviewed the services offered to ensure patient needs were met and to provide the best possible service in line with the patient feedback. For example, the location expanded from an imaging only site to include consulting room space in 2016 allowing patients to have appointments with consultants at the same site.
- The service took into account the different needs of people living with dementia, and physical limitations. For example, the centre provided a MRI compatible wheelchair service to patients who needed it. Staff supported patients and their family members, making them comfortable, sitting with them to alleviate their fears and anxiety. Staff told us that they did not see many adult patients with learning disabilities and were not able to think of any examples of when they had. Staff said that they would speak to the superintendent radiographer with questions about treating patients with learning disability when necessary.
- All staff undertook annual dementia training, which enabled them to understand the needs of people living with the condition and to recognise signs of undiagnosed dementia. The service had a dementia lead and used blue dots on registration forms to ensure staff were aware when patients had additional needs. The reception desk had a dementia clock which displayed the date and time to help orientate patients who may have dementia associated cognitive difficulties.
- The service had installed a hearing loop system after recognising they needed to provide more support for patients who used hearing aids. During the inspection, staff told us the service had plans to introduce training and amend the environment for patients with visual impairment.
- The service did not treat bariatric patients and staff told us these patients would be referred to the main London Bridge Hospital. Patients that required sedation would also be referred to the main hospital.
- The service had a chaperone policy and displayed chaperone signs throughout the service. During the inspection we saw a chaperone poster in Arabic.
- Staff had access to language interpreter services via telephone.

Access and flow

- **People could access the service when they needed it.** Waiting times from referral to treatment and arrangements to admit, treat and discharge patients were in line with good practice.
- All enquiries, referrals and appointments were managed by either the contact centre team based in Wales or the in-house business office team to ensure quick access for patients. The business team on site made appointments from GP referrals, booked in walk-ins and sent out reports to referring doctors. These teams were able to manage appointments and referrals dependant on consultant preference and availability to ensure that patients were seen rapidly and at a time that suits them. The booking centre scheduled appointments for patients, liaised with consultant's secretaries and cascaded the information to the relevant site.
- Given the location of the centre, patients could easily be offered alternative locations to suit their convenience. Patients received confirmation for their appointments via email and any changes were communicated via telephone.
- Patients could either self-refer or be referred by one of the other provider sites, private GP practices, NHS GP practices if they had private medical insurance and signposted to the service by insurance companies.
- All the referrals were triaged by radiographers and checked again before booking and finalising the patient using the Pause checklist in x-ray and MRI.
- The service did not have a waiting list so patients were seen at a time convenient to them. Patients that required an urgent scan could be seen on the same day. For example, if a patient needed an urgent MRI, the provider had ten MRI scanners across the London Bridge campus which patients could access.
- Between September 2017 and September 2018, the service completed 3,041 imaging scans and 257 outpatient appointments.
- Between September 2017 and September 2018, seven planned procedures/examinations were cancelled for a non-clinical reason. Of these, on all occasions the reason was due to machine breakdown or other equipment failure. Patients that had appointment cancelled would be offered a scan immediately at another HCA centre or could re-book their appointment.

Good

Diagnostic imaging

- Between September 2017 and September 2018, the service reported no incidences where planned examinations/procedures were delayed for a non-clinical reason.
- The service completed quarterly audits for the imaging turnaround times. We reviewed the 2018 results for quarter one to quarter three and found the service was meeting the key performance indicators (KPI) for the plain film average reporting time, MRI average reporting time and ultrasound average reporting time. The audit results confirmed that the local processes to ensure all imaging reports were concluded within the local KPI of 48 hours and escalation worked well. All modalities were within the KPIs and rated as green (i.e. care was safe and effective).
- During the inspection, we saw the turnaround times displayed in the MRI control room. For quarter three, the turnaround time for x-rays and MRI was 7.5 hours and 14 hours respectively. For quarter four, the turnaround time for x-rays and MRI was 6 hours and 12 hours respectively. Consultants told us the turnaround time for blood tests was within 24 hours.

Learning from complaints and concerns

- **The service treated concerns and complaints seriously, investigated them and learned lessons from the results, and shared these with all staff.**
- The centre had a corporate policy for managing complaints which stated formal complaints were acknowledged within two days of receipt. The service would fully investigate and respond within 20 working days. Where the timescale could not be met, the service would send a letter to the complainant outlining the current progress of the investigation and reason for delay. Between September 2017 and September 2018, the service received zero complaints and 36 compliments.
- The business manager was the local investigation handler and complaint handler. The risk manager reviewed investigations, managed deadlines and ensured lessons learnt were cascaded to staff whilst the Head of Governance reviewed investigation and provided the final facility response to the Chief Executive Officer for oversight and response to the complainant.
- The centre recognised the need to learn from patient feedback as an important factor in implementing positive change. All complaints were reviewed weekly at the Complaints, Litigation, Incident and Patient Experience (CLIP) meetings and at the monthly governance meeting where actions for improvements were agreed and disseminated to the wider teams. Equally compliments from patients were reviewed and discussed with the teams to ensure responsiveness to all patient feedback.
- The service displayed 'How to make a complaint' leaflets for patients. Staff were aware of the leaflets and offered these to patients should they wish to make a complaint. If any concerns were raised at the centre, the matter was addressed immediately by the nurse in charge or the superintendent and the business manager would be advised of the concern and action taken. If the matter could not be resolved immediately the matter was dealt with as a verbal complaint and escalated to the business manager.
- The service used patient feedback to improve the service. For example, a few patients had complained about the taste of the coffee and the service was in discussions about replacing the coffee machine.

Are outpatients and diagnostic imaging services well-led?

Good

We rated it as **good.**

Leadership

- **Managers at all levels had the right skills and abilities to run a service providing high-quality sustainable care.**
- Docklands Healthcare was one of the five satellite sites linked with the London Bridge Hospital campus. The Chief Executive of London Bridge Hospital was also the registered manager for Docklands Healthcare. Although the registered manager was based at the main hospital campus, staff told us they were accessible when needed at the centre. The registered manager told us they conducted regular visits to all the satellite sites.
- The registered manager was supported by the business manager, whose key responsibility was to monitor the performance of the centre and operationally manage

the centre. This included reviewing clinics and activity, meeting with all consultants to discuss practice changes and improvements. The superintendent radiographer and sister managed the daily running of the services.

- Staff told us the senior management were supportive. The business manager was visible on site and supported staff through regular training and reviews. The service had monthly team meetings to support open understanding and staff engagement. Staff told us that they enjoyed working at the centre.
- The service achieved an Investors in People Gold Award with a 76% response rate for the site. This meant the service was in the top 7% of participants with respect to leadership and management.

Vision and strategy

- The service had clear vision and values to promote an open and fair culture delivering the organisation's priorities for high quality and patient centred care.
- Staff we spoke with showed awareness of the service's vision and values. The service linked the values to staff appraisals whereby staff had to write statements to evidence how their work demonstrated each value.
- Staff told us a new nursing strategy had been implemented which looked at streamlining patient journey/experience to ensure the patient was booked for the right service and right site. Staff received updates on the strategy via the intranet.
- From the corporate vision and strategy, the business manager had business objectives which were site specific. For example, for Docklands Healthcare, one objective was to achieve an integrated centre within the community to provide a seamless pathway between primary and secondary care.

Culture

- **Managers across the service promoted a positive culture that supported and valued staff, creating a sense of common purpose based on shared values.**
- Staff described the culture as open and honest where everyone was able to voice their opinions. The service had monthly team meetings which was an open forum to discuss any concerns. The minutes for the team meetings were emailed to all staff and saved on shared drives.
- Staff described the teamwork as positive and said it felt like a family. Staff we spoke with told us they felt valued and confident to escalate concerns if needed.
- Senior leads told us staff were encouraged to change ways of working where needed. For example, staff had decided to change the process for obtaining patient feedback by requesting patients to complete the feedback forms whilst waiting for their scanned images to be put onto compact discs (CDs).
- The provider had introduced a new initiative called 'Epic Thank You' as a way to formally thank employees. Staff received emails and a message on the computer screen. Each month, there was a draw where staff could collect points and later use to redeem prizes from the catalogue.
- Staff had access to an ethics line to raise concerns. The service had an employee assistance programme which was a free phone number for staff to access support or raise concerns 365 days a year.
- The service had access to the corporate Freedom to Speak up Guardian. Senior leads told us the provider was currently working on posters for the satellite sites to increase staff awareness.
- The service used the corporate equality and diversity strategy which included an action for monitoring staff with protected characteristics. For example, the recruitment team worked with external organisations to proactively support women getting back into work by offering part-time and job sharing contracts.

Governance

- Docklands Healthcare was part of London Bridge Hospital campus governance structure. Any issues were raised through the governance processes and to the Head of Governance. The provider had monthly Governance and Quality Monitoring meetings which were attended by the head of Governance, medical governance lead, medical director and lead for Medical Advisory Committee. The business manager and the head of imaging also attended these meetings and fed back to the satellite sites.
- Each campus had their own local governance team who had monthly meetings with the business manager, head of imaging and lead nurse. The London Bridge campus consisted of the head of governance, quality manager, risk manager, two governance facilitators, risk lead, administrator, health and safety manager and infection prevention and control (IPC) lead. The governance team conducted regular visits to the locations whilst the governance facilitator was the link.

Good

Diagnostic imaging

- The provider had a corporate radiation safety committee which met four times a year. The committee was chaired by the Head of Governance and Risk and attended by the radiation protection advisor, physicist, imaging managers from the different sites, and the head of the learning academy. The service provided minutes for April and July 2018 which showed actions were logged from previous meetings with a named responsible person and update. The minutes showed the committee discussed facility assurance reports for all the sites, incident report, training update and the feedback from radiology managers meeting.
- The service had monthly imaging senior management team meetings. We reviewed the minutes provided by the service from January 2018 to September 2018 and found there was consistency in the format and structure of these meetings.
- The service had site-based team meetings which took place monthly. We reviewed the minutes for January 2019 and found discussions took place on previous meeting actions, health and safety, infection control, audits, incidents, complaints and compliments and feedback from additional meetings.
- Service line meetings took place monthly for all specialities and covered both the business and clinical aspects. Senior leads told us that Morbidity and mortality (M&M) meetings took place for specialities at London Bridge Hospital.
- The service reviewed practising privileges annually and where consultants had not completed any clinics for one year, the practising privilege would be removed.

Managing risks, issues and performance

- **The service had good systems to identify risks, plan to eliminate or reduce them, and cope with both the expected and unexpected.**
- The provider had a business continuity plan which included several satellite sites that patients could be diverted to and clinics transferred to in event of an emergency.
- Senior leads told us that major incident awareness for the service was covered under the Canary Wharf Security Management. During the inspection, we saw there was an evacuation bag in the reception area in event of any terrorist/major incident.
- The service completed an assessment of lone working for radiographers in 2017. As a result, the service eliminated lone working by increasing staff provisions to ensure two radiology staff were always present when conducting scans.
- Staff told us the service had two fire wardens. Senior leads told us staff had annual fire drill training with the last training completed in December 2018.
- Senior leaders had a good understanding of risks to the service and these were appropriately documented in risk management documentation with named leads and actions. The business manager reviewed the risk register as per the level of risk with support from the risk manager.
- Senior leads told us the main risk was there was no Resident Medical Officer (RMO) on site. This was linked to the site's risk around managing emergencies such as patients having a contrast reaction in MRI or a cardiac arrest. The service mitigated the risk by ensuring staff were intermediate life support (ILS) trained and by having resuscitation equipment on site. The service also completed mock cardiac arrest and anaphylactic reaction scenarios every six months. Staff told us the last resuscitation simulation took place in September 2018. Although senior leads told the service benefitted from emergency response and/or emergency advice from the medical team in the adjacent GP practice, there was no formal arrangement for this.
- Another risk for the location was security as a remote satellite site. The service did not have security presence on site but had access to the local Canary Wharf security team where first responders were available.

Managing information

- **The service collected, analysed, managed and used information well to support all its activities, using secure electronic systems with security safeguards.**
- All staff had undertaken data security and awareness training as part of their mandatory training. Staff we spoke with understood their responsibilities around information governance and the reported compliance rate for information governance training was 100%.
- All staff we spoke with demonstrated they could locate and access relevant policies and key records very easily and this enabled them to carry out their day to day duties successfully. All staff had access to the organisation's intranet to gain information relating to policies, procedures, national guidance and e-learning.

Good

Diagnostic imaging

- Electronic patient records could be accessed easily and were kept secured to prevent unauthorised access of data. Staff had access to all the information they needed to deliver care and treatment to patients in an effective and timely way.
- Information from scans could be reviewed remotely via the picture archiving and communication system (PACS) by referrers to give timely advice, and interpretation of results to determine appropriate patient care. Patients received password protected compact discs (CDs) with their scanned images.
- The service had access to the information technology (IT) support team based at the London Bridge Hospital campus and staff told us they were responsive. Staff had access to a computer in each clinic room.
- The marketing team produced monthly newsletters for the campus. We reviewed the February 2019 newsletter and found there was an update from the chief executive officer, employee of the quarter, new starters information, patient satisfaction results and information on clinical skills study day.

Engagement

- **The service engaged well with patients, staff, the public and local organisations to plan and manage appropriate services, and collaborated with partner organisations effectively.**
- The service acknowledged that the views of patients and staff were independent in delivering and achieving the best outcomes. The service used patient and staff surveys and patient feedback forms to identify trends and develop action plans to improve the service. For example, knee patients had fed back that a footstool would be beneficial for them whilst waiting and the service had recently placed an order for one.
- Staff concerns were dealt with in accordance to the corporate policy; risks identified, managed and mitigated in a manner that ensures quality care and promotes innovation and learning. Staff had opportunities to discuss clinical practice, service developments ideas and any challenges with the management team.
- Staff collected patient feedback via paper forms. The service provided data for January and February 2019 which showed the site received positive patient feedback.
- The service had a business development team who worked closely with NHS providers nearby and private primary care providers to find out the needs of the local population.
- Staff completed an annual staff survey and each campus had an action plan. The service provided the 2017 action plan for the London Bridge Hospital campus. Although the plan was not site specific, the plan showed the campus was working on four areas: recognition and reward, communication, growth and development and survey credibility. There were plans to start biannual shorter surveys called 'Vital Voices' in May 2019.
- Senior leads told us that each quarter, random staff were selected from across the campus to have afternoon tea with the Chief Executive Officer.
- The service also had a staff forum which met quarterly with the Chief Executive Officer and the senior management team. Staff were offered five sessions across a week to maximise attendance.

Learning, continuous improvement and innovation

- **The service was committed to improving services by learning from when things went well or wrong, promoting training and innovation.**
- The provider created "New for You" as a quick way to send information to the local teams at the satellite sites. The Business Manager and the leaders from the centres decided that having a snapshot of new information would be a simpler way of disseminating news rather than reading though multiple meeting minutes.
- There were plans to expand and make the service more accessible to patients. Currently, the private GP practice was situated on the opposite side of the building with a separate reception team. The service envisaged that by having both primary and secondary care working as one facility, patients would have a continuous stream of care rather than two separate systems.
- Senior leads told us they were plans to have imaging as a separate service line with one Head of Imaging across all campus facilities to ensure consistency.
- Business Managers had plans to commence quarterly peer reviews which aimed to have a more unified service with shared learning.

Outstanding practice and areas for improvement

Outstanding practice

- The service provided victims of domestic violence with a bar code sticker which discreetly included a telephone number which victims could use to access support and advice.

Areas for improvement

Action the provider SHOULD take to improve

- The provider should ensure there is local practising of the emergency evacuation procedure in MRI.

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.

This section is primarily information for the provider

Enforcement actions

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.