Dorset Heart Clinic LLP

Dorset Heart Clinic

Inspection report

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Date of inspection visit: 6 and 20 April 2022
Date of publication: 27/06/2022

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

Ratings

Overall rating for this location	Good
Are services safe?	Good
Are services effective?	Inspected but not rated
Are services caring?	Good
Are services responsive to people's needs?	Good
Are services well-led?	Requires Improvement

Summary of findings

Overall summary

We rated it as good because:

- There was enough staff to care for patients and keep them safe. Staff had training in key skills, understood how to protect patients from abuse, and managed safety well. Infection risks were controlled well. Staff assessed risks to patients, acted on them and kept care records. Medicines and incidents were managed well, and the service had oversight of this. The service completed patient records using the host trust's electronic patient record system in line with their partnership agreement.
- Staff provided good care and treatment, gave patients enough to eat and drink, and gave them pain relief when they needed it. Staff worked well together for the benefit of patients, supported them to make decisions about their care, and had access to good information. However, it was not always clear how patient outcomes were reviewed.
- Staff treated patients with compassion and kindness, respected their privacy and dignity, took account of their individual needs, and helped them understand their conditions. They provided emotional support to patients, families and carers. Patients told us they had received compassionate care when they contacted the service and when they attended for appointments or interventional procedures
- The service planned care to meet the needs of local people, took account of patients' individual needs, and made it easy for people to give feedback. People could access the service when they needed it and did not have to wait too long for treatment. However, information about how to make a complaint about care and treatment was not shared effectively with patients.
- There was lack of evidence to support safe recruitment processes. Local leadership had been impacted by the absence of a registered manager. Governance processes were not always carried out to demonstrate oversight of patient safety and outcomes and risks were not captured effectively. However, staff understood the service's vision and values, and how to apply them in their work. Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. Staff were clear about their roles and accountabilities. The service engaged well with patients and staff were committed to improving services continually.

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Diagnostic imaging	Good 	This was the first time we inspected the service. We rated it as good because: • There was enough staff to care for patients and keep them safe. Staff had training in key skills, understood how to protect patients from abuse, and managed safety well. Infection risks were controlled well. Staff assessed risks to patients, acted on them and kept care records. Medicines and incidents were managed well, and the service had oversight of this. However, the service did not hold their patient records but used the host trust electronic patient records. • Staff provided good care and treatment, gave patients enough to eat and drink, and gave them pain relief when they needed it. Staff worked well together for the benefit of patients, supported them to make decisions about their care, and had access to good information. However, managers did not review patient outcomes for patients who had received care in the service specifically. • Staff treated patients with compassion and kindness, respected their privacy and dignity, took account of their individual needs, and helped them understand their conditions. They provided emotional support to patients, families and carers. • The service planned care to meet the needs of local people, took account of patients' individual needs, and made it easy for people to give feedback. People could access the service when they needed it and did not have to wait too long for treatment. However, information about how to make a complaint about care and treatment was not shared effectively with patients • There was lack of evidence to support safe recruitment processes. Local leadership had been impacted by the absence of a registered manager. Governance processes were not always carried out to demonstrate oversight of patient safety and outcomes and risks were not captured effectively. However, staff understood the service's vision and values, and how to apply them in their work. Staff

Summary of findings

felt respected, supported and valued. They were focused on the needs of patients receiving care. Staff were clear about their roles and accountabilities. The service engaged well with patients and staff were committed to improving services continually.

We rated this service as good because it was safe, effective, caring and responsive, although leadership requires improvement.

Summary of findings

Contents

Summary of this inspection

Background to Dorset Heart Clinic

Dorset Heart Clinic is an independent healthcare provider specialising in interventional cardiac procedures and health screening. It is a limited liability partnership between a local NHS trust and Regent's Park Heart Clinics and was established in 2017 when it was registered with the Care Quality Commission. The service provides private cardiology services to people living in Dorset and the surrounding counties using the services and facilities provided by a local NHS trust (referred to as the host trust throughout the report).

The service offers a range of diagnostic tests including ECGs, ambulatory monitoring, echocardiography (to check how the heart's chambers and valves are pumping blood through the heart) and cardiac imaging. The service also offers treatment procedures which include coronary angiogram (a type of x-ray procedure used to check the blood vessels in the heart), coronary angioplasty (a procedure used to open blocked blood vessels surrounding the heart), insertion of cardiac pacemakers and implantable cardioverter defibrillators to treat cardiac arrhythmias. The service also offered electrophysiology (a test used to diagnose abnormal heartbeats) and ablation (a procedure used to treat irregular heartbeats).

The service employs 19 consultants working under practising privileges arrangements (a license agreed between individual medical professionals and private healthcare providers). All consultants hold substantive NHS consultant appointments. All consultants are registered with the General Medical Council with additional specialist registration. The service also employs two administration staff and a registered manager.

There are contractual partnership agreements (Service Level Agreement -SLA) which include information that the local NHS trust provides all facilities, equipment, medicines, clinical staff, policies and procedures. The SLA also sets out the arrangements for managing records, medicines and safety incidents.

The service is registered to provide diagnostic and screening procedures and treatment of disease, disorder and injury.

There was a registered manager who had been in post since December 2021. However, they were on long term sick leave at the time of our inspection.

The service had not previously been inspected. There were no special reviews or investigations of the service ongoing by the CQC during the 12 months before the inspection.

Activity (1 March 2021 to 28 February 2022)

- There were 164 inpatient and day case interventional procedures; all of these were privately funded or funded by private healthcare insurance.
- There were 791 outpatient appointments; all of these were privately funded or funded by private healthcare insurance.
- The service had carried out 925 diagnostic tests such as cardiac electrocardiogram (ECG, echocardiograms and exercise ECG tests; all of these were privately funded or funded by private health care insurance.

Summary of this inspection

How we carried out this inspection

The inspection team included a lead inspector and another inspector who carried out a site visit on 6 April and 20 April 2022. The inspection was overseen by Head of Hospitals Inspections Catherine Campbell.

During the onsite visit, we spoke with three members of staff, eight members of staff working for the host NHS trust and one patient. We looked at documentation and patient outcome data before, during and following the inspection.

We spoke with eight patients and two relatives by phone in the week following our onsite visit and arranged further interview with key people.

You can find information about how we carry out our inspections on our website: https://www.cqc.org.uk/what-we-do/how-we-do-our-job/what-we-do-inspection.

Outstanding practice

The service used technology in innovative ways to enhance diagnostic procedures and had introduced enhanced systems to monitor patient outcomes, including opportunities for patients to provide feedback.

Areas for improvement

Action the service MUST take is necessary to comply with its legal obligations. Action a service SHOULD take is because it was not doing something required by a regulation but it would be disproportionate to find a breach of the regulation overall, to prevent it failing to comply with legal requirements in future, or to improve services.

Action the service MUST take to improve:

- The service must ensure required information in respect of persons employed of appointed for the purposes of a regulated activity is obtained and updated to comply with Schedule 3 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Recruitment and employment records of consultants working under practising privileges did not include required information and did not clearly demonstrate each consultant's scope of practice as granted by their practicing privileges. (Regulation 19 Schedule 3)
- The service must ensure it holds the required information to assess the character of individual designated members of the limited liability partnership to comply with paragraph 4. The service did not hold information in line with requirements to demonstrate compliance. (Regulation 5)
- The service must ensure there are effective systems and processes to ensure compliance with good governance. Leaders did not always operate effective governance processes within the service. Staff at all levels were clear about their roles and accountabilities but did not have regular opportunities to meet, discuss and learn from the performance of the service. Patient safety and outcome data was not reported and shared effectively. Leaders and teams did not always use systems to manage performance effectively. They did not always identify and escalate relevant risks and issues or identified actions to reduce their impact. (Regulation 17 (2) (a) (b) (f))

Action the service SHOULD take to improve:

- The service should continue to submit monthly data to the Patient Health Information Network in line with national requirements.

Summary of this inspection

- The service should consider providing induction/information for NHS staff providing care and treatment for the private patients to ensure they were aware of the vision and values of the service.
- The service should improve processes to review and check declarations for staff working for the host trust, compliance with mandatory training
- The service should improve patient information to include how to make a complaint.

Our findings

Overview of ratings

Our ratings for this location are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Diagnostic imaging	Good	Inspected but not rated	Good	Good	Requires Improvement	Good
Overall	Good	Inspected but not rated	Good	Good	Requires Improvement	Good

Good

Diagnostic imaging

Safe	Good
Effective	Inspected but not rated
Caring	Good
Responsive	Good
Well-led	Requires Improvement

Are Diagnostic imaging safe?

Good

This was the first time we inspected and rated this service. We rated it as good.

Mandatory training

Staff received mandatory training and the service sought assurance that staff was compliant with mandatory training.

The service obtained an annual competency declaration, from the host trust (who provided the staff as part of the partnership service level agreement), to provide assurance that staff had completed their mandatory training and were competent to carry out their roles. Compliance was reviewed annually but without an additional review of trust records to support the declaration.

The service monitored mandatory training compliance for consultants with practicing privileges.

We were told consultants who had not complied with relevant documents concerning 15 topics, including mandatory training, could not carry out care and treatment appointments. However, data showed two of three consultants who were not compliant, had carried out patient appointments in March 2022. Following the inspection, we received further assurance to demonstrate consultants' compliance with mandatory training (see also well-led section).

Administration staff received and kept up to date with their mandatory training. Records showed staff working in the administration office had completed their mandatory training. It was comprehensive and met the needs of patients and their role. Staff had access to the host trust learning platform in line with the partnership service level agreement.

Safeguarding

Staff received safeguarding training and the service sought assurance that staff received safeguarding training at a level appropriate to their role. However, there were gaps in recruitment practices to ensure safe recruitment of consultants working under practicing privileges.

Staff received training specific for their role on how to recognise and report abuse. Staff knew how to make a safeguarding referral and who to inform if they had concerns. There had not been any safeguarding concerns reported in the last 12 months prior to our inspection.

However, there were gaps in safe recruitment practice including safety checks such as evidence about Disclosure and Barring Checks for consultants working under practising privileges arrangements. Please see the well-led section of the report.

Cleanliness, infection control and hygiene

Staff used equipment and control measures to protect patients, themselves and others from infection. They kept equipment and the premises visibly clean. However, oversight by the service of infection prevention and control audits were not always effective.

All areas we visited where Dorset Heart Clinic patients were seen, were visibly clean and had suitable furnishings which were clean and well-maintained.

Staff wore personal protective equipment and specific COVID infection prevention and control measures had been implemented during the COVID19 pandemic.

The service had not reported any post-procedure wound infections in the 12 months before our inspection.

Governance and oversight of infection prevention and control audits was not effective. The host trust was responsible for the cleaning and auditing to demonstrate compliance in line with the partnership service level agreement. An overview of compliance was part of the standard agenda for monthly operational meetings, but audit data was not shared with the service. Action was taken following our inspection on 6 April 2022 to re-establish regular meetings to improve oversight. However, minutes of previous meetings did not include any specific data regarding hand hygiene compliance, PPE compliance and cleaning audit.

Environment and equipment

The design, maintenance and use of facilities, premises and equipment kept people safe. Staff managed clinical waste well.

The premises and equipment used by Dorset Heart Clinic belonged to the host trust who were responsible for the servicing and maintenance. The service was allocated cardiac catheter laboratory slots and outpatient consultation room as required and in line with the partnership service level agreement. Servicing and maintenance records were discussed as part of a monthly operational meeting between the registered manager and a department manager from the host trust.

The design of the environment followed national guidance for safety. The service had suitable facilities and equipment to safely meet the needs of patients' and their families. Staff disposed of clinical waste safely.

Fire safety was managed by the host trust in line with the partnership service level agreement. The service monitored compliance with completion of annual fire awareness training.

All ionising imaging equipment was managed and maintained by the host trust in line with the partnership service level agreement. The service obtained regular audits of radiation dosages and exposure time by the consultants who operated the imaging equipment, for assurance of good practice.

Assessing and responding to patient risk

Staff completed risk assessments for each patient. They removed or minimised risks and updated the assessments. Staff identified and quickly acted upon patients at risk of deterioration.

Good

Diagnostic imaging

There was a standard operating procedure and policy for management and administration of private patients at Dorset Heart Clinic (v3, 2021). This set out admission criteria for patients who were eligible to be seen as private patients. Only adult patients over the age of 18 years were considered for private treatment and the service did not accept any emergency admissions.

Staff completed pre-assessments for all patients who were scheduled for interventional cardiac procedures.

Staff used established patient pathways and monitoring processes and escalated concerns when required. Staff did not use a specific tool, such as the early warning scoring system, to monitor and record vital observations during interventional procedures. However, all patients were closely monitored using procedures and medical staff were present during the whole procedure. Once patients were transferred to the ward area, staff used monitoring tools based on early warning scores to identify patients who may have post procedure complications. Enhanced care was available when needed including the need to admit patients to an NHS trust if complications arose. There was a transfer arrangement in place.

Staff used the World Health Organisation (WHO) safer surgery checklist for all interventional cardiac procedures. Managers monitored and discussed compliance in monthly operational meetings.

Compliance with pre-operative assessment, COVID-19 pathways, consent process, procedure documentation and follow up was audited as part of a monthly documentation audit.

Nurse staffing

There was enough nursing staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment.

Nursing staff working in the interventional cardiac laboratory were provided by the host trust as part of the partnership service level agreement.

There was a morning safety briefing which included a review of nurse staffing to ensure there were enough staff to provide safe care and treatment. If there were not enough nursing staff to run the catheter laboratory safely, procedures would be cancelled and re-scheduled as soon as possible. This had not happened in the 12 months before our inspection.

Medical staffing

There was enough medical staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment.

The service had enough medical staff to keep patients safe. Patients were booked in to see consultants and for interventional procedures in line with their availability to see private patients in the Dorset Heart Clinic. The services employed 19 consultants who worked under practising privileges as granted by the medical advisory committee. All consultants held substantive consultant posts in the local NHS trust network.

The service had processes to monitor medical staff, compliance with insurance, appraisal and professional registration, but these were not always effective as we found not all medical staff were compliant. The service provided data on consultant compliance, but this did not reflect our findings during the inspection. As of 22 March 2022, the oversight information showed three consultants were not compliant across all metrics including proof of medical indemnity

assurance, NHS appraisal and mandatory training. We were told consultants could not carry out regulated activities unless they were up to date with all measures. However, the operational report (March 2022) data showed one of the consultants had completed 13 consultations. Following the inspection, managers sent us further assurance which showed staff had completed their training and were up to date with their individual medical indemnity insurance cover.

Records

There were arrangements for contemporaneous documentation of patient care and treatment.

Staff recorded all patient care and treatment on the NHS host trust's electronic patient records system as part of the patient's NHS record. This was included in the partnership service level agreement. Although, patient information was easily available to staff treating the patients and if their care was transferred to the host provider, the record of care provided by the service, they did not retain those patient records.

All private patients were asked to sign a consent form for their care and treatment to be recorded as part of their NHS patient records. All patients signed a 'patient registration form', which included detail of how clinical records were managed and stored. These forms were audited for compliance with all details completed, as part of the monthly audit carried out by Dorset Heart Clinic (DHC). No issues were highlighted in audits carried out between July 2021 and February 2022.

The service employed designated administrative staff who ensured appointment correspondence was shared with patients in a timely manner.

Staff employed by Dorset Heart Clinic were given honorary contracts with the host trust to grant them access to clinical and administrative software applications as required by the trust. Computer access was password protected.

Medicines

There were systems and processes to safely prescribe, administer, record and store medicines.

Dorset Heart Clinic (DHC) outsourced the provision of medicines management to the host trust as part of the partnership service level agreement. Medicines were supplied by the host trust for use in procedures and on the four bedded unit where DHC patients were admitted to. Consultants prescribed medicines that was administered during the interventional procedures and prescribed medicines to take home. Nursing staff administered medicines in line with prescriptions. Staff did not report any shortages of medicines the required and links with pharmacists were well-established.

There had not been any incidents relating to medicines management for private patients treated and cared for by Dorset Heart Clinic, in the 12 months before our inspection.

Incidents

There were arrangements to report incidents and processes to investigate any incidents reported about private patients receiving treatment.

Staff knew what incidents to report and how to report them. They raised concerns and reported incidents and near misses on the host trust incident reporting system and following the host trust policy, in line with the partnership

Good

Diagnostic imaging

service level agreement. There had not been any incidents reported in the 12 months before to our inspection (from 1 March 2021 to 28 February 2022) for patients treat by Dorset Heart Clinic. We discussed this with leaders who explained they were assured staff would report any incidents or near misses and that there had been no reported incidents was proportionate with the relatively low volume of procedures carried out.

Staff we spoke with understood the duty of candour. Staff explained process to ensure they were open and transparent and gave patients and families a full explanation and apology when things went wrong.

Are Diagnostic imaging effective?

Inspected but not rated

We do not rate effective for these type of services.

Evidence-based care and treatment

Staff provided care and treatment based on national guidance and evidence-based practice. Managers checked to make sure guidance was current to reflect evidence-based care and treatment.

Staff followed up-to-date policies to plan and deliver high quality care according to evidence-based practice and national guidance. Care, treatment and support was delivered in line with legislation, standards and evidence-based guidance, including the National Institute for Health and Care Excellence (NICE) and other expert professional bodies, to achieve effective outcomes. However, policies and processes used were that of the host trust. There were processes to review policies and procedures to ensure these were current and reflected up to date evidence-based guidance. However, we reviewed documentation for patients having a cardiac device implanted such as a pacemaker and the pathway did not state when it was last reviewed by the host trust.

We were told work was in progress to develop national safety standards for all interventional procedures in line with national recommendations. The responsibility to develop and implement these was that of the host trust in line with the partnership service level agreement.

Nutrition and hydration

Staff gave patients enough food and drink to meet their needs and improve their health. The service made adjustments for patients' religious, cultural and other needs.

Staff made sure patients had enough to eat and drink. Patients were offered refreshments when they attended for outpatient appointments and when they were admitted for day case interventional procedures. If patients required overnight admission to hospital for monitoring purposes, they were offered food and drink to meet their needs.

All catering responsibilities were managed by the host trust in line with the partnership service level agreement.

Pain relief

Staff working for the host trust assessed and monitored patients regularly to see if they were in pain and gave pain relief in a timely way.

Good

Diagnostic imaging

Staff assessed patients' pain using a recognised tool and gave pain relief in line with individual needs and evidence-based practice. Patients received timely pain relief soon after it was identified they needed it, or they requested it.

Patients told us they had received adequate pain relief to ensure they were comfortable following interventional procedures.

Patient outcomes

Information relating to patient outcomes was not discussed in relevant meetings within Dorset Heart Clinic to provide clinical review and scrutiny. However, the service collected data to demonstrate the effectiveness of care and treatment.

The service participated in relevant national clinical audits. However, all data was submitted as part of data submitted by the host trust and this data was not reviewed specifically for patients treated by the service. We were told data could be separated out to include just data concerning private patients treated by the service. However, there was no evidence patient outcome data as submitted to national audits was discussed in relevant meetings such as the medical advisory group (MAC) meeting.

We saw local reports that showed outcomes for patients were positive, consistent and met expectations with regards to complications, but these were not discussed in relevant meetings such as the MAC meetings.

The service was responsible for submitting data to the Private Healthcare Information Network. Data had not been submitted consistently in the year prior to our inspection. We were told there had been technological difficulties with the reporting during the pandemic. This was noted in minutes of meetings for the MAC meeting in July 2021. Following the inspection, the service provided evidence that outstanding data had been submitted.

The service monitored readmission rates following interventional cardiology procedures which was provided by the host trust, but information was not benchmarked against other and similar services and there was no evidence the data was discussed in MAC meetings to consider improvements.

Competent staff

The service did not consistently obtain assurance that staff were competent for their roles. Managers carried out annual appraisals for staff directed employed by the service.

Consultants working for the service were employed under practising privileges. All consultants held substantive consultant posts within the local NHS hospital network. Consultants received annual appraisals and revalidation as required through their substantial NHS contracts. The service monitored compliance to ensure this was completed.

Consultants were required to provide up to date copies of their professional registration, qualifications, training, appraisals, indemnity insurance and disclosure and barring checks. We reviewed recruitment files for seven consultants and found this information was not always available. There was no clear scope of practice setting out procedures each consultant was competent and experienced to carry out and no evidence this had been considered as part of the granting of practising privileges.

Administration staff employed by Dorset Heart Clinic received induction and mandatory training from the host trust. Records showed one member of staff had not received their full induction since they were employed in November 2021. Following the inspection, we received assurance the induction had been completed.

Good

Diagnostic imaging

Other staff were not employed directly by Dorset Heart Clinic but provided by the host trust in line with the partnership service level agreement. The service received an annual statement to provide assurance that clinical staff such as nursing staff, were compliant with recruitment checks, mandatory training and appraisals. However, the service did not provide any information about the private health service as part of an induction programme for new staff employed by the host trust.

Multidisciplinary working

Staff worked as a team to benefit patients. They supported each other to provide good care.

All necessary staff, including those in different teams, services and organisations, were involved in assessing, planning and delivering care and treatment. Care was delivered and reviewed in a coordinated way when different teams, services or organisations were involved. Staff ensured people received consistent coordinated, person-centred care and support when they used, or moved between different services. There were daily staff briefings which allowed for a multidisciplinary team to discuss all patients listed for procedures, including private patients. Consultants spoke of host trust meetings which included discussion of patient outcomes, including private patients. Minutes of meetings showed patients were reviewed by a wider group of clinicians and ensured they received safe and high-quality care.

All relevant teams, services and organisations were informed when people were discharged from a service. Discharge was undertaken at an appropriate time of day and only done when any necessary ongoing care had been arranged.

Health promotion

Staff gave patients practical support and advice to lead healthier lives.

The service had not provided any private cardiac health screening between 1 March 2021 and 28 February 2022.

The website offered information about different tests and procedures available at the service but did not offer any information or link to health promotion relevant to cardiac disease.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

Staff supported patients to make informed decisions about their care and treatment. They followed national guidance to gain patients' consent. They knew how to support patients who lacked capacity to make their own decisions.

Staff received training and regular refresher updates to raise awareness of how to identify patients who may lack capacity to make informed decisions.

Staff saw patients at pre-assessment appointments and gained consent from patients for their care and treatment in line with legislation and guidance. Staff made sure patients consented to treatment based on all the information available and recorded consent in patients' records using adjusted NHS consent forms. We were told consent processes would follow usual NHS guidance on consent if a patient lacked capacity to consent to interventional procedures. The patient would be referred for discussion in a multi-disciplinary meeting and a designated consent form would be used. We were told this had never occurred, but admission exclusion criteria did not include patients who lacked capacity to consent to treatment.

The service monitored consent processes by auditing five patient records every month. Audit results and compliance were discussed in monthly operational meetings between the host trust and the registered manager for the service to evaluate if expectations were met or if improvement was required.

Good

Diagnostic imaging

Staff received and kept up to date with training in the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards.

Are Diagnostic imaging caring?

Good

This was the first time that we inspected this service. We rated it as good.

Compassionate care

Staff treated patients with compassion and kindness, respected their privacy and dignity, and took account of their individual needs.

Staff were discreet and responsive when caring for patients. Staff took time to interact with patients and those close to them in a respectful and considerate way. Patients said staff treated them well and with kindness.

Staff followed policy to keep patient care and treatment confidential. Staff understood and respected the personal, cultural, social and religious needs of patients and how they may relate to care needs.

Emotional support

Staff provided emotional support to patients, families and carers to minimise their distress. They understood patients' personal, cultural and religious needs.

Staff gave patients and those close to them help, emotional support and advice when they needed it. Staff understood the emotional and social impact that a person's care, treatment or condition had on their wellbeing and on those close to them.

Understanding and involvement of patients and those close to them

Staff supported and involved patients, families and carers to understand their condition and make decisions about their care and treatment.

Staff made sure patients and those close to them understood their care and treatment.

Patients told us they had been given full explanations about their treatment and staff talked to patients in a way they could understand. Patients and their families could give feedback on the service and their treatment and staff supported them to do this.

Patients and relatives gave positive feedback about the service. Feedback data consistently showed patients rated highly the care provided by the service. Feedback from patients included:

"I cannot fault the treatment I received from the staff on the ward, in the theatre and from the administration" and "an excellent service, staff very professional and personable. I couldn't have wished for better".

Are Diagnostic imaging responsive?

Good

Diagnostic imaging

Good

This was the first time we inspected the service. We rated it as good.

Service delivery to meet the needs of local people

The service planned and provided care in a way that met the needs of local people and the communities served.

Managers planned and organised services, so they met the needs of the local population. Facilities and premises were appropriate for the services being delivered. The service had access to premises and equipment when they needed it. There was no limit to how many procedures could be carried out. There was a partnership service level agreement which set out arrangements if evening and/or weekend slots were required to meet the needs of private patients.

Managers monitored and took action to minimise missed appointments. Managers ensured that patients who did not attend appointments were contacted. The service monitored missed and cancelled appointments.

Meeting people's individual needs

The service was inclusive and took account of patients' individual needs and preferences. Staff made reasonable adjustments to help patients access services. They coordinated care with other services and providers.

Information about patients' specific needs, including communication needs were assessed. Information was shared with relevant staff to ensure patients' needs were met as far as possible. Staff understood and applied the policy on meeting the information and communication needs of patients with a disability or sensory loss. Managers made sure staff, and patients, and carers could get help from interpreters or signers when needed.

People were supported during referral and transfer between services and discharge. Staff made reasonable adjustments so people with a disability could access and use services on an equal basis to others.

Staff could access translation services for patients through the host trust if required as part of the partnership service level agreement.

Access and flow

People could access the service when they needed it and received the right care promptly.

The service treated private patients only. Referrals were received by three different routes. Patients could be referred by their GP, from NHS consultants or by self-referral by patients who were on NHS waiting lists. These referrals were received by administration staff who would assign new patients to consultants with the appropriate speciality. However, there was a lack of oversight of each consultant's scope of practice to aid the onward referral process. We raised these concerns with the service at the time of our inspection.

Managers monitored waiting times and made sure patients could access services when they needed to. The average waiting time for consultations was three days in the year prior to our inspection. One patient told us they had attended a consultation on the same day they contacted the service.

Good

Diagnostic imaging

There had been no cancellations of interventional procedures in the year prior to our inspection and all patients had attended their booked appointments.

Staff moved patients only when there was a clear medical reason or in their best interest. When patients were discharged, information was shared with their GP.

Learning from complaints and concerns

It was easy for people to give feedback but information about how to raise concerns about care received was not always shared with patients effectively. The service treated concerns and complaints seriously, investigated them and shared lessons learned with all staff.

Information was available about how to provide feedback or make a complaint, but we did not see this information displayed in patient waiting areas or in the four-bedded inpatient facility. Some patients told us they had not received information about how to raise concerns about care and treatment and how to make a formal complaint, if they had felt this was required.

The service had received one complaint in the past year, although the concerns were not specific to the service. The complaint was investigated by the service and the host trust in a timely manner and in accordance with their policy and the partnership service level agreement.

Complaints was a standard agenda item in the Medical Advisory Group meetings and in the Executive Board Management meetings.

Are Diagnostic imaging well-led?

Requires Improvement

This was the first time we inspected the service. We rated it as requires improvement.

Leadership

Executive leaders had the skills, knowledge, experience and integrity to run the service. They understood the challenges to quality and sustainability and could identify the actions needed to address them. However, local leadership had been affected by the absence of a registered manager for almost five of the last 12 months.

There were clear pathways to provide effective communication between staff and the executive management board. Day to day running of the service was under the leadership of the registered manager. There was a medical advisory group which facilitated meetings for consultants and an overarching Executive Management Board. However, the effectiveness of the sharing of communication had been impacted by infrequent meetings at each level of the service.

There had been no registered manager for the service in almost five of the last 12 months. This was partly due to the time it had taken to recruit a manger. Senior leaders, such as the nominated individual made sure they spent more time in the unit to support the administration staff in the absence of the registered manager.

Good

Diagnostic imaging

Vision and Strategy

The service had a vision for what it wanted to achieve and a strategy to turn it into action, developed with all relevant stakeholders. The vision and strategy were focused on sustainability of services and aligned to local plans within the wider health economy. Leaders and staff understood and knew how to apply them and monitor progress.

There was a clear vision and a set of values including quality and sustainability. There was a strategy for achieving the priorities and delivering good quality sustainable care. The vision, values and strategy had been developed using a structured planning process in collaboration between the two business partners. Leaders knew and understood what the vision, values and strategy were, and their role in achieving them.

The strategy was considered for growth and aligned to local plans in the wider health and social care economy, and services had been planned to meet the needs of the relevant population. The strategy formed part of the plans for the partnership when this was formed in 2017 but had not yet progressed past phase one. Progress against delivery of the strategy and local plans was monitored and reviewed. However, the vision and values were not shared effectively with all staff involved with the treatment and care delivered on behalf of the service. Staff working in the service (provided by the host trust as part of the partnership service level agreement) f had not received any induction or information about the aims, objectives and values of the service.

Culture

Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. The service promoted equality and diversity in daily work and provided opportunities for career development. The service had an open culture where patients, their families and staff could raise concerns without fear.

Staff directly employed by Dorset Heart Clinic, felt supported, respected, valued and were positive and proud to work for the service. The culture was centred on the needs and experience of people who used services. Action was taken to address behaviour and performance was consistent with the vison and values, regardless of seniority.

Leaders and staff understood the importance of staff being able to raise concerns without fear of retribution and learning and action was taken because of concerns raised. The culture encouraged openness and honesty at all levels within the organisation, including people who used services, in response to incidents. Staff spoke of incident reporting, including raising near misses.

There were cooperative, supportive and appreciative relationships among staff. Teams and staff worked collaboratively, shared responsibility and resolved conflicts quickly and constructively. Staff worked together as a team. The administration office was within the footprint of the host trust cardiac catheter lab and meant staff had easy access to discuss patient related information or concerns.

Governance

Leaders did not always operate effective governance processes within the service. Staff at all levels were clear about their roles and accountabilities but did not have regular opportunities to meet, discuss and learn from the performance of the service. Patient safety and outcome data was not reported and shared effectively. Recruitment checks for consultants working under practicing privileges did not meet the requirements of Schedule 3 as set out in the Health and Social Care Act 2008.

There was a governance framework which outlined different levels of staff responsibility. Governance meetings included: monthly operational meetings, quarterly medical advisory group (MAC) meetings and quarterly Executive

Management Board meetings. However, it was not always clear how the provider monitored and improved the service. For example, the framework stated there was a clinical audit and governance sub-committee of the medical advisory group. We were told this meeting was embedded in the host trust's clinical audit and governance committee for cardiology services, but meeting of minutes did not show how treatment provided for private patients were discussed, reviewed and monitored.

Minutes of meetings at different levels of the governance structure did not demonstrate enough focus and time was assigned to consider patient safety and outcomes. However, following the inspection, the service shared a further 'MAC meeting pack' for the MAC meeting held 31 March 2022. This showed information about risks, infection prevention and control, equipment maintenance, WHO checklist compliance was shared which was reported as 100% compliant.

Meetings were not always held as often as they were meant to during the COVID-19 pandemic. There had been no medical advisory group meetings between July 2021 and March 2022 and the last monthly operations meeting before our inspection was held in January 2022.

Patient outcome data was not consistently reported to the Private Healthcare Information Network (PHIN) as required and in line with the partnership agreement between the two organisations when the service was established. Patient outcome data for national audits was embedded in and submitted by the host trust but there was little evidence of outcomes for private patients were discussed in MAC meetings or the Executive Management Board meeting.

Not all information required for safe recruitment of staff had been obtained and maintained. We reviewed seven staff files including the files for five consultants with practising privileges. The information contained within these files was not compliant with Schedule 3 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 or in line with the service's practising privileges application form. There was no evidence of Disclosure and Barring Service checks in six of the folders we reviewed; no evidence of references having been obtained; verified photo ID was inconsistent and there were no clear statements setting out consultants' scope of practice. Evidence of up-to-date mandatory training compliance was not included in five of the folders we reviewed. However, we saw credentials for professional qualifications were checked and there was proof of consultants' up to date indemnity insurance. Following the inspection, the service took immediate action and shared an action plan to address the breaches of Regulation 19 Schedule 3.

The service did not hold a staff file for one of the designated members of the limited liability partnership which was a breach of Regulation 5 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The service received an annual declaration of NHS nursing staff compliance with mandatory training and competency assessments. However, no further checks were made and there was no assurance provided by the host trust to support 100% compliance.

There were ineffective processes to monitor and review patient safety indicators. For example, information about staff compliance with personal protective equipment and hand hygiene for infection prevention and control for staff providing direct patient care, was not shared effectively at every level of the governance and leadership structure.

There was a partnership service level agreement which was reviewed regularly. However, the latest version (version 3) was not signed by the trust executive, although it had been signed on 21 March 2022 by the executive lead from Dorset Heart Clinic. Following the inspection, the service shared a signed copy for assurance.

Good

Diagnostic imaging

Management of risk, issues and performance

Leaders and teams did not always use systems to manage performance effectively. They did not always identify and escalate relevant risks and issues or identified actions to reduce their impact.

The organisation had a system of assurance systems, but performance issues were not always escalated through structures and processes. Processes to manage current and future performance were not always regularly reviewed and improved through clinical and internal audit. Leaders monitored quality, operational and financial processes but did not effectively identify where action should be taken.

Arrangements for identifying, recording and managing risks, issues and mitigating actions were not effective. Potential risks were not always considered when planning services, for example, seasonal or other expected or unexpected fluctuations in demand, or disruption to staffing or facilities. The risk register specific to the service, did not reflect all risks such as risks relating to business continuity or clinical risks specific to patients being treated on the private care pathway. However, staff told us they had no concerns of financial pressures compromising care.

Information Management

The service collected reliable data and analysed it. The information systems were integrated and secure. Data or notifications were mostly submitted to external organisations as required. However, data regarding care and treatment for private patients were not discussed in relevant meeting in the service.

Information was used to measure improvement, but patient safety, quality and sustainability did not receive balanced coverage in relevant meetings at all levels.

Staff had access to information and challenged it when necessary. There were service performance measures, which were reported and monitored but arrangements to ensure the information used to monitor, manage and report on quality and performance, was not always reviewed to ensure it was accurate. When issues were identified, information technology systems were used effectively to monitor and improve the quality of care.

There were arrangements to ensure data or notifications were mostly submitted to external bodies as required.

There were also mostly effective arrangements (including internal and external validation) to ensure the availability, integrity and confidentiality of identifiable data, records and data management systems, in line with data security standards. Lessons were learned when there were data security breaches.

Engagement

Leaders and staff actively and openly engaged with patients and staff/ They collaborated with partner organisations to help improve services for patients.

People's views and experiences were gathered and acted on to shape and improve the services and culture. The service used new and innovative measures to gather patient feedback which was consistently positive.

There were positive and collaborative relationships with external partners to build a shared understanding of challenges within the system and the needs of the relevant population, and to deliver services to meet those needs. There was transparency and openness with all stakeholders about performance which was included in an annual quality account report about the service.

Good

Diagnostic imaging

Learning, continuous improvement and innovation

Staff were committed to continually learning and improving services. They had a good understanding of quality improvement methods and the skills to use them. Leaders encouraged innovation and participation in research.

Leaders and staff aspired to continuous learning, improvement and innovation. This included nominations for different national awards for innovation such as the Health Investor award.

Staff regularly took time out to work together to resolve problems and to review individual and team objectives, processes and performance which lead to improvements and innovation. There were systems to support improvement and innovation work, data systems, and processes for evaluating and sharing the results of improvement work. The service was in the process of introducing an electronic platform which would allow the public to see feedback about the service, information about individual consultants alongside a rating based on patients' overall experience, the explanations given and the bedside manners of the consultant. At the time of our inspection, six consultants had signed up and there was a plan to get all consultants involved.

In March 2022, the service had introduced an ambulatory ECG monitoring 'patch' solution which was a small ECG monitoring device for patients who required seven day ambulatory ECG monitoring to help diagnose possible irregular heartbeat.

The service was working with the host trust to develop an electronic complications audit monitoring tool, which will provide an accessible and formatted way to report, review and feedback on procedural complications.