KIMS Hospital Limited

# Sevenoaks Medical Centre

**Inspection report**

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

## Ratings

| | |
|---|---|
| Overall rating for this location | Good |
| Are services safe? | Good |
| Are services effective? | Good |
| Are services caring? | Good |
| Are services responsive to people's needs? | Good |
| Are services well-led? | Good |

# Summary of findings

## Overall summary

We rated it as good because:

- The service provided mandatory training in key skills to all staff and made sure everyone completed it.
- 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.
- Staff monitored the effectiveness of care and treatment. They used the findings to make improvements and achieved good outcomes for patients.
- 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 development.
- Doctors, nurses and other healthcare professionals worked together as a team to benefit patients. They supported each other to provide good care.
- Staff treated patients with compassion and kindness, respected their privacy and dignity, and took account of their individual needs.
- Staff supported patients, families and carers to understand their condition and make decisions about their care and treatment.
- People could access the service when they needed it and received the right care promptly.
- 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.
- Leaders had the skills and abilities to run the service. They understood and managed the priorities and issues the service faced. They were visible and approachable in the service for patients and staff. They supported staff to develop their skills and take on more senior roles.
- The service controlled infection risk well. Staff used equipment and control measures to protect patients, themselves and others from infection. They kept equipment and the premises visibly clean.

However:

Diagnostic Imaging department

- Staff did not keep keys to the medicine cupboards in a secure place.
- The medicines cupboard temperature within the clinical room was found to be out of range and we did not see evidence that the high temperatures had been reported to the pharmacist. It was unclear whether the service had received guidance from the pharmacist as to the safety of the medicines stored inside.

Outpatient department

- Staff did not always keep control of substances hazardous to health (COSHH) secure. The service took immediate action to secure the cleaning products after we raised our concerns.
- The storage of bulk waste, waiting for collection, was not in line with guidance.

# Summary of findings

## Our judgements about each of the main services

| Service | Rating | Summary of each main service |
|---|---|---|
| **Outpatients** | Good  | We rated it as Good. See the summary above for details. |
| **Diagnostic imaging** | Good  | We rated it as Good. See the summary above for details. |

# Summary of findings

## Contents

# Summary of this inspection

## Background to Sevenoaks Medical Centre

Sevenoaks Medical Centre is operated by KIMS Hospital Limited. The service registered with us on 19 March 2020. The service provides outpatient clinics, minor treatments, diagnostic and imaging procedures and physiotherapy, to people aged 18 years and above. The centre also provides a private GP service. The services at the centre are offered to NHS, self-paying and privately medical insured patients.

Services are provided over three floors, with a waiting room on each floor.

The centre is registered to provide regulated activities of:

- Family planning
- Treatment of disease, disorder and injury
- Surgical procedures
- Diagnostic and screening procedures

The centre has had a registered manager since registering with the CQC. A registered manager is a person who has registered with the CQC to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements of the Health and Social Care Act 2008 and associated regulations about how the service is managed.

We have not inspected this service before. However, we monitored the service using our engagement and transitional monitoring approach. We did not receive any information of concern about the service prior to the inspection, and there were no serious incidents or safeguarding alerts.

Track record on safety:

- No reported never events
- No serious injuries reported
- No formal complaints received

## How we carried out this inspection

We inspected the service using our comprehensive inspection methodology. We spoke with six patients, 10 members of staff including, consultants, nurses, healthcare assistants, radiographers, and reception staff. We looked at five patient records and observed clinical practice.

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.

## 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.

# Summary of this inspection

**Action the service SHOULD take to improve:**

**Outpatients department:**

The service should ensure all substances hazardous to health are stored and managed in line with regulations.

The service should ensure that waste and materials must be managed in line with current legislation and guidance.

**Diagnostic Imaging department:**

The service should ensure all medicine cupboards are within the correct range of temperature.

# Our findings

## Overview of ratings

Our ratings for this location are:

| | Safe | Effective | Caring | Responsive | Well-led | Overall |
|---|---|---|---|---|---|---|
| Outpatients | Good | Good | Good | Good | Good | Good |
| Diagnostic imaging | Good | Inspected but not rated | Good | Good | Good | Good |
| Overall | Good | Good | Good | Good | Good | Good |

Good

# Outpatients

| | |
|---|---|
| Safe | Good |
| Effective | Good |
| Caring | Good |
| Responsive | Good |
| Well-led | Good |

## Are Outpatients 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 received and kept up to date with their mandatory training. The mandatory training was comprehensive and met the needs of patients and staff. Staff received mandatory training in safe systems, process and practices. They received training mostly through e-learning modules, with some face-to-face sessions, for example, basic and immediate life support training.

All staff we spoke with understood their responsibility to complete mandatory training. They told us they received the necessary mandatory training to do their jobs. Staff showed us the electronic records which showed their compliance with mandatory training. We looked at three staff records and saw all staff were 100% compliant with their training.

Clinical staff completed training on recognising and responding to patients with dementia. All staff had completed online and face to face dementia awareness training.

Managers monitored mandatory training and alerted staff when they needed to update their training. There was an electronic staff record where all training attended was documented. Compliance was monitored centrally, and all staff had access to compliance information so that they could be reminded to attend or complete on-line training. In addition, staff received an email alert when training was due for completion and could view the dates available. This meant individual staff had oversight of their mandatory training compliance.

The overall statutory and mandatory training rates for both permanent and bank staff who work in outpatients was 100%.

### 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.**

Staff received training specific for their role on how to recognise and report abuse. Records showed 100% of all eligible staff had completed safeguarding vulnerable adults level 1, 2, and 3 and safeguarding children level 1.

Staff could give examples of how to protect patients from harassment and discrimination, including those with protected characteristics under the Equality Act. Staff had a clear understanding of how to recognise and report abuse. Including identifying adults at risk of, or suffering, significant harm. Staff had training in equality and diversity.

Staff could identify the safeguarding leads for the service and explain the actions they would take if they had any concerns. The chief nurse was the safeguarding lead for the provider. Named professionals had a key role in promoting good practice within their organisation, providing advice, and expertise for colleagues. The safeguarding referral form was easily assessible on the intranet and staff knew where to find it. Staff told us the safeguarding lead would respond to a request to for support.

Staff knew how to make a safeguarding referral and who to inform if they had concerns. The service had separate policies related to safeguarding vulnerable adults and children. The policy provided guidance for staff, to recognise potential safeguarding issues and raise concerns with related individuals

Staff knew how to identify adults and children at risk of, or suffering, significant harm and worked with other agencies to protect them. Staff knew how to report abuse, including calling the police if there was an immediate risk to safety.

Staff followed safe procedures for children visiting the service. Safe were able to describe how to identify risks of abuse to children that visited the centre. The only children in the department were those attending with an adult as the service did not treat children.

### Cleanliness, infection control and hygiene

**The service controlled infection risk well. Staff used equipment and control measures to protect patients, themselves and others from infection. They kept equipment and the premises visibly clean. However, staff did not always keep control of substances hazardous to health (COSHH) secure.**

Clinical areas were clean and had suitable furnishings which were clean and well-maintained. Staff maintained the standards of cleanliness of the premises well. All areas of the outpatient department were visibly clean and tidy. The waiting areas, consultation rooms and treatment rooms had chairs and couches made with an impermeable, wipeable material to promote effective cleaning. All furnishings throughout the department were well maintained, clean and intact.

We saw for May 2022, that 100% of patients who responded to feedback, rated the cleanliness of the department as good or better.

The service kept substances hazardous to health in appropriate cupboards. The COSHH cupboard in the dirty utility was locked and inaccessible to the public. However, we found the cleaners cupboard unlocked, along with the COSHH cupboard. People using the premises had a potential health risk from hazardous substances. We raised our concerns with the registered manager, who told us that the chemicals stored in the cupboard had been reviewed and were not hazardous to health.

Following inspection, we received confirmation that all products had been reviewed and moved into the housekeeping room for easier access. All other low risk products and consumables had been moved to storage areas. The COSHH cupboard in the housekeeping room had now been clearly labelled as in use, locked, dated and the changes

communicated with internal and external stakeholders. This complied with the management of Control of Substances Hazardous to Health Regulations 2002 substances. These regulations provide a framework to help protect people in the workplace against health risks from hazardous substances used directly in the workplace, for example cleaning chemicals.

Staff followed infection control principles including the use of personal protective equipment (PPE). PPE, such as gloves, aprons and masks were readily available for staff, to ensure their safety when performing procedures. All staff were 'bare below the elbows' and wore PPE correctly in line with the service's policy.

There were enough handwashing sinks and alcohol-based hand sanitiser within all areas we visited. During our inspection we saw staff either wash their hands or used the alcohol-based hand sanitiser correctly in line with the 'five moments of hand hygiene' and National Institute for Health and Social Care Excellence (NICE) quality statement (QS) 61, statement three. Hand washing posters were on display.

Staff completed hand hygiene audits to monitor compliance monthly. The service sent us audits for February, March and April 2022. Records showed outpatients' staff had achieved 100% compliance for February and April 2022. There was one episode of non-compliance for March. Where there were episodes of non-compliance, we were told that members of staff were spoken with immediately.

The service managed COVID-19 infection prevention and control measures well. Reception staff asked people entering the centre about symptoms of COVID-19 or contact with anyone with symptoms. We saw visitors to the centre were reminded to clean their hands. Visitors were also offered face masks, if they did not have one of their own.

The service had an in-date infection prevention and control policy to minimise the risks to staff, patients and visitors developing a healthcare associated infection.

Single use items of sterile equipment were readily available in all areas we checked.

Staff managed sharp waste in a way that reduced the risk of spreading infections. Sharps bins were dated and available at the point of patient care. Temporary closure mechanisms were used when not in use, this meant if the container fell over the contents would not spill out.

Staff cleaned equipment after patient contact and labelled equipment to show when it was last cleaned. Equipment was visibly clean. Staff had a good understanding of responsibilities in relation to cleaning of equipment. Disinfection/ detergent wipes were available to clean equipment between patient contact. Good supplies were seen across all areas we visited. During our inspection, we saw staff cleaning equipment after it had been used on patients.

Disposable curtains were in use. Each curtain had a label showing the date it was changed. We looked at six and saw all were changed in the last six months.

The service monitored their effectiveness at reducing the risk of spreading infections. The registered manager from the centre attended the quarterly infection prevention and control committee. This included discussion on training compliance, audit performance, antimicrobial stewardship, and updates to infection prevention and control policy.

### Environment and equipment

**The design, maintenance and use of facilities, premises and equipment kept people safe. Staff were trained to use them. Staff managed clinical waste well.**

Good

# Outpatients

The design of the environment followed national guidance. The environment layout was in line with health building note guidance. All rooms had appropriate space for examination and treatment. Each consulting and treatment room had hand washing facilities.

Patients attending the centre were booked in at the reception desk which had clear plastic screens to help protect patients and staff from the spread of COVID-19.

All waiting areas were spacious and light with wipeable chairs. There was a wheelchair available to meet patients needs, and a lift to take patients to other floors. There was a drinking water dispenser in all the waiting areas, and a hot drinks dispenser in the ground floor waiting area.

Staff carried out daily safety checks of specialist equipment. There were emergency resuscitation equipment on each floor and stored within a short distance to all areas. We checked two resuscitation trolleys which were tamper evident. All equipment and drugs were within their use-by dates. We also saw checklists for all trolleys showing evidence staff checked the trolleys weekly. On the weekly check the tamper proof seal was removed, and all items checked. A new tamper proof seal was applied following the check, the number on the seals were recorded.

The service had suitable facilities to meet the needs of patients' families. The outpatient's department was set over three floors and had a waiting room on each floor. This allowed patients to wait closer to the room used by their consultant. The department had 17 consultation rooms, used by consultants to see patients. The consulting rooms were tidy and equipped with a desk, chairs and a couch area for examination.

We saw for May 2022, that 100% of patients who responded to feedback, rated the appearance and comfort of the waiting room environment as good or better.

There were two treatment rooms, one of which was used for minor procedures. The treatment rooms were tidy and equipped with a couch, portable oxygen and suction. There were trolleys in each room, which contained single use sterile disposable items, such as syringes, needles and wound dressings. All of which were in date.

The physiotherapy department consisted of a gym, where individual or group rehabilitation sessions were held. The gym was tidy and well equipped.

The service had enough suitable equipment to help them to safely care for patients. Staff we spoke with had no concerns about equipment availability. If any equipment required repair, they reported it and it was fixed quickly. Staff were aware of the process for reporting faulty equipment.

Staff received training on the use of medical equipment. Staff told us they were currently undertaking training on the decontamination of nasendoscopes, as an ear, nose and throat (ENT) clinic will be starting at the centre shortly. This meant the centre ensured staff were safe and competent to use medical equipment on patients

Point of care testing machines such as blood sugar level monitors, were quality checked and managed appropriately.

Staff disposed of clinical waste safely. Staff correctly sorted waste into clinical and non-clinical waste. The service had both clinical and non-clinical waste bins, with clear indication about what should be disposed of in them. All bins we looked in; waste was segregated correctly. This was in line with guidance.

Good

# Outpatients

The bulk storage area for waste waiting for collection was secure and located away from public areas. The storage compound was locked and inaccessible to the public. However, the bulk clinical waste storage container was not locked. In addition, we saw that clinical waste and sharps bins were stored in the same container. This was not in line with guidance.

### Assessing and responding to patient risk

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

The service assessed and responded to patient risks. The department held daily huddles, where risks or incidents were discussed. All staff on duty that day attended the meeting. The meetings discussed the pressures, risks and staffing at the centre. Safety huddles gave clinical staff opportunities to discuss and escalate any operational concerns.

Staff knew about patients with a medical history that represented an increased risk. Staff assessed patients before they attended for a minor procedure. Risk assessments were completed which included the patients' medical history to identify any associated risks. Staff on the day of the procedure had access to these assessments and confirmed if the patient was still suitable for their procedure as an outpatient.

Staff responded promptly to any sudden deterioration in a patient's health. Generally, acutely unwell patients would not attend the outpatient's department. However, patients could still become unwell while in the department. There were emergency procedures in place in the outpatient department including call bells to alert other staff in the case of a deteriorating patient or in an emergency. The centre assigned staff at the daily huddle to specific roles in the event of an emergency. This meant on every shift there was a designated person to fulfil each role if a patient became unwell.

Staff had all received basic life support training and there were processes at each site to manage medical emergencies. Records showed 100% of all eligible staff had completed basic life support training and immediate life support training.

Staff were able to explain what action they would take in the event of an emergency and described a recent event where a patient had become unwell, and the actions they had taken.

Staff told us if a patient was identified as having any health-related risks in a public area, such as the waiting room, then they would move the patient from the main waiting area to one of the consulting rooms. They would make sure a trained staff member would remain with the patient.

Patients who became medically unwell in outpatients would be transferred to the local acute NHS trust in line with the emergency transfer policy. Staff reported this rarely happened.

Staff shared key information to keep patients safe when handing over their care to others. When the service referred patients to other providers, including the patient's GP, for the next step in the patients care pathway, the service ensured all relevant information was shared. In addition, consultants wrote to the patient's GP to inform them.

### Staffing

**The service had enough staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed and adjusted staffing levels and skill mix, and gave bank and agency staff a full induction.**

There are no agreed national guidelines as to what constitutes 'safe' nursing levels in outpatients' departments.

Good

# Outpatients

The service had enough nursing and support staff to keep patients safe. The service employed seven members of nursing and support staff. Three registered nurses, four customer service administrators and one business office assistant. The service ensured nursing staff were not working alone at any time and that administration staff were present until nursing staff finished work.

Staff told us they had enough staff to keep patients safe. Patients said there were enough staff to meet their needs. There were enough staff numbers in the physiotherapy department to cover the outpatient's physiotherapy services. The service had enough reception staff to book in patients for their outpatient appointment.

The manager could adjust staffing levels daily according to the needs of patients. All clinics were booked in advance, and managers could review staffing levels in advance. Staff told us they worked flexibly to meet the needs of their patients.

The service had low vacancy rates. The service had recently recruited new nursing staff and had low vacancy rates. The service had two current vacancies, one registered nurse and one healthcare support worker.

The outpatients had access to a range of medical consultants, who were granted practising privileges to provide an outpatient service at the centre. Practicing privileges is a system of checks and arrangements whereby doctors can be granted practice in independent hospitals without being directly employed by them. Most of the consultants practising in the centre also worked within the NHS.

The service had low reducing sickness rates. The outpatient's department over the last 12 months had a sickness rate of 11.56% for all staff. This was predominantly due to absences caused by the pandemic.

Managers limited their use of bank and agency staff and requested staff familiar with the service. The service used one registered nurse and one healthcare assistant which they used as bank staff. Both of these staff worked regularly at the centre, and were familiar with the systems, processes and policies.

Managers made sure all members of staff including bank and agency staff had a full induction and understood the service. The service gave all new members of staff a full induction tailored to their role and experience before they started work. The induction programme included information about staff roles and responsibilities, and any mandatory and role-specific training. On the day of inspection, a new member of staff was undertaking their induction to the centre and was being shown specific elements to their role. They told us that they felt the induction met their needs, and that everyone "helpful", "supportive" and "patient".

### Records

**Staff kept detailed records of patients' care and treatment. Records were clear, up to date, stored securely and easily available to all staff providing care.**

Patient notes were comprehensive, and all staff could access them easily. The provider had an up-to-date medical records policy for staff to follow. All the information needed to deliver safe care and treatment was available to the relevant staff in a timely and accessible way. Records were both paper based and electronic.

Records were stored securely. No medical records were kept on site. Staff we spoke with told us the reservations team prepared the medical records for each clinic list every day. The medical records were transferred to the centre, via a courier. We saw medical records were stored in a lockable cabinet which was locked at the time of our inspection. This indicated records were being kept securely in this area.

The electronic patient records were only accessible through password protected systems to authorised staff. Staff could view and share patient information. Computers were locked when not in use.

We looked at five sets of medical records. All records were legible, signed and dated. Records contained all the relevant information, including a referral letter and any procedures or discussion that had taken place.

Medical records were audited regularly to ensure compliance with minimum record-keeping standards. We looked at the medical records audit for April 2022, that randomly sampled five sets of records, which showed 100% compliance.

### Medicines

**The service used systems and processes to safely prescribe, administer, record and store medicines.**

Staff followed systems and processes to prescribe and administer medicines safely. The service had an up-to-date medicines management policy in place, which included the arrangement for the ordering, receiving, storage and prescribing of medicines.

Staff stored and managed all medicines and prescribing documents safely. The medicine cupboards we inspected were locked, secure and all stock was within expiry dates. The service did not keep or administer controlled medicines. We saw keys to all lockable cupboards were labelled clearly and stored in a key safe.

Medicines requiring refrigeration were stored appropriately in a medicine fridge. The temperatures were checked and recorded to ensure medicines were stored within the correct temperature range and were safe for patient use. Staff understood the procedures to follow if the fridge temperature was out of range.

Staff reviewed each patient's medicines regularly and provided advice to patients and carers about their medicines. Patients were given advice about the medicines they had been prescribed for use at home. During our inspection we sat in on patient consultations. We saw that staff discussed and explained medicine options, including the risks and side effects to patients.

Medicine management were audited regularly to ensure compliance with minimum standards. We looked at three medicine management audits between 1 June and 21 July 2022, which showed 100% compliance with medicine management minimum standards.

Staff completed medicines records accurately and kept them up to date. Doctors hand wrote prescriptions on private prescription forms. We saw each prescription had a serial number on it. Doctors could request individual prescription forms during clinic sessions and a registered nurse would then issue the form. We noted unused prescriptions were checked and stored in a locked drawer at the end of clinic. This reduced the chance of prescription forms being lost or stolen.

Resuscitation 'crash' trolleys containing emergency medicines were accessible if needed in an emergency. Checks ensured emergency medicines were available and safe to be used if needed.

Medical gases were stored securely in a separate cupboard. Empty and full cylinders were clearly labelled and kept separately in the cupboard. All oxygen cylinders were in date and staff checked these daily whilst the clinic was open. There was no piped oxygen available at the centre, as medical gases were not routinely used.

There were processes in place for the stewardship of antimicrobials. The pharmacy manager was the antimicrobial guardian and undertook monthly audits across all settings within the provider. The data was collated in terms of percentages of compliance with the organisation's antimicrobial guidance. The information was recorded on the organisational dashboard, which was reviewed monthly, via the quarterly infection prevention and control committee and with the consultant microbiologist.

The centre did not have a pharmacy dispensary on site. This was provided by provider's main site. Staff told us the pharmacy team was readily available to offer support and advice to both staff and patients, maintained adequate stock levels, and dispensed prescriptions, for procedures at the centre, in a safe and timely manner.

### Incidents

**The service managed patient safety incidents well. Staff recognised incidents and near misses 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. Managers ensured that actions from patient safety alerts were implemented and monitored.**

There were effective systems in place to report incidents. Incidents were monitored and reviewed; staff gave examples of learning from incidents.

Staff knew what incidents to report and how to report them. An electronic based system was used to report incidents. Staff demonstrated how they would access and use the electronic incident reporting system which showed they were confident in using the system.

Staff raised concerns and reported incidents and near misses in line with the service's policy. We saw in the staff survey dated September/October 2021 that only 67% of staff who responded felt they were treated fairly when involved in an error, and 67% received feedback. In addition, only 69% of staff who responded felt there was an emphasis on putting it right and not blaming others.

However, all staff told us they were encouraged to report incidents and they were confident about reporting issues or raising concerns with senior staff and gave us examples where they had done this. They were aware of the types of incidents to report. Staff told us they made time to report incidents. Staff also said there was an open no blame culture for reporting incidents.

Staff received feedback from investigation of incidents. Staff confirmed they received feedback on incidents they reported including investigations and any outcomes or actions following it. We saw incidents were discussed at the daily huddle meetings, and at the weekly departmental meetings. We looked at the three department meeting minutes and saw that feedback and lessons learned were shared.

We saw in the last year for the centre, staff had reported 42 incidents, with 33 reported as no harm and 9 reported as low harm. There were no moderate or severe harm incidents reported.

The service had no never events. The service had reported no never events in the last year. A never event is a serious incident that is wholly preventable as guidance, or safety recommendations providing strong systemic protective barriers, are available at national level, and should have been implemented by all healthcare providers. They have the potential to cause serious patient harm or death, has occurred in the past and is easily recognisable and clearly defined.

Good

# Outpatients

The service had no serious incidents in the past 12 months.

Staff understood the duty of candour. They were open and transparent and gave patients and families a full explanation when things went wrong. Staff said they knew their responsibility to be open and honest with patients and relatives when things went wrong. They told us talking openly with patients when things had gone wrong helped their patients understand and allowed them to ask questions.

Managers investigated incidents thoroughly. There were five members of staff who had training in investigation of incidents. When an incident was reported it would be assigned to an investigator. We looked at three incident records which all had detailed investigations. Managers had identified any additional learning to further improve patient care beyond the direct cause of the incidents. Once the incident had been completed, it would be shared at the departmental meetings.

## Are Outpatients effective?

Good

We rated it as good.

### Evidence-based care and treatment

**The service provided care and treatment based on national guidance and evidence-based practice. Managers checked to make sure staff followed guidance. Staff protected the rights of patients subject to the Mental Health Act 1983.**

Staff followed up-to-date policies to plan and deliver high quality care according to best practice and national guidance. Patient pathways and policies followed National Institute for Health and Social Care Excellence (NICE). We checked a variety of policies, including infection prevention and control, medicines management and safeguarding vulnerable adults. We saw they were in date, referenced appropriate legislative standards and guidelines and there was a system of reviewing including a timetable for updating the polices and an allocated accountable person.

The service monitored the latest guidance to ensure policies and procedures were up to date. The provider's governance team disseminated new national guidance to staff through head of departments. The medical advisory committee (MAC), including consultants, assessed their relevance before dissemination.

Staff followed up to date policies to plan and deliver high quality care according to best practice and national guidance. Polices and guidance were accessed on the provider's intranet. Staff showed us how they accessed them.

We looked at the MAC meeting minutes for March 2022, they reviewed clinical performance, incidents and complaints.

The service participated in the provider's audit programme which demonstrated compliance and identified areas for improvements to patient care, treatment and outcomes. Results from audits were monitored and discussed at a variety of meetings including the provider's quality and governance and MAC and at corporate level. Any required actions were quickly shared with the department.

Good

# Outpatients

Staff protected the rights of patients subject to the Mental Health Act and followed the Code of Practice. Staff had a good understanding of the Mental Health Act and what their responsibilities were to protect patients subject to the Mental Health Act.

### Nutrition and hydration

**The service ensured patients had access to water and hot drinks during their appointment.**

Staff made sure patients had enough to drink. The service had water dispensers available in the all three waiting areas for patients to use.

In the main reception on the ground floor there was a machine where patients could make hot drinks free of charge.

### Patient outcomes

**Staff monitored the effectiveness of care and treatment. They used the findings to make improvements and achieved good outcomes for patients.**

The provider participated in relevant national clinical audits. At a corporate level, the provider participated in national audit programmes such as the National Joint Registry, patient reported outcome measures (PROMS), and patient reported experience measures (PREMS). Data from these audits provided an indication of the outcome of quality of care delivered by the service. However, there were no national audits relevant to this outpatient department.

The service submitted data to the Private Healthcare Information Network (PHIN), for benchmarking against other independent providers. PHIN is an independent source of information about private healthcare, aiming to enable patients to make better-informed choices of care provider. Outcomes for patients were positive and as expected.

Managers used information from the audits to improve care and treatment. The provider's clinical audit schedule outlined, when, how often and who would undertake the audits in various areas. There were a number of local audits planned for outpatients. These included auditing of consent, standards of record keeping, medicine management and hand hygiene.

In addition, results from audits were reported as a dashboard of audit performance across the provider. The dashboard was reviewed and discussed at the monthly quality and governance committee.

Managers shared and made sure staff understood information from the audits. Audit results were discussed at team meetings and any required improvements to performance were identified. Improvement is checked and monitored. If any non-compliances were found, measures were put in place and a repeat audit was undertaken to check compliance.

Outcomes for patients were positive, consistent and met expectations. We saw for May 2022, that 100% of patients that responded, rated their experience of the service as very good or good. This showed patients expectations were being met.

### 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 development.**

Good

# Outpatients

Staff were experienced, qualified and had the right skills and knowledge to meet the needs of patients. Staff had regular training to ensure they had the right skills and knowledge to keep patients safe. We saw in the staff survey dated September/October 2021 that 85% of staff felt they had access to learning and development to do their job well and were aware of the process to request additional training.

Training and education were embedded at the centre. Staff we spoke with told us they had completed competency assessments to make sure they had the skills and knowledge to carry out the roles they are employed to do. Regular study days were provided, and staff said they were encouraged to undertake continuing professional development, to support revalidation and progression in their career. We saw the new training prospectus that showed all the additional training that staff can undertake. Staff told us this training is open to everyone including bank staff.

Managers identified any training needs their staff had and gave them the time and opportunity to develop their skills and knowledge. We saw that 93% of staff at the centre had an up-to-date appraisal. All staff were required to have annual appraisals. Staff we spoke with told us they were useful and were a two-way process and were able to discuss any training or development needs.

We observed that staff were professional and competent in their interactions with colleagues, patients, and their relatives/carers on this inspection. Patients we spoke with told us they felt staff were appropriately trained and competent to provide the care they needed.

Managers gave all new staff (including bank staff) a full induction tailored to their role before they started work. All staff had completed a human resources checklist which included relevant recruitment checks and mandatory training. The service supported staff with a tailored induction based on their skills, competency and job role.

Managers made sure staff received any specialist training for their role. We saw a variety of additional specialist training was available to staff. One member of staff spoke to us about additional training they were attending, as they hoped to progress to a more senior role.

Managers made sure staff attended team meetings or had access to a full set of notes when they could not attend. We saw notes from meetings were available for staff. This meant staff who were not able to attend were able to see what was discussed at these meetings.

The provider required all consultants requesting practising privileges to submit an initial application form and CV. The medical director and /or chief executive then interviewed applicants. The medical director discussed with the lead for consultant business development as to whether the consultant's service was needed and whether their scope of practice fitted with KIMS Hospital Limited's business plan. The provider then requested proof of identity and other documentation to provide evidence of their competencies and scope of practice. This included evidence of registration with the General Medical Council (GMC), copies of professional qualification certificates, a full up-to-date appraisal and appropriate indemnity insurance. The medical advisory committee reviewed the application and would make a decision on whether to grant practising privileges.

Medical staff received clinical supervision from their substantive employer and the provider received evidence of this.

### Multidisciplinary working

**Doctors, nurses and other healthcare professionals worked together as a team to benefit patients. They supported each other to provide good care.**

Good

# Outpatients

We observed staff worked well together during our inspection. Nurses, healthcare assistants and doctors spoke of teamwork and joined up working, in a way that enhanced good working relationships as well as improved patient safety.

Staff told us they were proud of good multidisciplinary team working, and we saw this in practice. Staff were courteous and supportive of one another. Staff worked hard as a team to ensure patient care was safe. All staff told us managers were approachable and they felt comfortable asking them questions and raising a concern.

Staff held regular and effective multidisciplinary meetings to discuss patients and improve their care. There was a daily 'huddle' meeting in which all staff or representatives at the centre attended. The meeting was held at 8.30am every morning the centre was open. The huddle included discussion on patient numbers, staffing, risks, incidents or concerns.

Staff worked across health care disciplines and with other agencies when required to care for patients. Staff told us they worked well with others within their own discipline and with staff from other disciplines. Staff said there was good collaborative working, which had improved since the centre had changed to being run by KIMS Hospital Limited.

Staff also spoke about positive working relationships with the provider's main site. Staff were redeployed there during the pandemic and described how this had strengthened working relationships.

Patients could see all the health professionals involved in their care at one-stop clinics. There was a one-stop breast clinic at the centre.

### Seven-day services

**Key services were available seven days a week to support timely patient care.**

The centre opened Monday to Friday 8am to 8pm. Staff cover was provided during these times. The service booked appointments in line with patient need and availability of clinical staff.

Patients were able to have same day or next day appointments.

The pharmacist team provided a daily service Monday to Friday between 8.30am and 5pm, at the main provider site.

### Health promotion

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

The service had relevant information promoting healthy lifestyles and support. The service had removed the majority of health promotion and information leaflets and booklets from display in main areas during the pandemic. Staff told us that information was kept in the department and would be given to the patient based on individualised need. This included information on wound care, physiotherapy, and reduction of stress and dietary information.

During our observations of patient interactions, we saw staff explained and gave patients health promotion advice.

### 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.**

Good

# Outpatients

Staff understood the relevant consent and decision-making requirements of legislation and guidance, including the Mental Health Act, Mental Capacity Act 2005 and the Children Acts 1989 and 2004 and they knew who to contact for advice. Staff received and kept up-to-date with mandatory training on the Mental Capacity Act and Deprivation of Liberty Safeguards. Staff were aware of the provider's polices for Mental Health. They understood how and when to assess whether a patient had the capacity to make decisions about their care.

Staff gained consent from patients for their care and treatment in line with legislation and guidance. Staff demonstrated a good understanding of the legislation and best practice regarding consent, and we saw them follow this in practice. We observed multiple occasions where staff obtained consent prior to examining or carrying out care and treatment on patients. Patients we spoke with confirmed this.

Staff clearly recorded consent in the patients' records. We looked at five written consent forms. We saw they were fully completed and signed. In addition, we looked at three electronic records that nursing staff use when undertaken wound dressing changes with patients, which showed they had asked for consent prior to undertaking the procedure.

Staff completed consent audits to monitor compliance every other month. Records showed outpatients staff had achieved 100% compliance over the last three audits.

## Are Outpatients caring?

Good

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. There was a strong visible person-centred culture to providing care in the service. Patients were treated with dignity and respect. All staff we spoke with were very passionate about their roles and were dedicated to making sure patients received the best individualised patient-centred care possible.

Patients said staff treated them well and with kindness. Staff introduced themselves, and their role, and asked patients how they wanted to be addressed. We saw them explain who they were and what was going to happen in a discreet way.

During our inspection we saw a member of staff who was supporting a patient attending the centre for a blood test. The patient told staff that they had a needle phobia. We saw staff take their time and explain what will happen and made sure they were comfortable before taking bloods.

Staff took time to interact with patients in a respectful and considerate way. All the patients we spoke with were highly complementary about the care and support they received. They said that the staff were "lovely" and "kind", and they felt they were there, if needed, to provide help and support.

Good

# Outpatients

Staff followed policy to keep patient care and treatment confidential. People were always treated with dignity by all those involved in their care, treatment and support. Patients' privacy and dignity needs were understood and always respected. We saw for May 2022, that 100% of patients, who responded to feedback, answered 'yes always' when asked if they were treated with dignity and respect.

Staff understood and respected the individual needs of each patient and showed understanding and a non-judgmental attitude when caring for patients. There was a strong, visible person-centred culture, to care at the service. Staff were highly motivated and inspired to offer care that is kind and promotes people's dignity. Relationships between people who use the service and staff were witnessed to be strong, caring, respectful and supportive. We observed staff took the time to interact with people who used the service in a polite, respectful and considerate way.

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 supported patients who became distressed in an open environment and helped them maintain their privacy and dignity. Staff told us they took patients into a private room, sat with them, to listen, provide emotional support and provide them with a quiet space if they preferred.

Staff gave patients and those close to them help, emotional support and advice when they needed it. The centre had arrangements to provide support when needed, which included help from specialists such as breast care nurses or counselling services.

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. All treatment and consultation rooms were private and could be used to deliver any bad news, which may adversely affect a patient's future. Staff told us the consultants would inform them if they were about to break bad news to a patient so they would be available to support them. They spent as much time as was needed with the patient and those close to them.

Staff undertook training on breaking bad news and demonstrated empathy when having difficult conversations. Staff told us about how they showed empathy towards their patients when breaking bad news to them. They would attend these conversations to provide additional support to patients. They said if patients had received bad news they would comfort and sit with them after their clinic appointment in a private room. We saw that staff had undertaken additional training in breaking bad news.

### Understanding and involvement of patients and those close to them

**Staff supported 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 felt well informed and staff gave them the opportunity to ask questions. Patient feedback from May 2022 showed that 100% of patients answered 'yes definitely' when asked if things were explained in a way they could understand.

Good

# Outpatients

Staff talked with patients, families and carers in a way they could understand, using communication aids where necessary. The service identified where patients require additional communication support. The service organised support to ensure patients could understand, for example, arranging use of interpreters.

Patients knew who to contact if they were worried about their condition or treatment following their appointment. For example, we saw patients were given information about wounds, and contact numbers if they have concerns. When we reviewed the nursing records, we saw that nursing staff acted upon concerns, including actions such asking them to reattend the centre.

Following appointments, patients understood how and when they will receive results or follow up appointments. During our inspection we sat in on patient consultations, we saw the consultant fully explained next steps, including test results. If a follow up appointment was required, patients were able to book this prior to leaving the centre.

We saw for May 2022, that 100% of patients, who responded to feedback, rated the helpfulness of staff and consultants as good, very good or excellent.

Patients and their families could give feedback on the service and their treatment and staff supported them to do this. Patients were able to give feedback via feedback cards following their appointment, or via an app which they were encouraged to provide feedback on.

Patients gave positive feedback about the service. Patient feedback was overwhelmingly positive, complimenting the staff, environment and the ease of accessing the service.

## Are Outpatients responsive?

Good

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. It also worked with others in the wider system and local organisations to plan care.**

Managers planned and organised services, so they met the needs of the local population. The service organised clinics based on consultant availability, patient demand and local health system pressures. Clinics were flexible and patients were offered a choice of appointments based on the consultant chosen and the service aimed to ensure the patient saw the same consultant throughout their pathway. The service offered same or next day appointments.

The service held regular meetings with healthcare providers and local commissioners to determine how they could support the local health economy. For example, they are currently working with a local NHS provider to introduce a new orthopaedic pathway at the centre. Patients were given the choice to have their initial appointment, imaging and diagnostic, preoperative physiotherapy, pre-assessment and post-op physiotherapy and follow up all at centre. Patients would only have to attend the main hospital for their procedure.

Facilities and premises were appropriate for the services being delivered. The centre was easily accessible by public transport and car or foot. Waiting areas were comfortable. Treatment areas were spacious.

Good

# Outpatients

Managers ensured that patients who did not attend (DNA) appointments were contacted. The service told us due to the volume of patients that are currently being seen at the location, DNAs are managed on a case by case basis. The service reported a low DNA rate with only one reported in the 12 months before our inspection. However, as activity at the site increased a new system to help monitor this is due to be implemented.

The service had systems to help care for patients in need of additional support or specialist intervention. Staff assessed people's needs and made sure that support was there when needed, for example, staff invited carers to the centres to assess the environment to make sure it was adequate for the patient.

### 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.**

Staff made sure patients living with mental health problems, learning disabilities and dementia, received the necessary care to meet all their needs. Staff in outpatients told us they rarely encountered patients living with dementia or patients who lacked capacity. Staff told us how they supported patients living with mental health problems, learning disabilities and dementia. Staff gave us an example where they comforted a patient with anxiety in a private room. Staff told us about taking extra time to ensure patients living with dementia understood the information provided to them.

Staff understood and applied the policy on meeting the information and communication needs of patients with a disability or sensory loss. The service had access to large print patient information leaflets to ensure patients with limited vision were still able to access these resources. The registered manager told us they were looking to see if they can get access to information resources in braille.

The service had facilities to meet the needs of patients with reduced mobility and patients using a wheelchair. There was step free access to the centre, and a wheelchair available for use if needed. There was a lift available to patients with reduced mobility or using a wheelchair to access other floors. In the centre there were level floors with no steps between the entrance and the clinic rooms. The waiting areas had toilets which were accessible for wheelchair users.

One nurse told us the centre also accommodated assistance dogs if required and gave an example of a patient who attends with a guide dog. Assistance dogs are trained to aid or assist an individual with a disability. For example, guide dogs to assist the blind or visually impaired, or hearing dogs that assist people who are deaf or hard of hearing. Others include medical response dogs, which assist an individual who has a medical disability such as hypo alert dogs who alert their diabetic owners of dangerous changes in their blood sugar levels.

Hearing loops were available in the waiting area, which helped those who used hearing aids to access the service on an equal basis.

Managers made sure staff, patients, loved ones and carers could get help from interpreters or signers when needed. Staff had access to a telephone interpreting service, and this worked to ensure they had an interpreter for all patients that needed one. Staff said they would not use patients' relatives or friends as interpreters. This was in line with best practice.

The service had information leaflets available in languages spoken by the patients and local community.

Good

# Outpatients

Patients had a choice of a male or female staff who could act as chaperone, if required. This indicated that individual preferences were met.

### Access and flow

**People could access the service when they needed it and received the right care promptly. Waiting times from referral to treatment and arrangements to admit, treat and discharge patients were in line with national standards.**

Managers monitored waiting times and made sure patients could access services when needed and received treatment within agreed timeframes. Patients were at the centre of the decisions made about appointments. Patients chose appointments dates and times that suited them. Patients booked appointments with the service by phone or through the website.

The centre was open Monday to Friday, 8am to 8pm. Consultants had regular slots when they held their clinics, however if patients needed to attend on a different day the department arranged for them to either see another consultant with the same speciality or see their consultant at another location. The centre did not provide an emergency service, but same day and next day appointments were arranged for patients when needed.

Patients we spoke with said they had their first appointment within days of referral. They also reported that they did not wait long to see a nurse or a doctor when they attended for a clinic.

The centre mainly treated private patients, but also treated NHS patients through local contracts with NHS trusts and commissioners in Kent. This allowed local people to receive NHS-funded care at the centre. Between July 2021 and June 2022, we saw that 55% of patients were privately medically insured, 45% were self-pay and 1% were NHS funded.

Managers and staff worked to make sure patients did not stay longer than they needed to. The clinics ran on time and staff informed patients when there were disruptions to the service. All patients we spoke with said there was minimal waiting time when visiting the clinic.

Managers worked to keep the number of cancelled appointments to a minimum. When patients had their appointment or treatment cancelled last minute, managers made sure they were rearranged as soon as possible. Staff tried to be flexible to the patients' needs while rearranging to rebook these patients without excessive delays.

Reception staff greeted patients as they arrived at the centre, checked them in on the computer system, and directed them to the waiting area closest to the clinic room being used by their consultant. We saw patients were seen quickly after arriving at the centre. On the day of inspection, the centre was calm and well organised.

Staff arranged for patients requiring follow up appointments to be supported to book these before leaving the department. Staff arranged, where possible, for outpatients appointments, physiotherapy appointments and any tests to be undertaken on the same day to reduce the number of times patients needed to travel to the centre.

### Learning from complaints and concerns

**It was easy for people to give feedback and raise concerns about care received. The service treated concerns and complaints seriously, investigated them and shared lessons learned with all staff. The service included patients in the investigation of their complaint.**

Good

# Outpatients

Staff understood the policy on complaints and knew how to handle them. Staff we spoke with told us they always tried to address complaints or concerns immediately to see if they could resolve any issues before concerns escalated to become formal complaints

Managers investigated complaints and identified themes. If a complaint could not be resolved, a member of staff would be designated to the concern and had overall responsibility for responding to all written complaints. The service acknowledged complaints within three working days of receiving the complaint with an aim to have the complaint reviewed and completed within 20 days. There was an expectation that complaints would be resolved within 20 days. If they could not, a letter was sent to the complainant explaining why.

The centre received 19 complaints between July 2021 and June 2022. It was unclear from the information provided how many were answered within the identified time frame. During inspection, we looked three complaints all of which had a detailed investigation and response.

No complaints had been referred to Parliamentary and Health Service Ombudsman (PHSO) or the Independent Sector Complaints Adjudication Service (ISACS).

Managers shared feedback from complaints with staff and learning was used to improve the service. Staff told us they received feedback on any concerns or compliments about the service. Feedback was shared at the weekly department meetings.

Patients, relatives and carers knew how to complain or raise concerns. Patients we spoke with told us they had no concerns about the service provided. Information for patients on how to make a complaint is available for patients at the location and on the main website.

## Are Outpatients well-led?

Good

We rated it as good.

### Leadership

**Leaders had the skills and abilities to run the service. They understood and managed the priorities and issues the service faced. They were visible and approachable in the service for patients and staff. They supported staff to develop their skills and take on more senior roles.**

Leaders had the skills and abilities to run the service. The registered manager had responsibility for overall management of the centre. There was a simple management structure with clear lines of responsibility and accountability. The registered manager was supported by a lead for each department.

Leaders had a good understanding of the services they managed. They could explain clearly how the teams worked to provide high quality care. Staff told us they felt well supported by leaders. They felt there was a clear management structure within the team and leaders and senior staff were very approachable. If there was any conflict within the service, they would go to either their manager or the registered manager and seek support.

Good

# Outpatients

There was evidence of good local leadership. Leaders had the skills, knowledge, integrity and experience to deliver good quality care at local levels. Staff told us leaders operated an open-door policy and they could discuss concerns. The registered manager told us they had moved their office from the top floor of the centre to one on the ground floor, so they were more accessible to staff. The registered manager worked closely with other services within the provider and had a good understanding of the priorities for the service and the challenges faced.

Leadership development opportunities were available, including opportunities for staff below team manager level. We saw a member of staff had been supported to develop further leadership skills and a leadership course was available to staff to develop.

Leaders were visible in the service and approachable for patients and staff. Staff said that senior managers were supportive. Staff reported there was clear visibility of members of the senior leadership team throughout the service, and on the day of inspection we saw the chief nurse was on site. Staff could explain the leadership structure within the centre. All nursing staff spoke highly of the registered manager as a leader and told us they received good support. We observed good working relationships within the team.

We met with the registered manager, consultants, registered nurses, healthcare assistants, and receptionist staff during the inspection and found they were organised and demonstrated good and supportive teamwork and leadership. They were knowledgeable about the centre's performance against the priorities and the areas for improvement.

### 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. Leaders and staff understood and knew how to apply them and monitor progress.**

The provider's mission was to provide the highest quality of care in a world-class clinical environment for the people of Kent. The mission was underpinned by a set of values; People, Team, Caring, Confident, Integrity, Value and Dynamic.

The provider's strategy was a process of continuous measurable improvement through existing pathways, to put patients at the centre of everything the provider does.

Staff spoke about providing high quality care, which supported the provider wide vision of ensuring patient-centred care.

Staff told us the mission and values were discussed regularly and described how they tried to incorporate them into their working day. We saw in the September/October 2021 staff survey that 100% of staff who responded said they shared the same values as the organisation.

In addition, we saw that 100% of staff who responded agreed with the statement "I believe that the care and safety of our patients and service users is truly at the heart of everything we do".

### 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.**

The service promoted a positive, inclusive and collaborative culture that supported and valued staff. There was a sense of common purpose based on shared values.

Good

# Outpatients

Staff we met were welcoming, friendly and helpful. It was clear that an open and transparent culture had been established where the emphasis was on quality of care delivered to the patients. Staff we spoke with felt supported, respected and valued in their working environments. Staff felt listened to and said they worked well as a team. Openness and honesty were encouraged at all levels and staff said they felt able to discuss and escalate concerns.

Staff we spoke with expressed pride and commitment working for the service. Staff reported the team worked effectively together, with staff respecting each other and working together to provide the best possible care and treatment to patients.

There was strong collaboration, team-working and support across all functions and a common focus on improving the quality and sustainability of care and people's experiences. We found the care and service delivered at the service showed a strong cohesive team approach to work. All staff told us they felt valued in their roles and felt very much part of the team.

There was a culture of learning and development, innovation and creativity within the service.

The service had arrangements to promote the safety and wellbeing of staff.

The service promoted equality and diversity in daily work. The provider had an equality, diversity and inclusion team. The team was made up of six champions who worked within the equality, diversity and inclusion strategy. Staff we spoke with told us that the centre promoted and supported equality and diversity at work. In the breakroom, staff showed us the white board used to convey information discussed at the huddle such as lead roles for emergencies and a section to remind staff of other celebrations or important events. We saw at the time of inspection the centre was celebrating 'pride month'. We saw other events that were celebrated included black history month, and religious festivals such a Ramadan and Easter.

We saw in the September/October 2021 staff survey that 100% of staff who responded, felt their manager acted fairly with regard to career progression/promotion regardless of ethnic background, gender, religion, sexual orientation, disability or age.

We also saw that 100% of staff felt supported by the provider to strike a healthy balance between work and home life.

### Governance

**Leaders operated effective governance processes, throughout the service and with partner organisations. Staff at all levels were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service**.

The service had effective levels of governance and management structures that interacted with each other.

The registered manager attended a range of meetings, including the quality and governance meeting and medical advisory committee.

The provider's medical advisory committee provided the formal organisational structure through which consultants communicated. The MAC chairperson chaired the medical advisory committee, which met quarterly. The registered manager for the centre also sat on the medical advisory committee. A consultant surgeon from each surgical speciality represented surgery on the medical advisory committee. The medical advisory committee provided assurances around consultant and clinical matters to the providers management board.

Good

# Outpatients

The provider's quality and governance committee, chaired by the chief nurse, met monthly and provided assurances around quality and safety to the provider's management board. A range of different sub-committees including clinical effectiveness and audit, medicines management and infection prevention and control fed into the quality and governance committee.

The provider had a comprehensive quality dashboard, which monitored monthly performance in an extensive range of key areas relating to outpatients. Meeting minutes we reviewed showed the quality and governance committee meeting reviewed dashboard performance each month.

We saw the centre's audit schedule. This included audits in a range of key areas such as infection prevention and control, medicines management and record keeping. The provider's clinical effectiveness and audit committee met monthly to review audit performance and provided a quarterly report to the quality and governance committee.

There were clear lines of accountability from the department to the board through the provider's governance structure. Managers described the systems and processes of accountability within the centre. Staff we spoke with were clear about their roles and responsibilities and who or what they were accountable to or for.

Staff said they attended meetings. Staff also confirmed learning from incidents, complaints, audits and other quality improvement initiatives were communicated to them in a variety of ways such as; huddle meetings, e-mails and information on the notice board. We looked at the last three minutes for the department meeting and saw these were standing agenda items.

### Management of risk, issues and performance

**Leaders and teams used systems to manage performance effectively. They identified and escalated relevant risks and issues and identified actions to reduce their impact. They had plans to cope with unexpected events.**

The service had effective systems for identifying risks, planning to eliminate or reduce risks and coping with both the expected and unexpected. The service had a risk register which was current and up-to-date. The risk register was used as a tool for driving improvement and reducing risks. The service risk register fed into the provider risk register. Each risk was given an initial risk score and a current risk score after risk reduction strategies had been put in place.

The service sent us a sample of the risks included on their risk register. The risk register had an explanation of the risks, the registered manager had overall responsibility for the risk register, ensuing existing risk controls and actions were completed for each identified risk.

The risk register was incorporated into the online incident reporting system and could be accessed by other departments or the clinical leads for the directorate.

Risks were reviewed on a regular basis, discussed at the governance meeting, and escalated according to risk status; we saw these had been reviewed within the last 12 months.

Staff at all grades told us that they were encouraged to bring potential risk items for discussion as part of the daily huddles or weekly departmental meeting. Within this forum, staff would discuss and agree any items for addition, as well as review existing entries.

Daily ‘safety huddles’ took place every day to identify potential risks and allocate resources effectively.

Good

# Outpatients

The service had an up-to-date business continuity plan to enable the service to cope with unexpected events.

The service completed audits as set out in the provider's annual programme of audits. For example, the service completed regular audits of medicine management, medical records and hand hygiene.

### Information Management

**The service collected reliable data and analysed it. Staff could find the data they needed, in easily accessible formats, to understand performance, make decisions and improvements. The information systems were integrated and secure. Data or notifications were consistently submitted to external organisations as required.**

Information needed to deliver effective care and treatment was available to relevant staff in a timely and accessible way. The service used a combination of electronic and paper records. Paper records when not in use were stored in locked cabinets, in a locked room.

Staff had access to up-to-date accurate information on patients' care and treatment. Staff were aware of how to use and store confidential information. Records for patients were always kept securely. There were arrangements in place to ensure the confidentiality of patient information held electronically. Each member of staff had a unique pass code to use the system. Computers were locked when not in use. In the event of computer failure, essential information could initially be captured on paper.

Systems and processes ensured data and notifications were submitted to external bodies. For example, statutory notifications about safeguarding incidents which would need to be made to the Care Quality Commission.

Organisational policies and guidelines were stored in the electronic system. There was a requirement for staff to read, when updated. The system monitored the time staff accessed the policies

### Engagement

**Leaders and staff actively and openly engaged with patients, staff, equality groups, the public and local organisations to plan and manage services.**

The service gathered people's views and experiences in a number of different ways. The centre's website provided a wide range of information about the clinical services available. It also provided information about how to leave feedback. Patients could also complete a comment card after their appointment or use an app to provide feedback. We saw for May 2022, that 100% of patients, who responded to feedback, rated the experience of the service as 'good' or 'very good'.

The service collated compliments from patients and fed them back to staff. We saw feedback described staff as "helpful", "respectful", "friendly" and "welcoming".

The service included people who used the services, those close to them and their representatives actively via patient participation groups which engaged and involved them in decision-making to shape services and culture. Participation was voluntary and the group was advertised on the service's website. Patient participation groups were scheduled to be held every two months.

Good

# Outpatients

The service had regular opportunities to meet with staff and engage with them. The service had departmental level meetings every week. Their purpose was to update local teams on daily operations and share learning. Staff had regular meetings to discuss their contribution to the performance of the service.

The service had high levels of constructive engagement with staff. The provider had a staff forum called "KIMS Voice" chaired by the registered manager. KIMS Voice met monthly. Staff spoke positively of the forum and told us about suggestions they made that the senior management team subsequently implemented. Following a suggestion at this forum, all staff have an extra day's annual leave each year on their birthday

The service also conducted a staff survey yearly to receive feedback from staff. The service created an action plan following the staff survey results to address concerns raised.

To engage with consultants, the provider produced quarterly consultant newsletters.

### Learning, continuous improvement and innovation

**All staff were committed to continually learning and improving services.**

The provider had ongoing projects to drive continuous improvement. This included KIMS Voice an employee forum. The forum is chaired by the registered manager and allows staff to talk openly with each other to discuss ideas, problems, developments and proposed changes, to improve the quality of service provided to patients and environment.

Staff received a day off work on their birthdays. In addition, they received an additional day after three years' service at the centre.

The Good to Outstanding Fund is an idea scheme implemented to encourage innovation and promote development and engagement. Ideas are pitched to a panel and if successful there is financial reward.

Good

# Diagnostic imaging

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

## Are Diagnostic imaging 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 received and kept mostly up-to-date with their mandatory training. Staff used an online system to monitor and track their training. Staff told us they were notified in advance of when mandatory training was due.

The mandatory training was comprehensive and met the needs of patients and staff. Mandatory training included manual handling, basic life support, conflict resolution, equality and diversity, fire safety at work, health and safety awareness and infection control. All permanent and bank staff met the required target for mandatory training with most achieving 100%.

Clinical staff completed training on recognising and responding to patients with mental health needs, learning disabilities, autism and dementia.

Staff working with radiation had appropriate training in the regulations, radiation risks, and use of radiation. Staff could provide evidence of training and were aware of the *Ionising Radiation Regulations 2017 (IRR17) and the Ionising Radiation (Medical Exposure) Regulations 2017 (IR(ME)R17).*

### 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.**

Staff received training specific for their role on how to recognise and report abuse. There were arrangements in place to safeguard adults and children from abuse and this was set on in the local policy. All staff had been trained in safeguarding adults level one and two. The radiology lead and radiographer for the imaging department were trained to level 3 safeguarding for adults and level 2 for children.

Good

# Diagnostic imaging

Staff followed safe procedures for children visiting the service. The service did not provide imaging to children and young people under the age of 18 years. However, staff still completed the children's safeguarding training. The intercollegiate guidance *Safeguarding Children and Young People: Roles and competencies for Health Care Staff* states "all non-clinical and clinical staff who have any contact with children, young people and parents/ carers should be trained to level two".

Staff demonstrated a good understanding of safeguarding and their responsibilities around safeguarding.

All staff had been checked through the Disclosure and Barring Service (DBS). Staff demonstrated a good understanding of who to escalate safeguarding concerns to. Staff knew how to access the safeguarding policy and the policy outlined the different types of abuse including sexual exploitation and female genital mutilation.

Staff could give examples of how to protect patients from harassment and discrimination, including those with protected characteristics under the Equality Act. Staff had a clear understanding of how to recognise and report abuse. Including identifying adults are risk of, or suffering, significant harm. Staff had training in equality and diversity.

Staff knew how to make a safeguarding referral and who to inform if they had concerns. Staff were able to describe the referral processes and felt competent and well supported to make a safeguarding referral.

Processes were in place so that the right person received the right imaging procedure or radiological scan at the right time. The service checked three points of identification and used the Society of Radiographer's pause and check guidance.

### Cleanliness, infection control and hygiene

**The service controlled infection risk well. Staff used equipment and control measures to protect patients, themselves and others from infection. They kept equipment and the premises visibly clean.**

All clinical and reception areas were clean and had suitable furnishings which were clean and well-maintained. The service had outside cleaning contractors. However, the manager told us they were looking to bring the service in house to make sure standards were consistently high.

Staff cleaned equipment and areas thoroughly after use and cleaning audits were completed and stored electronically.

Cleaning records were up-to-date and demonstrated that all areas were cleaned regularly and staff compliance with cleaning. Standards of cleanliness and hygiene were well maintained. All clinical staff were bare below the elbows and cleaned hands between patient contact.

There were enough handwashing sinks and alcohol-based hand sanitiser within all areas we visited. During our inspection we saw staff either wash their hands or using the alcohol-based hand sanitiser correctly in line with the "five moments of hand hygiene" and *National Institute for Health and Social Care Excellence (NICE) quality statement (QS) 61, statement three*. Hand washing posters were on display.

Staff completed hand hygiene audits to monitor compliance monthly. The service sent us audits for February, March and April 2022. Records showed diagnostic imaging staff had achieved 100% compliance for April 2022. There was one episode of non-compliance for February and one for March. Where there were episodes of non-compliance, we were told that members of staff were spoken to immediately.

Good

# Diagnostic imaging

Staff followed infection control principles including the use of personal protective equipment (PPE).

The service completed infection prevention and control audits. The audits monitored staff compliance with personal protective equipment use, sharps storage and disposal.

The service had infection prevention and control (IPC) policies and procedures in place which provided staff with guidance on appropriate IPC practice.

The service managed COVID-19 IPC measures well. All staff wore disposable face masks and hand sanitising gel regularly. We saw sharps disposal bins located in each clinical room, all sharps disposal was labelled correctly and not overfilled.

Disposable curtains were in use. Each curtain had a label showing the date it was changed. We looked at three and saw all were changed in the last six months.

The service monitored their effectiveness at reducing the risk of spreading infections. The registered manager from the centre attended the quarterly infection prevention and control committee. This included discussions on training compliance, audit performance, antimicrobial stewardship, and updates to infection prevention and control policy.

The pharmacy manager worked across both the centre and the provider site. They were the antimicrobial guardian and anti-microbial audits were conducted monthly. This was reported through the quality and governance committee, quarterly IPC committee and monthly with the microbiologist and infection prevention control doctor.

Staff were trained in cannulation and they told us the process for monitoring the cannula site and disposing them correctly in the contaminated sharps container.

### Environment and equipment

**The design, maintenance and use of facilities, premises and equipment kept people safe. Staff were trained to use them. Staff managed clinical waste well.**

The design of the environment followed national guidance. The radiology department areas were spacious, clean and accessible. The environment layout was in line with *Health Building Note (HBN06).* The service had relevant risk assessment documents for each area of the department. For example, the x-ray room had a risk assessment which outlined the potential risk of radiation in the environment to patients and staff. This risk assessment included engineering controls to mitigate the risk.

Where radiation was being used, “radiation-controlled area” lights and signs were present. Access to rooms when radiation was in use was restricted. This was to make sure patients or staff could not accidentally enter.

Daily quality assurance tests on the Magnetic Resonance Imaging (MRI) machine were carried out and documented by the radiographers. The test assured the MRI equipment was in working order and safe to use. The MRI machine was serviced every six months by an external company. We saw up to date records of tests and servicing.

Staff carried out daily safety checks of specialist equipment. The service had research grade MRI and CT scanners. Scanners were wide bore which provide patients who struggled with confined environments more reassurance.

Good

# Diagnostic imaging

Maintenance of equipment was checked regularly, and we saw a sticker indicating when they were last serviced and when the next service was due.

Safety and warning notices were displayed in the control areas. There were notices detailing contact information for the MRI safety expert and the person responsible.

A control observation area allowed visibility of patients during the scan so staff could observe and monitor patients.

All equipment was checked and had the appropriate magnetic resonance labelling in accordance with *Medicines and Healthcare products Regulatory Agency (MHRA)* guidelines.

There was enough space around the MRI scanner, Computerised Tomography (CT) and X-ray equipment. Staff could move around the equipment safely. Patients had access to an emergency call bell during the scan and a microphone allowed constant contact between the radiographer and patient.

Patient weighing scales were available in the MRI suite and we saw where they had been appropriately service tested. There was a wheelchair, trolley and a moving and handling transfer board for patients requiring assistance to mobilise to the scanner.

Staff disposed of clinical waste safely. The service had a contract with an external organisation for the collection of waste. Clinical waste was contained in appropriate sealed bags while waiting for collection.

Arrangements for managing radioactive and clinical waste were in place. Waste was segregated with separate colour coded arrangements for general waste and clinical waste. Sharps, such as needles, were disposed of in line with national guidance.

### Assessing and responding to patient risk

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

Staff completed risk assessments for each patient on arrival, using a recognised tool, and reviewed this regularly, including after any incident. Risk assessments were developed in line with national guidance. We saw the patient MRI patient questionnaire and imaging check lists being completed prior to any procedure. All assessments requested information on medical history. MRI scans could not be carried out on patients with cardiac pacemakers, cerebral aneurysm clips, cochlear implants or intra-ocular metallic fragments. Documentation showed this was checked with patients prior to their referral.

We saw two examples of completed MRI patient questionnaires and all safety checks had been completed. Chaperones and family who are supporting patients in the scan room were also required to complete a risk assessment questionnaire.

Staff used a 'pause and check' system in line with the *Society and College of Radiographers (SCoR) and the legal requirements of Ionising Radiation (Medical Exposure) Regulations 2017 (IR(ME)R)*, to prevent radiation exposure to the wrong patient. We saw staff using the system which consisted of a six-point patient identification check. The check is used to reduce any errors when ensuring the right patient was having the right scan. We saw posters in all diagnostic rooms displayed as a reminder for clinical staff and we saw staff using the 'pause and check' system.

Good

# Diagnostic imaging

The service had a risk assessment in place for pregnant women. There was a pregnancy flow chart on the wall to remind staff to ask pre-scan pregnancy questions.

The service had pregnancy check notices in the waiting room and each clinical room, this was to prompt women who are or may be pregnant to inform staff before exposure to radiation. However, the service did not scan pregnant patients. If there was a requirement to scan a pregnant woman then this would be risk assessed prior to the scans, the flow chart would be followed and both a radiographer and consultant would be present throughout.

Local rules for wherever medical radiation was being used was displayed. This was a requirement by the Health and Safety Executive regulating IR(ME)R regulations. We saw a copy of the local rules on-line which had been signed by all staff to show they understood and adhered to the local rules. The local rules gave guidelines for staff to follow to ensure the safety of staff and patients.

There was a procedure for unexpected scan findings which supported early identification of untoward pathology and onward referral to expert medical advice. Staff had direct contact numbers for local radiologists who supported the service and were available to contact for advice during business hours.

The keys to the MRI suite and scanning department were not kept securely. We saw keys hanging on a hook within the radiographer's room. Following our inspection, the service purchased a wall key safe and we saw photographic evidence to confirm this.

Staff knew about and dealt with any specific risk issues. Staff undertook regular training in the assessment of deteriorating patients and in intermediate life support. There was a protocol to follow if a patient collapsed during a scan as well as a cardiac arrest policy.

Staff were able to tell us what they would do in the event of a deteriorating patient. Staff told us the bed detached away from the scanner and staff could bring the patient out of the area and ring the emergency call bell to alert staff and call 999.

### Staffing

**The service had enough staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed and adjusted staffing levels and skill mix, and gave bank, agency and locum staff a full induction.**

The service had enough clinical and support staff to keep patients safe. The service was small with a lead radiographer, radiographer, healthcare assistant and administration staff. The service always had a minimum of two radiographers working. There was also a lead mammographer who worked one day a week and a registered medical officer. The service also had access to all referring consultants and a medical physics expert.

Staffing levels were discussed during the centre's morning meeting and during monthly team meetings. Managers said they would cancel appointments if there were unsafe staffing levels.

The lead radiographer supervised the radiology department staff and coordinated shifts to make sure there were enough staff during each clinic. All staff knew who the lead radiographer was and told us they felt well supported.

The service rarely used bank staff but used when necessary to maintain staffing levels in both clinical and non-clinical areas. The service said staff were provided with information so they could work safely.

Good

# Diagnostic imaging

### Records

**Staff kept detailed records of patients' care and treatment. Records were clear, up to date, stored securely and easily available to all staff providing care.**

Patient notes were mostly paper records. The service used an electronic system to manage appointments, discharge letters and diagnostic scan reports.

Records were stored securely. No medical records were kept on site. Staff we spoke with told us the reservations team prepared the medical records for each clinic list every day. The medical records were transferred to the centre, via a courier. We saw medical records were stored in a lockable cabinet which was locked at the time of our inspection. This indicated records were being kept securely in this area. We were told there was never a delay in accessing notes for patient care.

Scans were sent to specific radiologists for review. There was an electronic system in place to show each process of reviewing the scan to report. Each section of the pathway lights up when completed to highlight it has been completed.

We reviewed five sets of patient records. All records were legible, signed and dated. Records contained all the relevant information, including a referral letter and any procedures or discussion that had taken place.

### Medicines

**The service used systems and processes to safely prescribe, administer and record. However, in some area's medicines were not stored securely or safely.**

Staff did not store all medicines safely. The medicine cupboards we inspected were locked and all stock was secure and all stock within expiry dates.

Medicine cupboard temperatures were checked and recorded daily. However, we found the medicine cupboard within the clinical room to have out of range temperatures.

We were told the air conditioner system was broken inside the room which meant the medicine cupboard temperatures showed a higher temperature reading. The temperatures were checked and recorded daily by staff and the readings reported to the registered manager.

We saw emails to show the registered manager had repeatedly followed up the broken air conditioner with the maintenance department. However, we did not see evidence that the high temperatures had been reported to the pharmacist. It was unclear whether the service had received guidance from the pharmacist as to the safety of the medicines stored inside.

The key to the medicine cupboards in the diagnostic department was not secure. We found the key to the medicine cupboard within the clinical room was kept in an unlocked drawer and the key to the contrast medicine cupboard was kept hidden behind a cupboard. Following, our inspection we received photographic evidence to show key safes were now fitted and all keys were kept secure.

The service did not keep or administer controlled medicines. Emergency medicines were available in the event of an anaphylactic reaction. These were in date and checked. When medicines were not used or past their expiry date, the service provided the ability for safe disposal of the medications. Medicines we reviewed were all in date.

Good

# Diagnostic imaging

### Incidents

**The service managed patient safety incidents well. Staff recognised incidents and near misses 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. Managers ensured that actions from patient safety alerts were implemented and monitored.**

Staff knew what incidents to report and how to report them. Staff raised concerns and reported incidents through the electronic incident reporting system in line with the service's policy.

We saw in the last year for the centre staff had reported 42 incidents, with 33 reported as no harm and 9 reported as low harm. There were no moderate or severe harm incidents reported.

During the year prior to our inspection, the service did not report any never events or serious incidents. A never event is a serious incident that is wholly preventable as guidance, or safety recommendations providing strong systemic protective barriers, are available at national level, and should have been implemented by all healthcare providers. They have the potential to cause serious patient harm or death, has occurred in the past and is easily recognisable and clearly defined.

The service had an incident management policy. This outlined staff responsibilities around incidents and how to report them. Staff understood how to report incidents and there was a good reporting culture.

Staff understood duty of candour. Staff said they knew their responsibility to be open and honest with patients and relatives when things went wrong. They told us talking openly with patients when things had gone wrong helped their patients understand and allowed them to ask questions.

Staff told us they were encouraged to report incidents and complete electronic incident report forms and the registered manager had full visibility of all incidents. Staff received feedback from investigation of incidents.

Managers investigated incidents thoroughly. All the departmental leads were involved in investigating incidents. An incident went to a departmental lead, it was investigated, actions taken, and staff met to discuss the feedback and look at improvements to patient care.

Incidents were discussed during weekly imaging departmental team meetings. Learning from imaging incidents and other core service incidents were discussed as a team and actions developed to implement learning. Actions were followed-up at the next team meeting.

## Are Diagnostic imaging effective?

Inspected but not rated

We do not rate effective.

Good

# Diagnostic imaging

### Evidence-based care and treatment

**The service provided care and treatment based on national guidance and evidence-based practice. Managers checked to make sure staff followed guidance. Staff protected the rights of patients subject to the Mental Health Act 1983.**

Staff followed up-to-date policies to plan and deliver high quality care according to best practice and national guidance. The service used up-to-date, regularly reviewed policies and procedures and best practice guidance. These followed recent guidance from the *British Medical Ultrasound Society, the Royal College of Radiologists and the National Institute of Health and Care Excellence (NICE).*

The service kept guidance of radiographic procedures undertaken within the service which showed the current evidence-based guidance and legislation.

A quality assurance folder for Computerised Tomography (CT) showed audits completed for image quality and contrast scale for scans. The service monitored radiation doses to ensure doses were kept as low as reasonably possible. The service completed a monthly audit of patient doses against local and national diagnostic reference levels for all types of imaging.

The service was in the process of completing a new auditing programme which would include exposure to radiation charts and dose audits for both CT and X-ray.

The service monitored the latest guidance to ensure policies and procedures were up to date. The provider's governance team disseminated new national guidance to staff through head of departments. The medical advisory committee (MAC), including consultants, assessed their relevance before dissemination. We looked at the MAC meeting minutes for March 2022, they reviewed clinical performance, incidents and complaints.

We saw local rules for radiation were in place and disseminated to staff to read and sign. A copy of local rules was within all clinical and non-clinical areas within the radiology department.

Staff followed up to date policies to plan and deliver high quality care according to best practice and national guidance. Polices and guidance were accessed on the provider's intranet. Staff showed us how they accessed them.

Staff we spoke to had a good awareness of policies and we saw the medical executive committee minutes showed clinical performance, audits and national guidance were reviewed alongside local policies and guidance. Audits and guidance were shared on departmental notice boards and meeting minutes.

Staff referred to the psychological and emotional needs of patients, their relatives and carers. When handing over to other clinical services, staff routinely referred to the psychological and emotional needs of patients, their relatives and carers. Staff understood the emotional impact that abnormal scans had on patients and we saw staff supporting patients during scans.

### Nutrition and hydration

There were no nutrition services provided by the unit for patients that attended for PET-CT scans. However, patients had access to tea and coffee services in reception and in the reception area. Staff encouraged patients to have some biscuits which they provided following the scan as patients often had to avoid eating for the scan.

Good

# Diagnostic imaging

### Pain relief

**Patients were asked by staff if they were comfortable during their appointment, however no formal pain level monitoring was undertaken as procedures undertaken were pain free.**

### Patient outcomes

**Staff monitored the effectiveness of care and treatment. They used the findings to make improvements and achieved good outcomes for patients.**

Managers used information from the audits to improve care and treatment. The providers clinical audit schedule outlined, when, how often and who would undertake the audits in various areas.

The service submitted data to the Private Healthcare Information Network (PHIN), for bench marking against other independent providers. PHIN is an independent source of information about private healthcare, aiming to enable patients to make better informed choices of care provider. Outcomes for patients were positive and as expected.

There was a comprehensive programme of repeated audits to check improvement over time. These were reviewed at quality meetings and discussed in regular staff meetings.

These included auditing of consent, standards of record keeping, medicine management and hand hygiene. In addition, results from audits were reported as a dashboard of audit performance across the provider. The dashboard was reviewed and discussed at the monthly quality and governance committee.

The service was part of the National Ligament and Joint Registry and collected image-based patient reported outcome measures which fed through to the provider data for improving services.

The service had in place an image quality audit. However, staff told us that due to low incident of image recalls the service does not routinely audit image quality.

### 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 development.**

Staff were experienced, qualified and had the right skills and knowledge to meet the needs of patients. Staff received regular mandatory and additional training to ensure they had the right skills and knowledge to keep patients safe.

Managers gave all new staff a full induction tailored to their role before they started work. All new staff had an induction which included core competencies and were signed off by their line manager.

Managers identified any training needs their staff had and gave them the time and opportunity to develop their skills and knowledge. Staff were supported to develop their skills through yearly appraisals with their line manager. Managers identified training and development opportunities during appraisals.

Staff were positive about the training provided and were confident they would be supported to attend additional training if required and were given protected time to complete training. Staff told us they had recently completed training on delivering bad news to patients. Although consultants were responsible for giving bad news to patients, we were told all staff undertook the training, so they had the competence and skills to support patients following difficult news.

Good

# Diagnostic imaging

We saw radiography and staff competency checklist on the notice board within the CT and Magnetic Resonance Imaging (MRI) control rooms. Managers made sure staff received any specialist training for their role. Staff files showed that all sonographers had gained additional qualifications in order to carried out specialist scans.

We reviewed staff compliance check list to ensure it met the requirements of *Schedule Three of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014*. The checklist showed staff checks such as, photo identification, qualifications and disclosure and barring service checks were all complete. All registered health professionals were confirmed as being registered with their appropriate professional regulatory body. There were processes for ensuring checks were carried out at least annually of all registered health professionals to ensure they remained registered and that all individuals had appropriate levels of indemnity insurance.

### Multidisciplinary working

**Radiographers, doctors, nurses and other healthcare professionals worked together as a team to benefit patients. They supported each other to provide good care.**

Staff worked across health care disciplines and with other agencies when required to care for patients. We saw the different teams within the medical centre work well together and there was a clear collaboration between core services.

Staff told us they felt fully supported by other staff groups and there was good communication within the teams. The service offered one stop clinics for breast patients which consisted of a team of mammographers, specialist breast consultants, specialist breast radiologists, breast care nurses and support workers working together collaboratively.

### Seven-day services

**Key services were available to support timely patient care.**

The service did not provide seven-day services. The service was open Monday to Friday 8am to 8pm. Staff did not work bank holidays or weekends.

### Health promotion

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

The service had posters and information leaflets in the waiting area of the department. These displayed relevant information about health and safety associated with radiation and diagnostic scans. These prompted patients to ask staff for support if they had any questions.

### 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 or were experiencing mental ill health.**

The service had an in date policy on *Mental Capacity Act 2005 (MCA)* which included Deprivation of Liberty Standards (DoLs). The policy outlined responsibilities of staff and what to do when they had concerns about a patient's capacity. Staff gained consent from patients for their care and treatment in line with legislation and guidance and understood how to assess whether a patient had capacity to make decisions about their care. Staff told us if they had any concerns regarding the patient's capacity to consent to treatment then they would not scan and seek further support and guidance.

Good

# Diagnostic imaging

Staff received mandatory training on consent. All staff were up to date with this training. Staff made sure patients were given all information available before a scan and gained consent. Staff completed consent audits to monitor compliance every other month. Records showed the diagnostic department staff had achieved 100% compliance over the last three audits.

## Are Diagnostic imaging caring?

Good

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 treated patients with dignity and respect. For example, patients were given gowns to wear during scans and made sure patients did not feel exposed or vulnerable.

Staff followed policy to keep patient care and treatment confidential. Conversations in treatment and scanning rooms could not be overheard.

Staff understood and respected the personal, cultural, social and religious needs of patients and how they may relate to care needs. Adjustments were made to clinical processes and communication when necessary. Patient information leaflets contained information about chaperones and there were notices offering this service in all scanning rooms.

Staff told us they felt the service did all that they could for the patient to make a difference and learning from patient feedback. For example, the voice of the patient was represented at board level. New identification badges for staff with 'Hello, my name is' to encourage staff to introduce themselves to patients with the aim to encourage a therapeutic relationship with patients and clients so they feel relaxed, welcomed, confident in staff and their care.

Patients were positive about the service and the care they received. Patient comments showed us that patients felt the environment was relaxed, staff were friendly and put patients at ease.

### 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. We saw staff provide reassurance and support, for example, a patient with mobility issues arrived late for their scan. Staff made sure the patient was still seen and staff took their time to provide reassurance and to support the patient with their mobility on to the scanner.

Staff gave us an example and we saw a thank you card from the family of a patient with dementia. The patient was scared of the noise the scanner made. The radiographer stayed with the patient throughout holding their hand and providing reassurance throughout.

Good

# Diagnostic imaging

Staff undertook training on breaking bad news and demonstrated empathy when having difficult conversations. The service had a statement of purpose in place for breaking bad news which showed the processes taken for staff to support patients when receiving bad news. Staff told us they would stay with patients when they had received bad news and would comfort and sit with them after their clinic appointment in a private room. We saw that staff had undertaken additional training in breaking bad news.

### Understanding and involvement of patients and those close to them

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

Patients and their families could give feedback on the service and their treatment and staff supported them to do this. The service had a patient forum which consisted of patients who had been treated at the medical centre or the provider's site. The forum met twice a month at the provider hospital and focused on patient experience and what improvements could be made to improve patient care.

Staff supported patients to make informed decisions about their care. Information was sent to patients when they booked a scan and on arrival staff took the time to explain the scan procedure to patients and what would happen during their appointment.

Staff talked with patients, families and carers in a way they could understand. Staff recognised when patients and their relatives needed additional support and reassurance. Patients with dementia or learning disabilities was able to have a relative or carer with them for support throughout the procedure if it was safe to do so. Patients could also listen to their favourite music or radio whilst having a scan to take away from the noise.

Patients gave positive feedback about the service. We saw positive patient feedback on how supportive and kind staff were.

One comment received said that they have been left feeling overcome with gratitude at how kind, patient, supportive and welcoming staff were at Sevenoaks Medical Centre from the reception staff to the radiographers. The patient felt welcomed and listened to and the care was taken at the patient's own pace. The patient felt part of the decision-making process and kept the patient as comfortable and as supported as possible during the MRI scan.

## Are Diagnostic imaging responsive?

Good

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. It also worked with others in the wider system and local organisations to plan care.**

Managers planned and organised services so they met the changing needs of the local population. The service was part of the provider-wide patient forum. The forum was mostly made up of past patients. The forum discussed and

requested information from both the leadership and clinical teams focusing on patient experiences to make improvements to patient care. Through the forum there had been the introduction of an online book and pay system. Although a referral from the GP was still required for some procedures it meant the patient had a wider choice of consultants and appointments. It also allowed patient to self-refer for some procedures.

However, without using the online payment system patients were offered a choice of imaging appointments.

The service minimised the number of times patients needed to attend the hospital, by ensuring patients had access to the required staff and tests on one occasion.

The service offered wellbeing overviews. The health check included medical and non-invasive tests and any specific health concerns raised meant that patients could be immediately referred to diagnostic team for diagnostic tests.

A one stop, consultant led breast clinic was held twice weekly, alongside an asymptomatic clinic for patients concerned about breast cancer but do not have any symptoms. The service had invested in a mammography system which was more comfortable for patients, with softer armrests to encourage less tension which can ease the breast compression during the scan and provide better scan images.

Facilities and premises were appropriate for the services being delivered. The one stop breast clinic room was designed to provide a more relaxed environment with a sense of calm. Staff felt this provided a better environment especially when having to deliver bad news.

The environment was appropriate, and patient-centred. The centre had a patient car park, there was signage all around the medical centre and clear directions within the scanning rooms as to where and where not patients could go.

The waiting room was spacious with seats spaced out. There was water and a hot drink machine and patients were able to help themselves.

Patients were provided with information in accessible formats before appointments. Appointment letters contained information required by the patient such as contact details and information relating to the procedure.

All appointments were confirmed prior to the patient's appointment to reduce the number of patients not attending their appointment and to provide an opportunity for patients to ask any questions.

### 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. Patients' individual needs were accounted for.**

Staff delivered care in a way that took account of the needs of different patients on the grounds of age, disability, gender, race, religion or belief and sexual orientation. Staff had received training in equality and diversity and had a good understanding of cultural, social and religious needs of the patient and demonstrated these values in their work.

The centre had an equality, diversity and inclusion team. The team was made up of six champions who worked within the equality, diversity and inclusion strategy. All patients were encouraged in the appointment letter to contact the unit if they had any needs, concerns or questions about their examination.

Good

# Diagnostic imaging

Staff made sure patients living with mental health problems, learning disabilities and dementia, received the necessary care to meet all their needs. All staff had completed online and face to face dementia awareness training. Link nurses and champions for dementia were in place to offer support and guidance to staff. Staff told us they would see patients with mental health problems, learning disabilities or dementia as soon as they arrived for an appointment to help relieve any worry or concerns for the patient.

The environment in the examination rooms and scanning was conducive to relaxation as there were environment lights and calm decoration. This was in line with *NICE QS15 Statement 9: Patients experience care that is tailored to their needs and personal preferences, considering their circumstances, their ability to access services and their coexisting conditions.*

The service had wheelchair access. Clinical rooms were large and spacious and there was a lift which could access the diagnostic floors. Staff gave us an example where they facilitated a patient with limited mobility. The centre was contacted by a local residential home regarding support in organising a scan for a patient. Staff assessed the patient and found it was unsafe for the patient to be scanned at the centre. An assessment was completed within the centre and staff organised for a scan to be completed at the provider site where there was an appropriate hoist available for the patient's safety.

Hearing loops were available in the waiting area, which helped patients hard of hearing to access services.

The service had information leaflets available in languages spoken by the patients and local community. The service was able to offer patient information leaflets which were translated to the patient's first language. The service had access to interpretation and translation services. The information was kept on notice boards within the clinical rooms and staff could access translation services easily.

### Access and flow

**People could access the service when they needed it and received the right care promptly. Waiting times for treatment were in line with national standards.**

Managers monitored waiting times and made sure patients could access services when needed and received treatment within agreed timeframes and national targets.

From June 2021 to June 2022 the diagnostic department had a total 3,042 patients attend the service. The service saw mostly private and insured patients although did work with the NHS to provide MRI scans to NHS patients.

NHS patients came through to the centre via a weekly tracker. The service then contacted patients and arranged appointments.

There was a quick turnaround for all diagnostic images and reports to the cancer multidisciplinary teams. The reporting radiologist is onsite during one stop breast clinics so that the report could be completed, electronically signed and sent to the referring clinician.

Managers monitored waiting times and made sure patients could access services when needed and received treatment within agreed timeframes and national targets. Patients are told of any delays when they arrive at reception, if required the service will call patients ahead of their appointment. Patients are also contacted if they do not attend their appointment or if they are running late so that the centre can accommodate them at a later appointment.

Good

# Diagnostic imaging

The service does not have waiting lists and appointments are offered within 48 hours of receiving a referral to the diagnostic service. Appointments were offered to patients at the provider site if a patient would prefer to be seen by a consultant working within that area.

The service was working with the local NHS trust to provide MRI appointments to support on their long waits for MRI's. The service has a tracker for NHS appointments and agreement for patients to be seen within 28 days. Currently patients booked from the NHS service were receiving appointments within 14 days of receiving the referral.

The service had key performance indicator for report turnaround times of two working days from scan to report. The service had an average scanning report time of 32.7 hours.

The service uses a network of radiologists, all of which had practising privileges. Radiologists were able to report whilst onsite and remotely for both routine and urgent scans.

### Learning from complaints and concerns

**It was easy for people to give feedback and raise concerns about care received. The service treated concerns and complaints seriously, investigated them and shared lessons learned with all staff. The service included patients in the investigation of their complaint.**

Patients, relatives and carers knew how to complain or raise concerns and we saw information on how to make a complaint or raise a concern clearly displayed in all patient areas. Patients could post anonymous feedback in a closed box within the reception areas. Patients we spoke with told us they had no concerns about the service provided. Information for patients on how to make a complaint is available for patients at the location and on the main website.

The service had a complaints policy and staff demonstrated an understanding of the complaints procedure and knew where and how to address complaints or concerns.

Managers investigated complaints and identified themes. If a complaint could not be resolved, a member of staff would be designated to the concern and had overall responsibility for responding to all written complaints. The service acknowledged complaints within three working days of receiving the complaint with an aim to have the complaint reviewed and completed within 20 days. There was an expectation that complaints would be resolved within 20 days. If they could not, a letter was sent to the complainant explaining why.

The diagnostic service had received five complaints between July 2021 and June 2022. All the complaints were resolved at a local level and were not referred to the Ombudsman.

Managers shared feedback from complaints with staff and learning was used to improve the service. Staff at all levels described an open and honest culture and a willingness to accept responsibility. Feedback on any complaints or compliments were shared at the weekly departmental meetings

All written complaints were acknowledged within two days of receipt. If further investigation was required, this was within a 20-day timescale in line with the complaints policy.

## Are Diagnostic imaging well-led?

Good

# Diagnostic imaging

Good

We rated it as good.

### Leadership

**Leaders had the skills and abilities to run the service. They understood and managed the priorities and issues the service faced. They were visible and approachable in the service for patients and staff. They supported staff to develop their skills and take on more senior roles.**

Leaders had the skills and abilities to run the service. The registered manager had responsibility for overall management of the centre. There was a simple management structure with clear lines of responsibility and accountability. The registered manager was supported by a lead for each department.

Leaders had a good understanding of the services they managed. They could explain clearly how the teams were working to provide high quality care. Staff told us they felt well supported by leaders. They felt there was a clear management structure within the team and leaders and senior staff were very approachable. If there was any conflict within the service, they would go to either their manager or the registered manager and seek support.

There was evidence of good local leadership. Leaders had the skills, knowledge, integrity and experience to deliver good quality care at local levels. Staff told us leaders operated an open-door policy and they could discuss concerns. The registered manager told us they had moved their office from the top floor of the centre to one on the ground floor, so they were more accessible to staff. The registered manager worked closely with other services in within the provider and had a good understanding of the priorities for the service and the challenges faced.

Leaders were visible in the service and approachable for patients and staff. Staff said that senior managers were supportive. Staff reported there was clear visibility of members of the senior leadership team throughout the service, and on the day of inspection we saw the chief nurse was on site. Staff could explain the leadership structure within the centre were accessible to staff. All nursing staff spoke highly of the service managers as leaders and told us they received good support. We observed good working relationships within the team.

We met with the registered manager, consultants, radiologists, healthcare assistants, and receptionist staff during the inspection and found they were organised and demonstrated good and supportive teamwork and leadership. They were knowledgeable about the centre's performance against the priorities and the areas for improvement.

### 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.**

The providers mission was to provide the highest quality of care in a world-class clinical environment for the people of Kent. The mission was underpinned by a set of values; People, Team, Caring, Confident, Integrity, Value and Dynamic

Staff spoke about providing high quality care, which supported the provider-wide vision of ensuring patient-centred care.

Good

# Diagnostic imaging

Staff demonstrated an understanding of the vision, values and strategy. Staff told us the mission and values were discussed regularly and described how they tried to incorporate them into their working day. We saw in the September/ October 2021 staff survey that 100% of staff who responded said they shared the same values as the organisation.

In addition, we saw that 100% of staff who responded agreed with the statement 'I believe that the care and safety of our patients and service users is truly at the heart of everything we do'.

**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 said they felt supported, respected and valued. There was a strong emphasis on the safety and wellbeing of staff. Staff spoke highly about the registered manager. They found the registered manager always happy to listen and approachable.

The service promoted a positive, inclusive and collaborative culture that supported and valued staff. There was a sense of common purpose based on shared values.

Staff we met were welcoming, friendly and helpful. It was clear that an open and transparent culture had been established where the emphasis was on quality of care delivered to the patients. Staff we spoke with felt supported, respected and valued in their working environments. Staff felt listened to and said they worked well as a team. Openness and honesty were encouraged at all levels and staff said they felt able to discuss and escalate concerns.

Staff we spoke with expressed pride and commitment working for the service. Staff reported the team worked effectively together, with staff respecting each other and working together to provide the best possible care and treatment to patients.

There was strong collaboration, team-working and support across all functions and a common focus on improving the quality and sustainability of care and people's experiences. We found the care and service delivered at the service showed a strong cohesive team approach to work. All staff told us they felt valued in their roles and felt part of the team very much.

There was a culture of learning and development, innovation and creativity within the service.

The service had arrangements to promote the safety and wellbeing of staff.

The service promoted equality and diversity in daily work. The provider had an equality, diversity and inclusion team. The team was made up of six champions who worked within the equality, diversity and inclusion strategy. Staff we spoke with told us that the centre promoted and supported equality and diversity at work. In the breakroom, staff showed us the white board used to convey information discussed at the huddle such as lead roles for emergencies and a section to remind staff of other celebrations or important events. We saw at the time of inspection the centre was celebrating 'pride month'. We saw other events that were celebrated included black history month, and religious festivals such a Ramadan and Easter.

Good

# Diagnostic imaging

We saw in the September/October 2021 staff survey that 100% of staff who responded, felt their manager acted fairly with regard to career progression/promotion regardless of ethnic background, gender, religion, sexual orientation, disability or age.

We also saw that 100% of staff felt supported by the provider to strike a healthy balance between work and home life.

### Governance

**Leaders operated effective governance processes, throughout the service and with partner organisations. Staff at all levels were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service**.

The service had effective levels of governance and management structures that interacted with each other.

The registered manager attended a range of meetings, including the quality and governance meeting and medical advisory committee.

The provider's medical advisory committee provided the formal organisational structure through which consultants communicated. The MAC chairperson chaired the medical advisory committee, which met quarterly. The registered manager for the centre also sat on the medical advisory committee. A consultant surgeon from each surgical speciality represented surgery on the medical advisory committee. The medical advisory committee provided assurances around consultant and clinical matters to the providers management board.

The provider's quality and governance committee, chaired by the chief nurse, met monthly and provided assurances around quality and safety to the providers management board. A range of different sub-committees including clinical effectiveness and audit, medicines management and infection prevention and control fed into the quality and governance committee.

The provider had a comprehensive quality dashboard, which monitored monthly performance. Meeting minutes we reviewed showed the quality and governance committee meeting reviewed dashboard performance each month.

We saw the centre's audit schedule. This included audits in a range of key areas such as infection prevention and control, medicines management and record keeping. The provider's clinical effectiveness and audit committee met monthly to review audit performance and provided a quarterly report to the quality and governance committee.

There were clear lines of accountability from the department to the board through the provider governance structure. Managers described the systems and processes of accountability within the centre. Staff we spoke with were clear about their roles and responsibilities and who or what they were accountable to or for.

Staff said they attended meetings. Staff also confirmed learning from incidents, complaints, audits and other quality improvement initiatives were communicated to them in a variety of ways such as; huddle meetings, e-mails and information on the notice board. We looked at the last three minutes for the department meeting and saw these were standing agenda items.

Good

# Diagnostic imaging

### Management of risk, issues and performance

**Leaders and teams used systems to manage performance effectively. They identified and escalated relevant risks and issues and identified actions to reduce their impact. They had plans to cope with unexpected events. Staff contributed to decision-making to help avoid financial pressures compromising the quality of care.**

The service had effective systems for identifying, planning to eliminate or reduce risks and coping with both the expected and unexpected. The service had a risk register which was current and up to date. The risk register was used as a tool for driving improvement and reducing risks. The service risk register fed into the provider risk register. Each risk was given an initial risk score and a current risk score after risk reduction strategies had been put in place. The service sent us a sample of the risks included on their risk register. The risk register had an explanation of the risks, the registered manager had overall responsibility for the risk register, ensuing existing risk controls and actions were completed for each identified risk.

The risk register was incorporated into the online incident reporting system and could be accessed by other departments or the clinical leads for the directorate.

Risks were reviewed on a regular basis, discussed at the governance meeting, and escalated according to risk status; we saw these had been reviewed within the last 12 months.

Staff at all grades told us that they were encouraged to bring potential risk items for discussion as part of the daily huddles or weekly departmental meeting. Within this forum, staff would discuss and agree any items for addition, as well as review existing entries.

Daily ‘safety huddles’ took place every day to identify potential risks and allocate resources effectively.

The service had an up-to-date business continuity plan to enable the service to cope with unexpected events.

The service completed audits as set out in the provider's annual programme of audits. For example, the service completed regular audits of medicine management, medical records and hand hygiene

### Information Management

**The service collected reliable data and analysed it. Staff could find the data they needed, in easily accessible formats, to understand performance, make decisions and improvements. The information systems were integrated and secure. Data or notifications were consistently submitted to external organisations as required.**

Information needed to deliver effective care and treatment was available to relevant staff in a timely and accessible way. The service used a combination of electronic and paper records. Paper records when not in use were stored in locked cabinets, in a locked room.

Staff had access to up-to-date accurate information on patients’ care and treatment. Staff were aware of how to use and store confidential information. Records for patients were always kept securely. There were arrangements in place to ensure the confidentiality of patient information held electronically. Each member of staff had a unique pass code to use the system. Computers were locked when not in use. In the event of computer failure, essential information could initially be captured on paper.

Good

# Diagnostic imaging

Systems and processes ensured data and notifications were submitted to external bodies. For example, statutory notifications about safeguarding incidents which would need to be made to the Care Quality Commission.

Organisational policies and guidelines were stored in the electronic system. There was a requirement for staff to read, when updated. The system monitored the time staff accessed the policies

### Engagement

**Leaders and staff actively and openly engaged with patients, staff, equality groups, the public and local organisations to plan and manage services. They collaborated with partner organisations to help improve services for patients.**

The service gathered people's views and experiences in a number of different ways. The centre's website provided a wide range of information about the clinical services available. It also provided information about how to leave feedback. Patients could also complete a comment card after their appointment or use an app to provide feedback. We saw for May 2022, that 100% of patients, who responded to feedback, rated the experience of the service as 'good' or 'very good'.

The service collated compliments from patients and fed them back to staff. We saw feedback described staff as "helpful", "respectful", "friendly" and "welcoming".

The service included people who use services, those close to them and their representatives actively in-patient participation groups to engage and involve them in decision-making to shape services and culture. Participation was voluntary and the group was advertised on the service's website. Patient participation groups were scheduled to be held every two months.

The service had regular opportunities to meet with staff and engage with them. The service had departmental level meetings every week. Their purpose was to update local teams on daily operations and share learning. Staff had regular meetings to discuss their contribution to the performance of the service.

The service had high levels of constructive engagement with staff. The provider had a staff forum called 'KIMS Voice' chaired by the registered manager. KIMS Voice met monthly. Staff spoke positively of the forum and told us about suggestions they made that the senior management team subsequently implemented. Following a suggestion at this forum, all staff have an extra day's annual leave each year on their birthday.

The service also conducted a staff survey yearly to receive feedback from staff. The service created an action plan following the staff survey results to address concerns raised.

To engage with consultants, the provider produced quarterly consultant newsletters.

### Learning, continuous improvement and innovation

**All 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.**

The provider had ongoing projects to drive continuous improvement. This includes KIMS Voice, an employee forum. The forum is chaired by the registered manager and allows staff to talk openly with each other to discuss ideas, problems, developments and proposed changes to improve the quality of service provided to patients and environment.

Good

# Diagnostic imaging

Staff received a day off work on their birthdays. In addition, they received an additional day after three years' service at this centre.

The Good to Outstanding Fund is an idea scheme implemented to encourage innovation and promote development and engagement. Ideas are pitched to a panel and if successful there is financial reward.

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.