Sterling Healthcare Group Ltd

New Malden Diagnostic 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	Requires Improvement
Are services safe?	Requires Improvement
Are services effective?	Requires Improvement
Are services caring?	Good
Are services responsive to people's needs?	Good
Are services well-led?	Requires Improvement

Summary of findings

Overall summary

We had not previously rated this location under the current provider. We rated it as requires improvement because:

- The provider's practising privileges policy did not set out what mandatory training was required by consultants.
- The service did not always manage infection risks well. There were no checklists to indicate when the patient toilets had last been cleaned and not all staff were bare below the below.
- Consultants held their own records which other staff could not access. The service was unable to demonstrate how they assessed and managed individual risks.
- The design, maintenance and use of facilities, premises and equipment did not always keep people safe. At the time of our inspection, not all electrical equipment had up to date safety tests.
- Staff did not use a recognised tool to identify deteriorating patients. Staff did not use the World Health Organisation safer surgery checklist when undertaking minor procedures.
- The service did not have a comprehensive programme of clinical audits to monitor the effectiveness of care and treatment.
- Leaders did not always operate effective governance processes. They did not use systems to manage performance effectively.

However:

- The service had enough staff to care for patients and keep them safe.
- Staff worked well together for the benefit of patients. Key services were available to suit patients' needs.
- Staff treated patients with compassion and kindness, respected their privacy and dignity, took account of their individual needs, and helped them understand their conditions. They provided emotional support to patients, families and carers.
- The service planned care to meet the needs of local people, took account of patients' individual needs, and made it easy for people to give feedback. People could access the service when they needed it and did not have to wait too long for treatment.
- Staff understood the service's vision and values, and how to apply them in their work. Staff felt respected, supported and valued. They were focused on the needs of patients receiving care.

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Outpatients	Requires Improvement 	We had not previously rated outpatients at this service. We rated it as requires improvement because: • The service did not always manage infection risks well. Hand hygiene audits were undertaken annually and not at regular intervals. • Patient notes were limited to nursing records of minor procedures. • The design, maintenance and use of facilities, premises and equipment did not always keep people safe. At the time of our inspection, the service was not up to date with equipment testing. • The service did not have a comprehensive audit programme to monitor the effectiveness of care and treatment. • Leaders did not demonstrate full understanding of the issues the service faced or how to manage them. They did not always operate effective governance processes. Leaders and teams did not use systems to manage performance effectively. They did not always manage risks effectively. However: • The service had enough staff to care for patients and keep them safe. Staff had training in key skills and understood how to protect patients from abuse. Staff worked well together for the benefit of patients. Key services were available to suit patients' needs. • Staff treated patients with compassion and kindness, respected their privacy and dignity, and helped them understand their conditions. They provided emotional support to patients, families and carers. • The service planned care to meet the needs of local people, took account of patients'

Summary of findings

individual needs, and made it easy for people to give feedback. People could access the service when they needed it and did not have to wait too long for treatment.
- Staff generally understood the service's vision and values, and how to apply them in their work. Staff felt respected, supported and valued. They were focused on the needs of patients receiving care.

Surgery

Requires Improvement

We had not previously rated this service. We rated it as requires improvement:

- The providers practicing privileges policy did not set out what mandatory training was required by consultants.
- Staff did not use a recognised tool to identify deteriorating patient.
- Staff did not use World Health Organisation (WHO) safer surgery checklist in theatres, which was designed to prevent avoidable mistakes.
- Hand hygiene audits were undertaken annually.

However:

- The service had enough staff to care for patients and keep them safe. Staff had training in key skills, understood how to protect patients from abuse, and managed safety well. Staff kept good care records. They managed medicines well. The service managed safety incidents well and learned lessons from them.
- Staff provided good care and treatment advised patients pain relief when they needed it. Staff worked well together for the benefit of patients. Key services were available six days a week.
- Staff treated patients with compassion and kindness, respected their privacy and dignity, they provided emotional support to patients.
- The service planned care to meet the needs of local people and made it easy for people to give feedback. People could access the service when they needed it and did not have to wait too long for treatment.
- Staff understood the service's vision and values, and how to apply them in their work. Staff felt respected, supported and valued. They were focused on the needs of patients receiving care.

Summary of findings

Staff were clear about their roles and accountabilities. The service engaged with and staff were committed to improving services continually.

Diagnostic imaging

Requires Improvement

We rated the service as requires improvement because:

- The doors to the MRI suite were not self-closing and locking with security locks that could be operated by MR authorised personnel only from the outside but freely opening from the inside in case of emergency.
- Not all equipment at the time our inspection had an up to date portable appliance test.
- Not all staff were up to date with all mandatory training including safeguarding and there was no safeguarding lead at the time of our inspection.
- The service was not able to evidence quality assurance programmes were in place for all modalities.
- The service did not have a comprehensive audit programme in place.
- The service did not use the World Health Organisation (WHO) surgical safety checklist for radiological interventions for invasive procedures such as ultrasound guided injections.
- We found a medicines cabinet in in the department which did not have a lock and contained medicines.
- The service did not manage infection risk well. The service stored patient gowns on top of locker cabinets where they could collect dust. There were no checklists to indicate when the patient toilets had last been cleaned and not all staff were bare below the below.
- There was a poster in the radiology department which had incorrect instructions and referred to a previous provider's policy.
- The service did not have regular formal radiology team meetings that were minuted.

However:

- The service had enough staff to care for patients and keep them safe.

Summary of findings

- Staff worked well together for the benefit of patients. Key services were available to suit patients' needs.
- Staff treated patients with compassion and kindness, respected their privacy and dignity, took account of their individual needs, and helped them understand their conditions. They provided emotional support to patients, families and carers.
- The service planned care to meet the needs of local people, took account of patients' individual needs, and made it easy for people to give feedback. People could access the service when they needed it and did not have to wait too long for treatment.
- Staff generally understood the service's vision and values, and how to apply them in their work. Staff felt respected, supported and valued. They were focused on the needs of patients receiving care.

Services for children & young people

Requires Improvement

We rated it as requires improvement because:

- Not all staff were up to date with all mandatory training including safeguarding and there was no safeguarding lead at the time of our inspection.
- The service did not have a comprehensive audit programme in place and systems for monitoring the effectiveness of the service.
- The provider's practising privileges policy did not set out what mandatory training was required by consultants.
- Leaders did not run services using reliable information systems, such as having a comprehensive risk register.

However:

- The service had enough staff to care for children and young people and keep them safe. Staff provided good care and treatment. Key services were available six days a week and made sure staff were competent.
- Staff treated children and young people with compassion and kindness, respected their privacy and dignity, took account of their

Summary of findings

individual needs, and helped them understand their conditions. They provided emotional support to children and young people, families and carers.

- The service planned care to meet the needs of local people, took account of children and young people's individual needs, and made it easy for people to give feedback. People could access the service when they needed it and did not have to wait too long for treatment.
- Staff understood the service's vision and values, and how to apply them in their work. Staff felt respected, supported and valued. They were focused on the needs of patients receiving care.

Summary of findings

Contents

Summary of this inspection

Background to New Malden Diagnostic Centre

New Malden Diagnostic Centre is operated by Sterling Healthcare Group Ltd. The centre provides outpatient consultations, diagnostic imaging, minor surgery and treatment for all ages. The centre is located within an NHS GP practice.

Facilities at the centre include a diagnostic imaging unit, a treatment room and six consulting rooms. One of the consulting rooms is equipped with specialised Yttrium Aluminium Garnet (YAG) laser equipment for ophthalmology.

The centre offers a range of specialities including cardiology, neurology, dermatology, endocrinology, ENT, ophthalmology, orthopaedics and respiratory services.

The centre provides a range of diagnostic imaging services such as x-ray imaging, interventional and diagnostic ultrasound, electrocardiograms and magnetic resonance imaging (MRI). The service also has a service level agreement with a local NHS trust to carry out scans to help increase the trust's capacity.

The centre opened in 2010 and was managed by another provider until its sale and transfer to Sterling Healthcare Group in 2020. This is the first time we have inspected the service under Sterling Healthcare Group.

The provider is registered for the following regulated activities:

- Treatment of disease, disorder or injury
- Diagnostic and screening procedures
- Maternity and midwifery services
- Family planning
- Surgical procedures

How we carried out this inspection

We carried out a comprehensive inspection of the service on 21 March 2023. The CQC team comprised of 4 CQC inspectors and 2 specialist advisors. We carried out interviews with patients on 31 March 2023 and 4 April 2023.

We spoke with 12 members of staff including medical staff, nursing staff, imaging staff, administrative staff and senior managers. We spoke with 11 patients and a relative who were using the service at the time of our inspection. We reviewed a range of policies, patient records and observed patient care.

Summary of this inspection

To get to the heart of patients' experiences of care and treatment, we ask the same five questions of all services: are they safe, effective, caring, responsive to people's needs, and well-led? Where we have a legal duty to do so we rate services' performance against each key question as outstanding, good, requires improvement or inadequate. Throughout the inspection, we took account of what people told us and how the provider understood and complied with the Mental Capacity Act 2005.

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.

Action the service MUST take to improve:

In outpatients, surgery, diagnostic imaging and children and young people:

- The service must ensure all equipment are safety tested regularly. (Regulation 12(2)(e)).
- The service must ensure there are effective systems for monitoring the effectiveness of care and treatment. This includes implementing a comprehensive audit programme in order to identify risks and improve patient outcomes. (Regulation 17(1)(2)(a)(b)).
- The service must ensure there are effective systems to monitor, escalate and mitigate risks appropriately. (Regulation 17(1)(2)(b)).
- The service must ensure there are effective governance processes in place. This includes implementing systems for reviewing audits, risks and practising privileges. (Regulation 17(1)(2)(a)(b)).
- The service must maintain contemporaneous record in respect of each service user. (Regulation 17 (1)(2)(c).

In diagnostic imaging:

- The service must ensure that the doors to the MRI suite should be self-closing and locking with security locks that can be operated by MR authorised personnel only from the outside, but freely opening from the inside in case of emergency. (Regulation 12(2)(e)).
- The service must ensure cabinets containing medicines are lockable. (Regulation 12(2)(g)).
- The service must ensure staff are up to date with all mandatory training (Regulation 12(2) (c)).
- The service must ensure the checklist for the emergency grab bag matches the contents of the bag and that consumable items are in date. (Regulation 12(2)(a)).
- The service must ensure that quality assurance programmes are in place for all modalities. (Regulation 17(2)(b).
- The service must control infection risk well. This includes ensuring all staff are bare below the elbow. The service must ensure that cleaning checklists are completed in patient toilets and patient gowns are stored appropriately where they can be kept clean and free of dust. (Regulation 12(2)(h)).
- The service must ensure there are regular formal radiology team meetings that are minuted. (Regulation 17(2)(a)).

In surgery:

- The service must ensure the use of the World Health Organisation (WHO) safer surgery checklist, and the New Early Warning System (NEWS2) to identify deteriorating patients are implemented. (Regulation 12 (1)(2)(b)).

Summary of this inspection

Action the service SHOULD take to improve:

In outpatients, surgery, diagnostic imaging and children and young people:

- The provider should ensure staff document a comprehensive risk assessment for each individual patient.
- The service should ensure consultant's working under practising privileges have their mandatory training requirement identified.
- The provider should ensure that minutes of meetings contain sufficient detail to provide a clear understanding of what was discussed.

In children and young people's services:

- The service should ensure that children, young people and their families are given practical support and advice to lead healthier lives.

In diagnostic imaging:

- The service should ensure posters in the department accurately reflect the current provider's procedures and do not refer to the previous provider's policies.
- The service should provide gowns to all patients before their scans.
- The service should check that information about the radiation used during common imaging procedures is available in the radiology department for patients and their carers.
- The service should check that information about how to make a complaint is available in the radiology department for patients and their carers.
- The service should ensure that all consumables are in date.
- The service should use and audit the use of the World Health Organisation (WHO) surgical safety checklist for radiological interventions.
- The service should consider putting posters up on how to report a safeguarding concern.
- The service should consider a separate paediatric waiting area in the main waiting area of the service.
- The service should check that the sign at the entrance of the c-arm room is in operation and is lit up to indicate whether it is in use or not. The room should also have the name and number of the radiation supervisor written on the front of the door.
- The service should consider installing grab rails within the changing rooms to help those with mobility needs.
- The service should consider putting space within records to include patients' additional needs such as phobias or mobility.

Our findings

Overview of ratings

Our ratings for this location are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Outpatients	Requires Improvement	Inspected but not rated	Good	Good	Requires Improvement	Requires Improvement
Surgery	Requires Improvement	Requires Improvement	Good	Requires Improvement	Requires Improvement	Requires Improvement
Diagnostic imaging	Requires Improvement	Inspected but not rated	Good	Good	Requires Improvement	Requires Improvement
Services for children & young people	Requires Improvement	Requires Improvement	Good	Good	Requires Improvement	Requires Improvement
Overall	Requires Improvement	Requires Improvement	Good	Good	Requires Improvement	Requires Improvement

Requires Improvement

Outpatients

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

Is the service safe?

Requires Improvement

We had not previously rated safe at this service. We rated it as requires improvement.

Mandatory training

The service provided mandatory training in key skills to all substantive staff. However, a significant number of consultants were not up to date with mandatory training.

Staff received and kept up-to-date with their mandatory training. We reviewed the staff training matrix and nursing staff had completed all their mandatory training modules.

The mandatory training was comprehensive and met the needs of patients and staff. Mandatory training requirements included a range of areas such as, immediate life support, infection prevention and control, equality, diversity and inclusion, medicines management and safeguarding among others.

Managers monitored mandatory training and alerted staff when they needed to update their training. Staff confirmed they could access their mandatory training records and received alerts when training was due.

Consultants working under practising privileges were required to provide evidence of compliance with mandatory training. However, the practising privileges policy did not set out what mandatory training was required by consultants. We reviewed training matrix for consultants which showed a completion rate of 63.5%.

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. At the time of our inspection, all nursing staff had completed level two safeguarding training for adults and for children. However, it was unclear who the safeguarding lead was.

Requires Improvement

Outpatients

Following our inspection, we were provided an updated training matrix which showed that all nursing staff had completed level three safeguarding training for adults and children. We were provided further updates showing that lead nurse had completed level four safeguarding training in April 2023 to act as the safeguarding lead.

Safeguarding training included information about female genital mutilation and child exploitation.

The service had two up-to-date safeguarding policies, one for children and one for adults. Each policy included details of how to escalate concerns.

Staff knew how to identify adults and children at risk of, or suffering, significant harm and worked with other agencies to protect them. Staff could give examples of concerns they would report and knew how to report safeguarding concerns. Staff could give examples of how to protect patients from harassment and discrimination, including those with protected characteristics under the Equality Act.

The service posted information about domestic violence agencies and where to report it in patient toilets.

There were no safeguarding incidents in the previous 12 months.

Cleanliness, infection control and hygiene

The service did not always manage infection risk well. While equipment and premises were mostly visibly clean, hand hygiene audits were not conducted frequently.

Clinical areas were clean and had suitable furnishings which were clean and well-maintained. We observed that most areas of the clinic were visibly clean and free from clutter. However, we found the top of the medicines' cabinet was dusty.

Following our inspection, we were provided with a cleaning schedule which highlighted all areas of the clinic and the cleaning frequency.

Staff were 'bare below the elbow' and adhered to infection control precautions throughout our inspection, such as handwashing and using hand sanitisers when entering and exiting the unit and wearing personal protective equipment (PPE) when caring for patients. Staff cleaned equipment after patient contact.

Hand hygiene audits were undertaken annually and not at regular intervals. Data provided for September 2021 and 2022 demonstrated the service scored 100%.

Hygiene and personal protective equipment (PPE) audits were carried out monthly. We looked at the audits from the last six months which showed 100% compliance in all areas assessed.

Environment and equipment

The design, maintenance and use of facilities, premises and equipment did not always keep people safe. Staff managed clinical waste well.

The service had suitable facilities to meet the needs of patients' and their families. The outpatient had sufficient number of consultation rooms and waiting areas.

Requires Improvement

Outpatients

We checked a random sample of equipment and found that the suction unit and blood pressure machine were due for testing in June 2021.

Following the inspection, the service provided evidence to show that electrical testing had been undertaken in April 2023.

Staff carried out daily safety checks of specialist equipment. The resuscitation trolley was checked regularly by staff. Oxygen cylinders were stored securely and in date.

Staff disposed of clinical waste safely. There were adequate arrangements for handling, storage and disposal of clinical waste, including sharps. Waste was segregated with separate bins for general waste and clinical waste.

Assessing and responding to patient risk

Staff informed us consultants completed risk assessments to determine patient suitability for procedures. However, staff did not have access to the consultants' notes and we were unable to review risk assessments completed. As a result, we were unable to review how risks were assessed. The service had plans to implement a single system for all staff.

All staff had completed basic or intermediate life support training to care for patients in an emergency. Patients requiring medical intervention were transferred to the hospital via an ambulance in line with the provider's policy. Staff informed us the service would receive support in an emergency from the GP service they shared a building with. However, there was no service level agreement covering emergency support from the GP service.

Staff shared key information to keep patients safe when handing over their care to others. Staff followed a standard process to share clinical information with GPs when necessary.

Nurse staffing

The service had enough nursing and support staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment.

The service had enough nursing and support staff to keep patients safe. The service had 2 nurses and 1 health care assistant (HCA).

Nursing cover was calculated based on the number of clinics and procedures during each shift. There was always a minimum of two nursing staff on duty.

All staff had received a full induction and understood the service. All new staff were supervised and required to complete competencies before they were able to work independently.

Medical staffing

The service had enough medical staff to keep patients safe. Outpatient clinics were led by consultants who worked under practising privileges. Practising privilege is a well-established system of checks and agreements, whereby doctors can practise in hospitals without being directly employed by them. Clinics were scheduled to suit each specialist's availability and obligation as part of their practising privileges contract. The centre had 46 consultants working under practising privileges.

Requires Improvement

Outpatients

Records

Staff kept nursing records of patients' care and treatment. Nursing records were clear, up-to-date and stored securely. However, staff could not access consultant notes.

Patients notes we reviewed consisted of basic nursing records of minor procedures. Each record included details of the patients, the procedure involved, medication, advice provided, follow up required and details of the clinical staff involved.

Consultants held their own records which other staff could not access. The provider informed us the results from any blood tests were sent to the consultant involved.

Senior staff informed us of plans to introduce a new system which would be compatible with electronic records used by consultants. Following the inspection, the provider informed us staff could access blood test results when required.

The service audited nurses notes quarterly. Data provided for the nurses notes audits for the period February 2022 to January 2023 showed that 15% (9 out of 60) of the records did not detail follow up information and 3% (2 out of 60) records did not document procedure notes. The audits did not record if action points had been identified and nursing meeting minutes did not record any discussion of the nursing notes audit.

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 provider had a medicines management policy, which described the storage, prescribing, and safe administration of medicines.

Staff recorded details about patient medicines in patient records. This included information about any patient allergies.

Staff stored medicines safely. Medicines were stored in a secure cabinet. We reviewed a random sample of medicines and found that they were in date. The service did not store or administer controlled drugs.

Medicines requiring cold storage were stored in locked fridges and the temperature was monitored daily. Staff also monitored the temperature of the room where medicines were kept.

Incidents

The service managed patient safety incidents well. Staff recognised incidents and near misses and reported them appropriately.

Staff knew what incidents to report and how to report them. They raised concerns and reported incidents and near misses in line with the service's policy. Staff reported incidents on an incident form which was escalated to the registered manager. Staff informed us they received feedback about incidents investigated. We reviewed the incident tracker for the last 12 months and saw that staff reported 7 incidents regarding the centre.

The incident tracker highlighted lessons learned and action taken to improve the service. For example, the main entrance doors were repaired after they failed to open during a fire alarm test. Staff were informed to use the fire exit while being repaired.

Requires Improvement

Outpatients

Staff understood the duty of candour. They told us it involved being open and transparent and giving patients and their families a full explanation if and when things went wrong.

Is the service effective?

Inspected but not rated

We do not rate effective in outpatient services.

Evidence-based care and treatment

The service provided care and treatment based on national guidance and evidence-based practice.

Staff followed up-to-date policies to plan and deliver high quality care according to best practice and national guidance. Staff had access to policies on the provider's system. Policies were in date and developed in line national guidance such as the National Institute of Health and Care Excellence (NICE) guidance.

The service carried out some audits to monitor staff compliance with guidelines. This included hygiene and PPE audit, and the nurses notes audit.

Nutrition and hydration

Patients had access to beverages and water in the waiting areas.

Pain relief

The service advised pain scoring tools would be managed by the consultant in charge and documented in the consultants' notes. Following our inspection, we were provided with assessment tools used to assess patient pain.

Patient outcomes

Staff did not monitor the effectiveness of care and treatment.

The service did not participate in national audit programmes. Local audits were limited to nursing notes and hygiene and PPE audits.

Patients attending the centre often required diagnostic imaging services or surgical procedures. However, the service did not carry out a comprehensive programme of repeated audits to check improvements over time. This meant we were not assured that outcomes for patients were positive, consistent and met expectations such as national standards.

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 had completed relevant training required for their role. Managers regularly reviewed the registrations and revalidations of relevant clinic staff to make sure they were up to date.

Requires Improvement

Outpatients

Managers gave all new staff a full induction tailored to their role before they started work. New members went through a probationary period and completed competency training.

Managers supported staff to develop through yearly, constructive appraisals of their work. All nursing staff had received an appraisal within the last one year.

Consultants with practising privileges were required to provide evidence of appraisals, revalidation, and professional registrations and this was monitored by the service. Data provided showed that 81% of the consultants had an up to date appraisal.

Multidisciplinary working

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 when required to care for patients. Medical staff, nurses and diagnostic imaging staff worked together to deliver patient care. Staff told us they had good working relationships with other members of staff in the centre.

Seven-day services

Key services were available to support timely patient care.

The service operated from Monday to Friday 8am to 8pm, and Saturdays from 8am to 6pm.

Staff could call for support from doctors and other disciplines, including diagnostic tests.

Health promotion

Staff assessed each patient's health at every appointment and signposted patients to relevant organisations for their care. The service referred patients to local support groups for smoking cessation, emotional distress and anxiety among others.

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.

Staff gained consent from patients for their care and treatment in line with legislation and guidance.

Staff understood how and when to assess whether a patient had the capacity to make decisions about their care. Staff could describe their roles and responsibilities under the Mental Health Act.

Staff had received training in Mental Capacity Act and Deprivation of Liberty Safeguards as part of their mandatory training.

Requires Improvement

Outpatients

Is the service caring?

Good

We had not previously rated caring at this service. We rated it as good.

Compassionate care

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

Staff took time to interact with patients and those close to them in a respectful and considerate way. Our observation of patient care showed staff engaged well with patients, they were polite, caring and compassionate.

Staff were discreet and responsive when caring for patients. They followed policy to keep patient care and treatment confidential. Discussions took place in dedicated consulting rooms to protect patient privacy and dignity.

Patients said staff treated them well and with kindness. Patients and their relatives spoke positively about their care. They said staff were “very good”, “thorough” and “answered all questions clearly”. Patients said they were very pleased with their consultation and would recommend the service.

Staff understood and respected the personal, cultural, social and religious needs of patients and how they may relate to care needs. Patients were offered a chaperone for their appointment. Posters offering chaperone services were located in all clinical areas.

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. Our observation of patient care showed staff were re-assuring and comforting to patients. Patients confirmed that staff helped to put them at ease.

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. Staff understood the anxiety or distress associated with procedures and engaged patients to ensure they were comfortable.

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. Our observation of patient care showed that patients were given clear information regarding the benefits and risks of their treatment and were given the opportunity to ask questions. Patients informed us they received clear information about the cost of their treatment.

Staff engaged well with patients and involved patients in their care.

Requires Improvement

Outpatients

Patients and their families could give feedback on the service and their treatment and staff supported them to do this. Patients gave positive feedback about the service. We reviewed patient feedback on an online patient review portal. The service achieved 4.9 out of 5 for overall experience, friendliness and cleanliness.

Is the service responsive?

Good

We had not previously rated responsive at this service. We rated it as good.

Service delivery to meet the needs of local people

The service planned and provided care in a way that met the needs of their patient population.

Managers planned and organised services so they met the changing needs of patients. The department operated an appointment based service from Monday to Saturday. Appointments were arranged with patients, at a time and date convenient for them. A wide range of outpatient services were available to meet patient need. Specialist services offered included neurology, dermatology, ophthalmology, orthopaedics and paediatric services amongst others. Patients also had access to diagnostic imaging services and minor surgical services.

The service had adequate number of consulting rooms, a treatment room and waiting areas. Patients had access to beverage making facilities in waiting areas and free car parking was provided on site. The service offered evening and Saturday clinics, which could be more convenient for patients with childcare commitments during the week.

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.

All clinical staff had completed training on recognising and responding to patients with mental health needs and disabilities. All staff had completed equality and diversity training and understood the importance of providing care without prejudice to people with protected characteristics under the Equality Act.

Staff understood and applied the policy on meeting the information and communication needs of patients with a disability or sensory loss. Staff used communication aids to help patients become partners in their care and treatment. The service also had a portable hearing loop for patients with hearing impairments.

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

Managers made sure staff, and patients, loved ones and carers could get help from interpreters or signers when needed. Staff could arrange interpreting services to support patients whose first language was not English.

The service referred patients to local support groups for counselling, smoking cessation, domestic violence, emotional distress and anxiety among others.

However, the service did not have a lift for patients with limited mobility to access the first floor where the minor procedures treatment room was located.

Requires Improvement

Outpatients

Patients with limited mobility needs could access the first floor via a lift which was located in another part of the building operated by another healthcare provider.

Access and flow

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

Appointments were booked around patients' and consultants' schedule. Patients told us they found it easy to book an appointment and were able to choose a date convenient for them. In addition, patients had access to same day or next day appointments.

Managers worked to keep the number of cancelled appointments to a minimum. There were 10% (1070) cancellations in the last year and this was mainly due to cancellations by patients who needed to reschedule.

The service advised patients who did not attend (DNA) a consultation with a consultant would be managed by the consultant and their team. If patient attended the service for a blood test they would be contacted if they did not attend and have their appointment rescheduled.

Patient provided positive feedback about waiting times. The service achieved 4.8 out of 5 for waiting time on the patient feedback portal.

Learning from complaints and concerns

It was easy for people to give feedback and raise concerns about care received. The service investigated complaints and shared lessons learned with all staff.

Senior staff informed us the service sent out communication following patient appointments with a link for patients to provide complaints or feedback about the service. There was also information on how to make a complaint on the provider's website.

Staff understood the policy on complaints and knew how to handle them, however, the service did not display information about how to raise a concern in patient areas.

The provider had a complaints policy which set out the complaint process. The policy stated that complaints will be acknowledged within two working days. The service aimed to resolve complaints within 20 working days.

Managers investigated complaints and identified themes. The service received four complaints in the last 12 months. All complaints were resolved within the stipulated time in line with the provider's policy.

Managers shared feedback from complaints with staff and learning was used to improve the service. For example, the service developed product tick sheets where staff could select tests performed which provided clarity regarding the prices of any additional tests following a consultation.

The service did not subscribe to any independent adjudication services that could support investigating complaints objectively when they could not be resolved locally.

Is the service well-led?

Requires Improvement

Outpatients

Requires Improvement

We had not previously rated Well led at this service. We rated it as requires improvement.

Leadership

Leaders were visible and approachable in the service for patients and staff. They supported staff to develop their skills. However, leaders did not demonstrate full understanding of the issues the service faced or how to manage them.

A chief executive officer (CEO) had overall accountability for the service and was supported by the senior management team. The team included the general manager (who was also the registered manager for the service) and the medical director.

The service had a nursing lead and radiology lead.

Staff were positive about the leadership of the service. They informed us managers were visible and approachable. They felt well supported by the medical director and registered manager of the service.

Managers had some understanding of the priorities of the service including implementing environmental risk assessments and having a business continuity plan in place.

We were provided with a risk register following our inspection. The risk register was not comprehensive and did not reflect all the risks identified during our inspection. As a result, we are not assured that leaders understood the challenges the service faced and could identify actions needed to address them.

Vision and Strategy

The service had a vision for what it wanted to achieve and a strategy to turn it into action. The vision and strategy were focused on sustainability of services. Leaders and staff understood and knew how to apply them and monitor progress.

The provider had a clear vision for the service. The provider's aim was to become a fully integrated outpatient diagnostic centre with the highest standards of delivery and offering the latest technology available.

They had a philosophy which was built on 5 pillars: "Excellent and continuous care for patients intended to reach an accurate diagnosis and clear management plans, investment in leading medical consultants and therapists providing the highest quality of care, investment in cutting-edge technology, from therapeutic interventions to diagnostic technology, pricing to compete with competitors, communicating clearly and helpfully to ensure that the service's message reaches those who can benefit most."

The service had a business development strategy for achieving the priorities over three phases.

Staff were familiar with the vision and were committed to providing high quality care.

Culture

Staff felt respected, supported and valued. They were focused on the needs of patients receiving care.

Requires Improvement

Outpatients

Staff informed us there was a positive culture within the service. They felt respected, supported and valued. Staff had opportunities for training and development.

The service had an open culture where staff could raise concerns without fear. Staff felt able to raise concerns and report incidents locally.

Patients we spoke to were positive about the culture of the service.

The service had a diverse team of staff, and staff we spoke to felt they worked in a fair and inclusive environment.

Staff felt they worked well together in a good team and confirmed they were focused on the needs of patients.

Governance

Leaders did not always operate effective governance processes.

Managers were unable to demonstrate they had effective oversight of the service. There were ineffective structures, processes and systems of accountability to support the delivery of good quality and sustainable services. For example, the service did not carry out a programme of repeated audits to monitor the effectiveness of care and treatment.

The service held monthly senior management, head of department and nursing team meetings. Minutes recorded very brief discussions which included incidents and patient feedback. The minutes did not contain sufficient detail to provide a clear understanding of what was discussed.

The service did not have a formally constituted Medical Advisory Committee (MAC). Senior staff informed us the MAC had two members. We requested for minutes of MAC meetings, but these were not provided. We were therefore not assured about the processes for granting and reviewing practising privileges.

Portable appliance testing of equipment were out of date at the time of the inspection. Although, equipment testing had been updated following our inspection, equipment reviewed during our inspection were last tested in June 2021. This meant the service was not monitoring equipment performance during the period between June 2021 and April 2023 which had the potential to negatively impact on patient safety.

Management of risk, issues and performance

Leaders and teams did not use systems to manage performance effectively. The service did not have a risk register to record the management or mitigation of risks. They had plans to cope with unexpected events.

We requested for a copy of the local risk register for the centre covering all services provided, however, the risk register provided did not cover outpatient services.

Following our inspection, we were provided with a risk register for the centre. The risk register identified 12 risks, most of which were related to patient and staff safety. However, it was not clear when they had been added to the register as individual risks were not dated and there was no review date. The risk register did not include some of the main risks around equipment maintenance, clinical audits and governance identified during our inspection.

Our review of meetings minutes showed that risks were not routinely reviewed.

The service did not perform routine clinical audits to monitor the quality of care for continuous improvement. This meant the service could not identify risks and improve outcomes for service users.

The service had conducted several environmental risk assessments which included health and safety risk assessments (October 2021), health and safety risk assessments walk arounds (January, March, June 2022), legionella (June 2022) and Control of Substances Hazardous to Health (COSHH) (April 2023). However, it was unclear how senior staff disseminated the findings to staff. Minutes of meetings reviewed did not reference any discussions related to findings from the risk assessments.

The service had a business continuity plan to mitigate any business continuity risks.

Information Management

The information systems were secure. However, staff did not have access to systems used by consultants.

Staff had received training in information governance and General Data Protection Regulations (GDPR) as part of their mandatory training.

The provider had an up-to-date data protection policy which was in line with relevant legislation and the requirements of GDPR.

All staff had access to the organisation's electronic system to gain information relating to policies, procedures, national guidance and e-learning.

Access to individual patient's records was restricted to authorised staff. Electronic devices were password protected and staff signed out of computer systems when they were not in use.

However, staff did not have access to consultant notes or results of blood test results. The results of any blood test results were sent directly to the consultant involved. Senior staff informed us of plans to introduce a new system which would be compatible with electronic records used by consultants.

Engagement

Leaders and staff actively and openly engaged with patients and staff.

The service engaged patients through feedback questionnaires and used feedback to improve the service. For example, non-clinical staff had completed customer service training in the last year in order to improved customer service following patient feedback.

The provider informed us that as a small unit, staff were encouraged to discuss any feedback related to the centre. The service held staff meetings and staff had access to a feedback form which they could complete anonymously.

Senior staff told us the service held a "chill out" session every month where staff could meet to build a stronger bond.

Learning, continuous improvement and innovation

All staff were committed to continually learning and improving services.

The service had systems to monitor staff training and development. Staff had taken advantage of the opportunities available to learn, develop and improve their skills.

Requires Improvement

Outpatients

The provider had signed a new contract for a comprehensive patient management system following feedback from consultants and their secretaries about the booking system.

Requires Improvement

Surgery

Safe	Requires Improvement
Effective	Requires Improvement
Caring	Good
Responsive	Requires Improvement
Well-led	Requires Improvement

Is the service safe?

Requires Improvement

We had not previously rated safe at this location. We rated it as requires improvement.

Mandatory training

The service provided mandatory training in key skills to all clinic staff. However, the providers policy did not set out what mandatory training was required by consultants working under practising privileges.

Staff received and kept up to date with their mandatory training. Data provided showed mandatory training completed by nursing and non-medical staff. Staff told us they had completed mandatory training and data provided showed completion was 100%.

Mandatory training met the needs of patients and staff. The training included a range of topics such as equality and diversity, fire safety, moving and handling, infection control, health and safety.

Consultant's working under practising privilege were required to provide evidence they had undertaken mandatory training, however the providers granting and reviewing practicing privileges policy did not set out what mandatory training was required. Data provided by the service showed mandatory training was monitored and completion was 63.5%.

Safeguarding

Staff understood how to protect patients from abuse. 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. Safeguarding children and adults formed part of the mandatory training programme for staff. Records showed 100% of clinical staff had received safeguarding children level 2 and safeguarding adults' level 2 training. Following the inspection two of the nursing staff undertook level 3 safeguarding adults and children training. The provider advised the lead nurse had been booked to complete a level 4 safeguarding adults' course in April.

Requires Improvement

Surgery

Staff spoken with had a good understanding of adult safeguarding. Staff knew who to inform if they had concerns and could access support if needed. The service had a safeguarding adult at risk policy which was not dated to indicate when it had been issued.

The service advised there had been no safeguarding concerns raised in the last 12 months.

Cleanliness, infection control and hygiene

The service did not always control 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.

Clinic areas were clean and had suitable furnishings which were clean and well-maintained. Clinical staff were responsible for cleaning the treatment room and other clinical areas. The service advised the clinical staff are responsible for the deeper clean within their respective areas. However, we found cleaning at high level on the top of the medicine's cabinet was not being undertaken routinely. The service's domestic team was responsible for cleaning other areas.

Hand hygiene audits were undertaken annually. Data provided for September 2021 and 2022 demonstrated the service scored 100%. Hand washing facilities and hand sanitiser gel dispensers were available in line with infection prevention and control guidelines. Staff had access to adequate supplies of personal protective equipment (PPE) such as gloves and aprons. Staff were bare below elbow.

The service undertook monthly hygiene and PPE audits. Data provided for the period September 2022 to February 2023 demonstrated the service was mostly compliant. However, it was not clear what actions were taken when issues were identified or when the issue had been addressed.

Disposable curtains were in use to screen patients, these had been dated when they came into use.

Environment and equipment

The design, maintenance and use of facilities, premises and equipment did not always keep people safe. Staff managed clinical waste well.

One of the consultation rooms had a YAG laser which was used for ophthalmic procedures. Removable laser warning signage was hung on the door when ophthalmic consultations were in progress to alert patients and staff there was a risk of being exposed to a naked laser beam.

The keys for the YAG laser were held securely in the key cabinet in the treatment room, however the keys were not signed in or out, which was not in line with best practise.

The service held YAG laser logbook which recorded the date, time, patients name, consultants name, number of burns, spot size. We found this had been completed consistently but identified one gap in the record. The service had undertaken a total 15 procedures since January 2023. The treatment room included a treatment bed, a privacy curtain, overhead lamp, and a nurse's station. All the equipment looked visibly clean and was still under warranty. However, we observed the equipment did not have 'I am clean' green stickers on equipment as adopted by both NHS and some independent health care providers to identify equipment that had been cleaned. The treatment room appeared clean and tidy. The dirty utility area was located next to the treatment room.

Requires Improvement

Surgery

The provider used single use surgical equipment.

Electrical appliance safety testing was undertaken annually. A random check of equipment found the suction unit and blood pressure machine had not been checked in the last 12 months. The labels recorded that the next checks were due June 2021. Following the inspection, the service provided evidence to show that electrical testing had been undertaken in April 2023.

The service had a back-up generator for use in the event of a mains failure.

Staff carried out daily safety checks of specialist equipment. The resuscitation trolley was in the treatment room and was checked regularly by staff. Current emergency protocols were laminated were attached to the trolley. Oxygen cylinders were full, stored securely and in date.

Sharps bins were available in each clinical room and on the emergency trolley. Sharps bins had been signed when had come into use. They were not over filled.

Staff disposed of clinical waste safely. Clinical and non-clinical waste were correctly segregated and collected separately, either in clinical waste bins or sharps instrument containers, which were not over filled. All waste was kept in separate waste bins in secure storage external to the service and was collected by a specialist waste company on a weekly basis.

Assessing and responding to patient risk

Staff did not always complete risk assessments for each patient.

Staff did not use a recognised tool to identify deteriorating patients such as the New Early Warning System (NEWS2). Staff recorded patients' blood pressure and heart rate prior to and post minor surgery.

Staff did not use World Health Organisation (WHO) safer surgery checklist in theatres, which was designed to prevent avoidable mistakes. At the time of the inspection no check list was in place.

The service used a procedural log which was saved onto the shared drive, to provide an audit trail of patients and if necessary, facilitate any re-call of products. The service advised they would not treat patients needing sedation or general anaesthetic for a procedure.

Basic life support (BLS) or immediate life support (ILS) was part of the mandatory training programme for all clinical staff. Data provided showed completion was 100%. The service had a resuscitation policy which had been reviewed in April 2023 and was awaiting approval.

The service had a standard operating procedure for patient medical emergency policy for the emergency transfer of a patient which had been reviewed in March 2023. The service advised an ambulance would be called and a handover sheet would be completed and handed to the paramedics for to enable a safe transfer.

Nurse staffing

The service had enough nursing and support staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment.

Requires Improvement

Surgery

The service had enough clinical staff to keep patients safe. Staffing levels and skill mix were planned and reviewed so that patients could receive safe care and treatment.

Staff included 2.5 whole time equivalent (WTE) nurses and 1 WTE health care assistant (HCA). Staff advised consultants book the treatment room in advance so appropriate staffing can be provided.

Medical staffing

The service did not directly employ any medical staff. The service had 43 consultants who were able to work at the service with practising privileges. Practising privileges are a well-established system of checks and agreements, whereby doctors can practise in hospitals without being directly employed by them.

Records

Staff kept detailed records of patients' care and treatment. Records were stored securely and easily available to staff providing care.

The service used paper and electronic patient records (EPR). Electronic records could only be accessed by authorised personnel. Computer access was password protected and staff used individual log-ins. Staff told us that paper records were scanned onto the system. Leaders advised they were planning to introduce a introduce a new EPR system later this year which would be compatible to electronic system used by the consultants with practicing privileges.

Consultants held their own records which the service could not access. Following the inspection, the provider advised staff were able to access blood test results when required.

One consultant we spoke with advised the service did not provide patient labels for requesting further tests for example blood tests and MRI (magnetic resonance imaging) scans which meant consultants had to hand write all requests which was time consuming and there was room for error.

The service audited nurses notes quarterly. Data provided for the nurse's notes audits for quarters for the period February 2022 to January 2023 showed that 15% (9 out of 60) of the records did not detail follow up information and 3% (2 out of 60) records did not document procedure notes. The audits did not record if action points had been identified and nursing meeting minutes did not record any discussion of the nursing notes audit.

Medicines

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

Staff stored and managed all medicines. All medicines were stored securely in locked cupboards and fridges. Staff monitored fridge temperatures to confirm that fridge temperatures were within the range, and we saw these were recorded.

We reviewed a selection of medicines held by the provider and found they were in date. Medicines expiry dates were monitored to ensure medicine would be used in advance of their expiry dates.

The provider was not licensed to hold controlled drugs and no controlled drugs were stored at the service.

Requires Improvement

Surgery

Medical gases and equipment were checked regularly, in date and readily accessible to staff. Gases were stored away from flammable materials.

The service did not hold medicines to take out (TTO).

Incidents

Staff recognised and reported incidents and near misses. Managers investigated incidents and shared lessons learned however it was not clear how this was communicated.

Staff knew what incidents to report and how to report them. Staff we spoke with told us they were encouraged to report incidents. Senior management team and nursing team meeting minutes reviewed recorded the discussion of incidents was part of the agenda but found little reference to incidents in minutes.

The service used a central system to report and monitor incidents, so all clinical and non-clinical incidents were reported and logged. During the period May 2022 to March 2023, staff reported 7 incidents. The log did not identify any themes and the incidents were not categorised; however, the log did identify lesson learnt and indicated learning had been shared, but it was not clear how this was communicated.

Is the service effective?

Requires Improvement

We had not previously rated effective at this location. We rated it as requires improvement.

Evidence-based care and treatment

The service did not always provided care and treatment based on national guidance and evidence-based practice.

The service was not using a tool for identifying deteriorating patients or the WHO or other safer surgery checklist.

We reviewed a sample of the providers policies and found appropriate reference to relevant National Institute for Health and Care Excellence (NICE) guidelines. All the policies and procedures we reviewed were up to date and had a scheduled review date clearly marked on them. But it was not clear what the process was for signing off approval for new policies or changes to existing policies or how this was disseminated to staff. Policies documented they had been approved by the clinical governance committee. We requested minutes of these meetings, but they were not provided.

All staff had access to the providers policies, procedures and guidelines, staff demonstrated they knew how to access them.

Nutrition and hydration

Patients were not required to fast before surgery. Patients had access to drinking water and hot drinks as needed or required whilst in the department.

Requires Improvement

Surgery

Pain relief

Staff did not formally assess patients pain level using a recognised tool. Patients were encouraged to take regular painkillers if required. The service advised pain scoring tools would be managed by the consultant in charge, this would be documented in the consultants notes which are not held by the service.

Patient outcomes

Staff did not monitor the effectiveness of care and treatment.

The service had a local audit programme which included nurse notes and hygiene and PPE audits and to review the effectiveness of care and treatment.

The service advised it does not participate in national audit programmes.

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 told us they received an induction.

Managers supported staff to develop through yearly appraisals of their work. The appraisal tracker showed staff were due appraisals within the next 3 months. One member of staff advised nursing staff appraisals had been booked for the following week. Staff we spoke with advised they had regular supervision.

Staff spoken with told us there were not many opportunities for learning and development.

Consultants with practising privileges were required to provide evidence of appraisals, revalidation, and professional registrations and this was monitored by the service. Data provided showed that 81% of the consultants had an up-to-date appraisal. One consultant we spoke with told us when they applied practising privileges, they had to provided evidence of provided Indemnity Insurance, last appraisal and references.

Multidisciplinary working

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

We saw evidence of multidisciplinary working between consultants and nursing staff. Staff described good working relationship between staff members. Staff told us they all worked well as a team and were able to support each other as required.

Seven-day services

Key services were available to support timely patient care.

Requires Improvement

Surgery

The service was open 6 days a week opening from 8:00am to 8.00pm Monday to Friday and Saturdays 8.00am to 6.00pm offering consultations and minor surgery.

Health promotion

Staff did not give patients practical support and advice to lead healthier lives.

The service did not undertake health promotion activities. Staff told us following certain procedures some consultants ask for leaflets to be given to patients which explained the procedure and post operative care.

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.

Staff gained consent from patients for their care and treatment in line with legislation and guidance. Consultants gained consent from patients for their care and treatment in line with legislation and guidance.

The provider had a consent policy, which had been reviewed in November 2022.

The Mental Capacity Act and Deprivation of Liberty Safeguards was part the mandatory training programme and 100% of nursing staff had completed this training.

Is the service caring?

Good

We had not previously rated caring at this location. 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.

We spoke with one patient following our inspection. The patient told us staff treated them with kindness and respect and that the staff were friendly.

Staff ensured patients' privacy and dignity was maintained by ensuring patient's information was kept secure, and privacy curtains were closed. The patient we spoke with confirmed this.

The service used an online system for patients to leave feedback. Data provided by the service showed 56 patients had left a review in the previous 30 days at the time of the inspection. The service was rated 5 stars by 94.6% (53) of the patients and the patients trust score was 4.86.

Emotional support

Requires Improvement

Surgery

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

Staff gave patients emotional support and showed sensitivity to patients. The patient we spoke with advised if they were having an examination the consultants would ask as a nurse to act as chaperone.

Understanding and involvement of patients and those close to them

Staff supported patients to understand their condition and make decisions about their care and treatment.

Patients were supported to make informed decisions about their care. The patient we spoke with told us they were involved in their care and were actively involved in all decisions. They were given the opportunity to ask questions about care and the consultant always explained everything and they felt well informed.

Is the service responsive?

Requires Improvement

We had not previously rated responsive at this location. We rated it as requires improvement.

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.

The service provided a minor surgery to self-funding patients both from the local area and other parts of the country. Managers planned and organised services to meet the needs of the patients booked for minor surgery. All admissions were pre-planned, and patient details were sent to the service by the consultants in advance.

The facilities and premises were appropriate for the services that were planned and delivered. There was enough seating in the waiting area where there was a drinks machine and bottled water, and disabled toilet facilities on the ground and first floor.

Meeting people's individual needs

The service did not always take account of patients' individual needs and preferences. Staff did not have access to communication aids to help patients become partners in their care and treatment.

There was no information, or signage suitable for visually impaired patients. The provider had a portable hearing loop for patients with hearing impairments. Information was available on the providers website which was available in a range of languages.

Requires Improvement

Surgery

The entrance was on the ground floor and was easily accessible. Disable toilet facilities were available near the reception area and on the first floor. The service did not have a lift for patients with limited mobility so they could access the first floor where the minor procedures treatment room was located. Following the inspection the provider advised patients could access the first floor via a lift which is located in another part of the building operated by another health care provider.

Staff had access to a telephone interpreting service for patients whose first language was not English.

Patients had access to cold and hot drinks in the waiting room and could serve themselves whilst waiting for their appointment.

Treatment and consultation rooms had notices for patients to request a chaperone.

The service advised they did not cater for patients with complex needs.

The patient registration form included the providers terms and conditions. The providers website provided further information for patients who were self-funding and had private health insurance.

Access and flow

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

Patients under the care of a consultant with practising privileges could use the service. Admissions to the service could only be made by consultants who had admitting rights.

Following the inspection, the provider advised doctors registered with the General Medical Council (GMC) can refer patients for testing.

All appointments were booked in advance and depending on availability further testing could be provided immediately after patient's consultation. The service was open 6 days a week.

All minor procedures were undertaken as day cases with patients discharged on the same day. Patients were given follow up appointments by their consultants if required.

Data provided for the period March 2022 to March 2023 showed there were a total of 10,599 appointments offered, with 84% (8917) attendances. The cancellation rate for this period was 10.5% (1070). A total of 6,125 patients used the New Malden Diagnostic Centre with 5% (310) patients using the nurses' services.

The service advised patients who did not attend (DNA) a consultation with a consultant would be managed by the consultant and their team. Patients attending for blood tests, the patient would be contacted when they DNA. If the patient cannot be reached, the referring clinician would be contacted.

Learning from complaints and concerns

People could give feedback and raise concerns about care received. Complaints were investigated; however, it was not clear how lessons learned were shared with all staff.

Requires Improvement

Surgery

The providers complaints procedure was available online and set out the process for how complaints could be raised. The procedure set out a time frame for acknowledging and investigating complaints. Complaints were acknowledged within two working days of receiving a complaint. The provider aimed to respond within 28 working days. Patients could access the provider's formal complaints policy online.

The service had received four complaints within the last 12 months. Information on how to make a complaint was available on the providers website. However, the service did not display information about how to raise a concern or complaint. The provider advised if patients raise any concern, they will call back within 24/48 hrs. There was no record of complaints or concerns being discussed in senior management team (SMT) meeting or nurses' meeting. In the heads of department (HOD) meetings minutes provided we saw there was reference to one complaint.

The provider was not a member of the Independent Sector Complaints Adjudication Service (ISCAS). Leaders advised that if required complaints would be escalated internally to the chief executive officer (CEO), clinical director or chairman for arbitration.

Is the service well-led?

Requires Improvement

We had not previously rated well-led at this location. We rated it as requires improvement

Leadership

Leaders were visible and approachable in the service for patients and staff. They supported staff to develop their skills. However, leaders did not demonstrate full understanding of the issues the service faced or how to manage them.

There was a clear leadership structure. A chief executive officer (CEO) had overall accountability for the service and was supported by the senior management team. The team included the general manager (who was also the registered manager for the service) and the medical director The leaders had the skills, knowledge, and experience they needed for their roles.

Staff described their immediate managers as accessible and had confidence in them. Staff we spoke with were clear about the management structure and who they could contact in case of any issues. Staff described managers as approachable and supportive. Staff were visible throughout the inspection and motivated to provide high quality of care.

A consultant advised they received no newsletters or updates from the provider but told us 'The nurses are worth their weight in gold, always smiling and very accommodating, nothing too much, absolutely lovely'.

Vision and Strategy

The service had a vision for what it wanted to achieve. The vision and strategy were focused on sustainability. Leaders and staff understood and knew how to apply them and monitor progress.

Requires Improvement

Surgery

The provider had a clear vision for the service. The provider's aim was to provide first class independent outpatient and diagnostic facilities and health care.

This vision was delivered through the provider's core values of the needs and wishes of patients always remain a priority, and that patients are treated with compassion, respect, and dignity. All the staff we spoke with were motivated and aware of their contribution in achieving this.

Culture

Staff felt respected, supported and valued. They were focused on the needs of patients receiving care.

Staff were focused on the needs of patients receiving care. Staff told us there was good teamwork and they were committed to delivering a good service. Staff were enthusiastic about the care and services they provided for patients. Staff described the service as a good place to work and were proud of the service.

Staff felt able to raise concerns and report incidents locally.

There were opportunities for further learning and development. Staff had an annual appraisal and regular one-to-one meetings with the line manager.

Governance

Leaders did not always operate effective governance processes. 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 did not have an effective governance structure. The service did not have a formally constituted Medical Advisory Committee (MAC) and did not meet the criteria to be considered as formal or structured. The service advised the MAC had two members. We requested minutes of the meetings, but these were not provided. One consultant we spoke with advised they were not aware of any MAC meetings.

Data provided showed senior management team (SMT) meetings were held weekly and heads of departments (HOD) meetings were held monthly. Minutes did not identify who was chairing the meeting; nevertheless, there appeared to be a standard format that the meeting followed. Minutes recorded very brief discussions which included incidents and patient feedback.

Nursing team meetings were held monthly. Minutes provided recorded very brief discussions; however patient feedback was not part of the standing agenda.

The provider had a clinical governance policy and process which had been reviewed in October 2022.

Management of risk, issues and performance

Leaders did not always identify and escalated relevant risks and issues and identified actions to reduce their impact. They had plans to cope with unexpected events.

Requires Improvement

Surgery

We requested a copy of the risk register which covered clinical, operational and technical risks which covered all aspects of the service, but this was not provided. The risk register was subsequently provided. The risk register identified 12 risks; most of the 46.5% (5) risks related to patient and staff safety. However, it was not clear when they had been added to the register as the risks were not dated and there was no review date. The risk register did not reflect the risks we had identified during the inspection.

The service had a programme of internal audit which included health and safety risk assessments (October 2021), health and safety risk assessments walk arounds (January, March, June 2022) legionella (June 2022) and COSHH (April 2023). However, it was not clear what the process was disseminating the findings to staff. Minutes of SMT, HOD and nurses' meetings did not reference any discussions related to finding from the risk assessments.

The provider had a business continuity plan which was published in October 2022.

Information Management

Staff could find the data they needed, in easily accessible formats.

Electronic patient records were kept secure to prevent unauthorised access and could be accessed easily. Staff were able to locate and access records easily, this enabled them to carry out their day to day roles.

The provider had an up to date protection policy. Information. Governance information training was part of the mandatory training programme with 100% staff having completed the training.

The provider had a data protection policy, which was reviewed in November 2022. Records showed 100% of staff had completed GDPR.

Engagement

Leaders and staff engaged with patients and staff to manage services.

The service received feedback via online review platforms which were used to populate the providers website. However, the service recognised that this may not be convenient for all patients, a handwritten questionnaire is kept at the reception desk should patients wish to leave feedback whilst on site.

The service provided 7 examples of changes that had been introduced following feedback. These included requiring 48 hours' notice from consultants' secretaries about changes to consultants lists and customer service training for non-clinical staff.

All staff we met were welcoming, helpful and friendly. The service advised staff met informally monthly, leaders also operated an open door policy to encourage discussions and staff were able to feedback anonymously online if have concerns.

The provider had a whistleblowing policy, which was reviewed in October 2022.

Learning, continuous improvement and innovation

Requires Improvement

Surgery

All staff were committed to continually learning and improving services.

The providers overview and business development 2022 – 2023 document growth and development strategy included upgrading the treatment room and providing a recovery area, a more advance bed with attachments for a range of specialities and expanding the ophthalmology services. **O**

Requires Improvement

Diagnostic imaging

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

Is the service safe?

Requires Improvement

Mandatory training

The service provided mandatory training in key skills to all staff but did not make sure everyone completed it.

Mandatory training was comprehensive and met the needs of patients and staff. Modules which were a mixture of online and face to face, included but not limited to: safeguarding adults and children level 1, 2 and 3, female genital mutilation, equality, diversity and inclusion, moving and handling, infection prevention and control, GDPR, disability awareness, immediate life support and paediatric immediate life support.

The service was in the process of transitioning to a new provider for mandatory training which offered more modules for staff to complete. However, when we looked at completion of training of the modules on the old and new mandatory training system, for the radiology department staff, compliance rates were low. For example, for mental capacity training, of the four staff members in radiography, two members of staff were up to date with their training, one member had not completed the training and one member had not completed the yearly refresh of the training.

Of the four members of radiography staff group, one member was up to date with conflict resolution training, equality and diversity, GDPR, health and safety, infection control, safeguarding level 2 and duty of candour. Other members of staff had either not completed the training or had not had their yearly refresh of the training. No members of radiography staff had completed medicines management training, or disability awareness. It was also not clear why some modules such as disability awareness were marked as 'not applicable' for radiography staff.

All radiography staff were up to date with immediate life support and paediatric immediate life support. Manual handling training compliance rates for radiography staff was 100%.

We were told that the registered manager monitored mandatory training and alerted staff when they needed to update their training.

Safeguarding

Requires Improvement

Diagnostic imaging

Staff understood how to protect patients from abuse. However, at the time of our inspection, staff were not trained to level 3 safeguarding children and there was no safeguarding lead trained to level 4 safeguarding at the service. Not all staff were up to date with their safeguarding adults level 2 training. We also did not see posters within the department about how to report a safeguarding concern.

We reviewed the service's safeguarding adults and safeguarding children policy which was in date and available on the service's intranet. The policy detailed individual responsibilities and processes for reporting and escalation of concerns and who to contact.

However, we did not see posters within the department about how to report a safeguarding concern.

At the time of our inspection, radiology staff had not received level 3 child safeguarding training which did not comply with the intercollegiate document Safeguarding Children and Young People: Roles and Competencies for Healthcare Staff. We also saw that not all staff were up to date with their safeguarding adults level 2 training.

We were informed by the provider that level 3 child safeguarding and level 3 adult safeguarding training had been completed following our inspection.

Staff we spoke with had good awareness and knowledge about female genital mutilation (FGM) which was including within safeguarding training however they did not know who the safeguarding lead was. At the time of inspection, the service did not have a safeguarding lead trained to level 4 safeguarding. Following the inspection, we were told that the provider's lead nurse had enrolled in level 4 safeguarding training.

All staff we spoke with demonstrated a good understanding of safeguarding vulnerable adults and children. Staff were able to identify the potential signs of abuse, the process for raising concerns and what would prompt them to make a referral. Staff could give examples of how to protect patients from harassment and discrimination, including those with protected characteristics under the Equality Act.

The service had not had to make any safeguarding referrals in the last 12 months.

Cleanliness, infection control and hygiene

The service did not manage infection risk well. While equipment and premises were visibly clean, there were no cleaning checklists for the toilets and gowns for patients to change into were piled on top of locker cabinets which meant that they could not be kept clean and could gather dust.

Clinical areas were clean and had suitable furnishings which were clean and well-maintained. However, we saw a pile of gowns for patients to change into for their scan, stacked on top of a locker cabinet in the changing area and not stored in a cupboard. This meant that the gowns could not be kept clean and could gather dust which is an infection risk.

We also found empty ultrasound gel bottles cluttered on the ultrasound machine which should have been disposed of and hand gel in the room which was out of date.

We saw that staff cleaned equipment after patient contact. We viewed the daily cleaning checklists for the rooms within the radiology department and found them to have been completed. However, there was some confusion within the

department regarding who was responsible for cleaning the areas within the radiology department. We also were not able to find a cleaning checklist for ultrasound probes. We were told following the inspection that an additional checklist for the cleaning of ultrasound probes was about to be implemented. We requested the cleaning logs for the toilets but were not provided with these.

Hand hygiene audits were conducted yearly. The latest hand hygiene audit was conducted in September 2022 which showed staff in the radiology department had achieved 100% compliance. Hygiene and personal protective equipment (PPE) audits were carried out monthly. We looked at the audits from the last 6 months which showed 100% compliance in all areas assessed.

The service also had access to an infection control specialist who advised on any changes and updates to infection control policies.

Staff generally followed infection control principles including the use of PPE and washing their hands before and after patient contact. However, not all staff during our inspection were bare below the elbow which meant they were not following the service's infection control policy and there could be a potential risk of cross infection from contaminated clothing.

During our inspection there were no infectious patients who were being scanned. However, staff told us that if there was an infectious patient, they would place them at the end of the list and the room would then be deep cleaned afterwards.

Deep cleans were undertaken on a weekly basis by cleaning staff.

Environment and equipment

The environment was suitable for the service provided. However, there was no oversight of the equipment used for reporting and we found that some equipment had not had a recent portable appliance test. We found that some consumables within the emergency grab bag were out of date and the contents did not match the daily checklist.

The imaging department was on the ground floor of the building. The patient waiting area was spacious and had enough seating. However, there was no separate paediatric waiting area with seating for children.

The service had an MRI scanner, x-ray, c-arm (a mobile imaging unit used primarily for fluoroscopic imaging during surgical and orthopaedic procedures) and an ultrasound room.

The MRI room, x-ray room and ultrasound room area of the radiology department was accessible by swipe card by authorised personnel only.

There was clear signage indicating the x-ray room and a light that indicated if the room was in use or not. However, the door to the MRI scanner was not locked from the outside while the MRI scanner was in use during the day. This is against the guidelines the MHRA safety guidelines for magnetic resonance imaging equipment in clinical use which state: "all doors to the MR suite should be self-closing and locking with security locks that can be operated by MR authorised personnel only from the outside, but freely opening from the inside in case of emergency."

We also noted that the c-arm room had a light which would indicate if it was in use or not but the light was not in operation at the time of our inspection, and the door of the room which had a sign to indicate the name of the radiation protection supervisor had been left blank.

Staff had enough space to move around the MRI scanner and for scans to be carried out safely.

During scanning, all patients had access to an emergency call alarm and ear plugs. Patients could also speak to the radiographer through a microphone.

There were appropriate safety precautions for staff such as lead aprons and dosimeter badges.

During our inspection, we checked the service dates for equipment, including scanners. Portable appliance testing stickers on the ultrasound machine, emergency equipment such as the defibrillator and suction machine indicated a next test due date of October 2022. All non-medical electrical equipment we checked such as computers and a CD burner also had the same next test due date of October 2022. Following the inspection, the service sent through evidence of portable appliance testing for the equipment which had taken place after the inspection in April 2023 with the next test due date in April 2024.

Servicing certificates for the ultrasound machine, x-ray, c-arm and MRI scanner were in date. Staff showed us how they completed safety checks on all equipment and logged these. They told us the department had good relationships with manufacturers and they came promptly if a fault was reported.

We checked the emergency grab bag in the imaging department and were told that the equipment was checked daily and weekly. We viewed the checklist for the grab bag and found that they did not match the contents of the bag. This meant that staff had not been properly checking the contents of the grab bag during the daily and weekly checks. In addition, we found two consumable items were out of date.

We inspected sharps bin and found them to be correctly labelled and not filled above the maximum fill line.

Waste management was handled appropriately, with different colour coding for general waste, and clinical waste. All clinical bins were seen to be operated with lids and were not overfilled. Waste management and removal including those for contaminated and hazardous waste was in line with national standards.

We were told cleaning chemicals subject to the Control of Substances Hazardous to Health Regulations 2002 (COSHH) were stored in a locked cupboard in a different part of the building and a risk assessment had been completed.

Assessing and responding to patient risk

Staff completed and updated risk assessments for each patient and removed or minimised risks. Staff knew how to identify and quickly act upon patients at risk of deterioration. However, we found posters within the department which referred staff to a policy which belonged to the previous provider and instructions which referred to equipment which was no longer in the place it stated. We also found that the anaphylaxis box was stored in the MRI scanner room which meant that it was inaccessible to those who required it if the scanner was in use.

Staff completed risk assessments for each patient at the point of booking and on arrival. The service used a ‘pause and check’ system, as per guidance from the British Medical Ultrasound Society.

Requires Improvement

Diagnostic imaging

The service checked the patient's full name, date of birth, pregnancy status, allergies, recent surgery, and received confirmation that the patient expected the diagnostic testing. We saw from our observations and checks of patient records that all patients underwent a risk assessment and gave verbal and written consent to the diagnostic test before their scan.

The department used an MRI patient safety questionnaire. Risks were managed positively and updated appropriately to reflect any change in the patient's condition such as if the patient was claustrophobic or had new allergies. We saw that any known patient allergies were noted on a patient's record.

Not all patients we observed were asked to change into gowns prior to their MRI scan. It is a recommendation in the MHRA Safety Guidelines for Magnetic Resonance Imaging Equipment in Clinical Use that "patients change into appropriate clothing provided by the MR unit to ensure safety" as there is a risk of minor patient burns from scanning patients wearing fabrics containing conductive fibres.

For radiological examinations requiring contrast (dye), patients completed a questionnaire to identify if they had any renal problems which may prevent them receiving contrast.

The service had an anaphylaxis box which was kept in the MRI scanner room in case of allergic reaction however if a patient had a reaction elsewhere in the department and the scanner was in use, this meant the box could not be retrieved. This is a risk to patient safety because the anaphylaxis box is not in an easily reachable location for all patients using the diagnostic imaging department who could have an allergic reaction. Following the inspection, we were told that a second anaphylaxis kit was now located in the same location as the emergency grab bag.

The service treated medically stable patients; however, the service did have a patient medical emergency policy which outlined what staff should do in the event of a patient deterioration. Staff we spoke with knew how to respond to any sudden deterioration in a patient's health. There was an emergency button in all rooms in the department which staff could press for assistance. The service shared its premises with a GP service and was able to call upon support from doctors in the service if required. However, this was an informal agreement and the service did not have a formal service level agreement for this.

There was a deteriorating patient protocol poster on the walls of the radiology department however the instructions referred to a resuscitation trolley within the radiology department which no longer existed and also referred to the resuscitation policy of the provider which previously managed the service.

Staff were able to explain the process to escalate unexpected or significant findings at examination or upon reporting which matched the protocol outlined in the service's critical findings policy. The radiographer told us that any unexpected or significant findings were escalated immediately and confirmation of receipt from the radiology and referring clinician was always required. Radiographers told us they would email and call the radiologist to escalate their concern so that findings could be expedited and relayed to the referring consultant quickly. The service told us they were about to start implementing a logging system whereby unexpected or significant findings would be logged on a shared drive to record that the radiologist and clinician had confirmed receipt of the notification.

The service had four permanent radiographer staff members; one of whom provided a radiation protection supervisor role. This meant that they had received additional training in the Ionising Radiation Regulations 2017 and were responsible for ensuring compliance with the regulations and the local rules. The service had also appointed another radiographer to hold the radiation protection supervisor role who was scheduled for training in May 2023.

Requires Improvement

Diagnostic imaging

The service had access to a radiation protection advisor and medical physics expert who was provided through a service level agreement with an external organisation. Staff could access them if there were radiation concerns relating to the equipment.

Not all staff we spoke with were aware of how to contact the radiation protection advisor for concerns in relation to compliance with the regulations or incidents involving radiation exposure. They told us they would first consult with the radiation protection supervisor.

The service did not use the World Health Organisation (WHO) surgical safety checklist for radiological interventions for invasive procedures such as ultrasound guided injections.

We saw posters in the patient changing area which provided patients with information about pregnancy and requesting chaperones.

All staff in the radiology department were immediate life support training and paediatric immediate life support training.

Staff had undertaken fire safety and evacuation training. They could explain the evacuation procedure and had recently completed a practice evacuation in the month prior to our inspection.

Radiography 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.

The service had enough staff of relevant grades to keep patients safe.

At the time of our inspection, we were told that the service was in the process of recruiting an imaging lead. The radiation protection supervisor was working as the interim lead and worked with the registered manager in the day to day management of the department. Radiographers were employed on a mixture of part time and full-time basis, and worked flexibly to cover the shifts. Sickness rates were low at 1.6%.

Radiologists working under practising privileges used the ultrasound room and were accompanied by healthcare assistants who acted as chaperones. Radiologists working with the provider under practising privileges were available for advice during the hours of operation.

There were two administrative members of staff who managed the reception desk and signposted patients and visitors to the correct department.

Bank and agency staff received a full induction.

Clinical responsibility for patients remained with their referring consultant who held practising privileges with the provider. Radiography staff directed any clinical issues and patient concerns to the referring consultant by telephone or email.

Records

Requires Improvement

Diagnostic imaging

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 however, they did not contain space for recording patients' additional needs such as phobias or mobility.

Patient notes were comprehensive and all staff could access them easily. The service used a mixture of electronic and paper patient records which were scanned into a cloud based server.

Patients were given copies of their scan on a CD. Consultants would send letters to a patient's general practitioner (GP) around the outcome of scans.

Records we reviewed were comprehensive and detailed. Patients completed safety screening questions and recorded the patients' consent to care and treatment. Referral forms included a detailed set of safety questions such as whether the patient had any allergies.

However, the form did not have anywhere to flag any phobias or additional needs the patient had.

Records audits were carried out yearly. The audit looked at a sample of 5 patients and areas such as recording of patient identification, date of birth, address, insurance company details and reason for attending. The latest audit showed not all information was fully recorded. Actions were in place for staff to ensure they contacted secretaries to obtain full information.

Patients' personal data and information were kept secure and only staff had access to the information. We observed staff logging out of computers after use.

Medicines

The service used systems and processes to safely prescribe, administer, record and store medicines. However, we found a medicines cabinet in the lung function room which did not have a lock and contained medicines.

We saw that staff followed systems and processes when safely prescribing, administering, recording and storing medicines. We saw that the service had an up to date medicines management policy.

Patients received a letter prior to their procedure advising them to continue with their usual medicines regime. All patient allergies were documented and checked on arrival for their scan.

The service had access to a pharmacist who could provide guidance and support to the imaging department regarding all issues related to medicines management.

We saw there were patient group directions in place for the administration of certain medicines. Patient group directions are written instructions to help with the supply and administration of medicines to patients, usually in planned circumstances.

The service used contrast media (dye) which are chemical substances used in some MRI scans. The service kept medicines within a locked cabinet and access to the room was restricted to authorised staff only. We saw that temperature logs for the medicines cabinet was completed daily. Controlled drugs were not stored or administered as part of the services provided. We checked a sample of medicines and found they were in date.

Requires Improvement

Diagnostic imaging

However, in the lung function room, which was based within the radiology department, we found a medicines cabinet which did not have a lock and contained medicines. This was a risk as unauthorised persons could easily access the cupboard and take the medicines within it. We were told following the inspection that repairs to install a lock on this cupboard were to take place.

The service sent through a pharmacy audit following the inspection which was dated 31 March 2023 which was after our inspection. It was unclear what the frequency of these audits were. Results showed that the radiology department scored 79% which was lower than the service's target of 95%. Actions were in place where there were concerns; for example: there was no signature list for staff receiving medicines in the radiology department. The action was for the lead radiographer to implement a new process however there was no planned completion date, but a section on the plan to input a date once the action had been completed. The audit had noted the lack of a lock on a medicines cupboard in the lung function room. There was a date in place for when the lock would be installed.

We were told that medicines were replenished by the lead nurse for the service but there was no clear process of ordering new items. This was recognised within the March 2023 medicines management audit but there was no detail around what action would be taken apart from 'further discussion'.

Incidents

The service managed patient safety incidents well. Staff recognised incidents and near misses and reported them appropriately however we were unable to see if incidents were discussed at radiology team meetings as we were not supplied with the minutes of these meetings.

The service managed patient safety incidents well. Staff recognised and reported incidents and near misses. However, we were unable to see evidence that these were discussed at team meetings.

Staff were aware of their responsibilities for reporting incidents and near-misses and were able to explain how this was done. The service used an electronic incident reporting form.

In the last 12 months, there had been four incidents related to the radiology department. service recorded incidents. All four were categorised as low harm incidents and lessons learned had been recorded with the incident log. There had been no IRMER incidents in the last 12 months.

The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain 'notifiable safety incidents' and provide reasonable support to that person. Staff we spoke with were able to explain the duty of candour fully.

Is the service effective?

Inspected but not rated

We do not currently rate effective for diagnostic imaging.

Evidence-based care and treatment

Requires Improvement

Diagnostic imaging

The service provided care and treatment based on national guidance and evidence-based practice. We requested to see a clinical audit programme but was not supplied with this information.

Staff followed up-to-date policies to plan and deliver high quality care according to best practice and national guidance.

We reviewed policies, procedures and guidelines produced by the service. These were based on current legislation, national guidance and best practice and included policies and guidance from professional organisations such as the Medicines and Healthcare Regulatory Agency (MHRA), as well as the Royal College of Radiologists and the Society and College of Radiographers (SCoR).

Staff had access to policies and procedures based on national guidance on the service's intranet.

We saw that staff used the Society and College of Radiographers 'pause and check' system which is a six step-guide to help prevent incidents. Checks including confirming the patient's identity, checking with the patient the site/side to be imaged, the existence of previous imaging and for the operator to ensure that the correct imaging modality is used.

NICE guidance was followed for diagnostic imaging pathways as part of specific clinical conditions. We also saw posters with exposure guidelines in control rooms.

Staff assessed patients' needs and planned and delivered patient care in line with evidence. The service did not have a comprehensive audit programme with details of the frequency of the audits. This meant that the service was not able to ensure effectiveness of the service as they were not monitoring areas to identify improvements.

It was not clear how often the lead apron audit took place. The audit which was sent to us was dated April 2023 which was after our inspection. No issues had been identified in the audit.

We were told that audit results were discussed at monthly team meetings but we were not given the minutes of the radiology department team meetings to evidence this.

The service had local rules based on the Ionising Radiation Regulations (IRR) 2017. We saw in the x-ray room that the local rules had been signed by staff but the local rules document had a review date of April 2022. The service later sent through the local rules document for the x-ray room which had been signed and showed a review date of April 2023.

We viewed the radiation protection advisor/medical physics expert annual audit which took place in March 2021 and found the overall management of radiation proception to be good and judged to be substantially in compliance with relevant radiation protection legislation and guidance. There were some recommendations around ensuring templates to be customised for local use and irrelevant procedures to be discarded and for radiation risk assessments to be reviewed and updates as necessary. We requested the most recent report from March 2022 but this was not sent through to us.

Nutrition and hydration

Due to the nature of the service, staff were not required to provide patients with food and drink to meet their needs and improve their health.

Staff told us that patients were not generally offered food, however, they were offered coffee, tea or water before or after their scan. There was a coffee machine and water dispenser available for patients and visitors in the waiting area.

Requires Improvement

Diagnostic imaging

Pain relief

Staff assessed and monitored patients regularly to see if they were in pain, and gave pain relief in a timely way.

Staff assessed patients' pain before, during and after the procedure. Patients were directed to their GP if they required pain relief. Radiographers told us that if patients were particularly needle phobic, a numbing cream could be used so they would not feel pain from cannulation. The service did not use pain scoring tools or pain diaries due to the types of patients the service saw.

Patient outcomes

Managers did not use information local audits to improve care and treatment. Staff did not monitor the effectiveness of care and treatment.

The service did not carry out a comprehensive programme of repeated audits to check improvement over time. This meant we were not assured that outcomes for patients were positive, consistent and met expectations such as national standards. We requested the service's clinical audit programme but was not provided with one. We did not see evidence of benchmarking against other providers or similar services or evidence of regular discrepancy meetings and peer feedback process with staff.

We viewed scan report audits which were conducted quarterly. Any deficiencies were highlighted to the medical director but we did not see evidence this was fed back to the member of staff for their learning.

We were told patients were given appointments within 48 hours of an imaging request being made. Imaging reports were produced within 24 hours. Local audits such as infection control, records and scan reports were completed but it was not clear if the data was reviewed or discussed with the clinic team and if learning was shared.

The service captured patient feedback through an online external website. The service had made changes as a result of feedback such as clarity on additional tests by creating a pricelist sheet which was given to the patient.

The service did not participate in the national clinical audits such as patient reported outcome measures (PROMS).

Staff we spoke with were able to describe how to perform the daily quality assurance (QA) programme for the MRI machine but told us they did not routinely do this for the x-ray and was not sure about the ultrasound machine. We requested the QA programmes for all of the modalities within the radiology department but were not provided with these. This meant that the service was not ensuring that consistent, reliable results were provided by the machines and were not fully monitoring deterioration of equipment performance which could negatively impact on patient safety.

Dose reference levels are used in medical imaging to indicate whether, in routine conditions, the dose to the patient administered in a specified radiological procedure for medical imaging is unusually high or unusually low for that procedure. The service told us that they did not have a policy on dose reference levels but that they use the national dose reference levels and received advice from the radiation protection advisor.

Competent staff

The service made sure staff were competent for their roles. Managers appraised staff's work performance.

Requires Improvement

Diagnostic imaging

The service made sure staff were competent for their roles. In the reporting period, 100% of staff in the department were compliant with either completion of their probationary period of six months or annual performance review.

Staff were experienced, qualified and had the right skills and knowledge to meet the needs of patients. Radiographers had individual competency checklists which recorded training and competency assessments for each of the imaging modalities. All radiographers were registered with the Health and Care Professions Council (HCPC).

New staff received a full corporate induction and a competency assessment framework which was signed off once completed.

Multidisciplinary working

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

Staff commented on good team working and spoke of informal meetings where they would be able to speak with the registered manager where needed.

Radiographers told us they were able to contact radiologists easily if there was an unexpected finding that required urgent action.

Seven-day services

Key services were available to support timely patient care.

The service operated from Monday to Friday 8am to 8pm and Saturdays 8am to 6pm. Appointments were flexible to meet the needs of patients, including evening slots to accommodate patients to attend after work.

Health promotion

The service had limited opportunities to be involved in promoting healthy lifestyles.

Staff assessed each patient's health at the appointment and said they would signpost patients to their GP should they require any support to live a healthier lifestyle.

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.

Staff supported patients to make informed decisions about their care and treatment. They followed national guidance to gain patients' consent. Staff understood how and when to assess whether a patient had the capacity to make decisions about their care. Staff received training in the Mental Capacity Act.

Staff gained consent from patients for their care and treatment in line with legislation and guidance. This included written and verbal consent.

Requires Improvement

Diagnostic imaging

Records we reviewed, showed that staff clearly recorded consent.

Interventional scans were not undertaken on children. A parent or guardian was required to sign a consent form and accompany their child. Staff we spoke with understood Gillick competence.

Is the service caring?

Good

We rated caring 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. We observed staff taking the time to interact with patients in a respectful and considerate way.

Patients we spoke with told us staff treated them well and with kindness.

We saw that staff followed policy to keep patient care and treatment confidential.

Staff understood and respected the personal, cultural, social and religious needs of patients and how they may relate to care needs. Posters about chaperones were on the walls throughout the service and patients were asked if they would like a chaperone when they arrived for their appointment.

Patient feedback was positive. Comments included: “the radiographer was very understanding; I was nervous but was reassured by staff; it was a positive experience.”

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 observed staff spending extra time explaining the scan in detail to a patient before starting a scan and informing the patient during the scan how long was left of the scan as well as reassuring the patient that they ‘were doing really well’.

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. Patients we spoke with told us staff were very reassuring and supportive throughout the examination.

Understanding and involvement of patients and those close to them

Requires Improvement

Diagnostic imaging

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 and their families could give feedback on the service and their treatment and staff supported them to do this. There were QR codes within the waiting room so patients could give feedback in real time using their mobile phones. However, we did not see any posters on how patients could make a complaint. The registered manager told us that patients were signposted on how to make a complaint through the service's website.

New Malden Diagnostic Centre used an online patient review site which collected feedback from patients. Feedback showed, of the 58 reviews posted about the service as a whole, they achieved 4.9 out of 5 for overall experience, friendliness, cleanliness and 4.8 out of 5 for wait time.

Staff told us that a carer or loved one could remain with their relative during their scan and that they would complete the necessary checks to ensure that they were able to safely stay with the patient.

Patients we spoke with told us they were included in discussions about their treatment plan and felt able to ask the consultants any questions they had. Information on the cost of procedures was provided at the point of booking.

Patients told us that conversations about finances were done so with sensitivity and that they had all the information they needed before deciding to proceed.

However, we did not see any posters or information on-site providing information to patients and their carers about the radiation used during common imaging procedures. Posters and information help make patients aware that the potential small risk from ionising radiation from the imaging procedure has been assessed by a specialist, and that the test can go ahead because the benefits outweigh the risks.

Is the service responsive?

Good

We rated responsive 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 their patient population.

New Malden Diagnostic Centre provided a range of services such as general x-ray imaging, c-arm (a mobile imaging unit used primarily for fluoroscopic imaging during surgical and orthopaedic procedures), interventional and diagnostic ultrasound, echocardiograms and magnetic resonance imaging (MRI). The service operated from Monday to Friday from 8am to 8pm and Saturdays from 8am to 6pm.

Requires Improvement

Diagnostic imaging

Patients could make appointments to suit their schedules. Information was provided to patients before their appointments. Appointment letters contained information about any tests or intervention including any preparation such as fasting if required.

The imaging department did not monitor the length of time patients waited to be seen for their scan although staff told us that delays were very rare. Patients we spoke with told us they did not need to wait long before being called for their scan.

The facilities and premises were appropriate for the services that were planned and delivered. The waiting area was spacious and there was access to disabled toilets.

The service also had a service level agreement with a local NHS trust to carry out ultrasound, echocardiograms and MRI scans to help increase the trust's capacity.

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.

The service was inclusive and took account of patients' individual needs and preferences.

Staff made reasonable adjustments to help patients access services and patients were able to have appointments to suit their plans and commitments. Patients with reduced mobility could easily access the imaging department which was on the ground floor; there was wheelchair access into the centre and corridors were wide enough to accommodate wheelchairs. Changing rooms were large enough to accommodate wheelchairs however there were no grab rails within the changing rooms to help those with mobility needs.

Staff received training in equality, diversity, human rights and inclusion and had a good understanding of cultural, social and religious needs of patients and demonstrated these values in their work.

Patients told us that the scan was explained in detail to them by the radiographer before commencing so that they understood exactly how long it would take and what they were required to do.

Interpretation requirements were identified at the point of booking including support for patients who required British sign language interpreters. Staff could arrange interpreting services to support patients whose first language was not English.

The service engaged with patients who were anxious, nervous or phobic. For example, patients told us that there was a mirror within the MRI scanner so that they could always see the radiographer which helped ease their anxieties. Staff were also able to speak to the patient during scans through a microphone and patients could listen to music during their scan if they wished.

We were told that the service rarely saw patients with learning disabilities or dementia, but in these cases, patients could bring relatives or carers with them to support them during a scan. Staff told us they would make sure in these cases, carers and relatives were appropriately screened to ensure they could safely support their loved one.

Requires Improvement

Diagnostic imaging

Leaflets about diagnostic procedures were given to patients prior to their appointment. Some leaflets were available in other languages such as Arabic which was the most common second language of patients seen at the service. Translations into other languages were ongoing at the time of our inspection.

A picture exchange communication system (PECS) was available for aiding non-verbal patients.

The service also had a portable hearing loop for patients with hearing impairments.

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.

Patients told us the booking process was easy and they were able to receive an appointment quickly within 48 hours or to suit their schedule.

Patients told us that they received their results which was explained to them by their consultant within 24 hours of receiving their scan. Monthly audits of the turnaround time for reports showed that in all modalities, the majority of reports were available on the same day or within 24 hours.

Patients we spoke with told us they waited under 5 minutes in the waiting area before they were called to their scan.

In the last year, 3390 appointments were made for the imaging department at New Malden Diagnostic Centre. Did not attend rates were low at 1% for MRI and x-ray and 6% for ultrasound. If a patient did not attend their scan, the reception team would follow up by telephoning the patient and re-booking them. If a patient was not contactable, the booking team would notify the referring consultant. Cancellations were under 13% across the modalities and was mainly due to cancellations made by patients who needed to reschedule.

Learning from complaints and concerns

It was easy for people to give feedback and raise concerns about care received. However, the service did not subscribe to any independent adjudication services that could support investigating complaints objectively when they could not be resolved locally.

Staff understood the procedures around handling a complaint however we did not see posters in the department on how to make a complaint.

Staff told us they had not received any complaints in the last 12 months but would try to resolve concerns when they were raised. Staff told us that the main types of informal complaint they received was around the availability of car parking spaces for the centre which shared its premises with a GP practice.

The service did not subscribe to any independent adjudication services that could support investigating complaints objectively when they could not be resolved locally.

Is the service well-led?

Requires Improvement

Diagnostic imaging

Requires Improvement

We rated well-led as requires improvement.

Leadership

The leadership team for New Malden Diagnostic Centre had an understanding of issues, challenges and priorities in the radiology department. However, the department had been without a lead radiographer at the time of our inspection and staff were unclear who was leading the department in the interim.

The radiology department had been without a lead radiographer for some months according to staff. Staff were unclear who was leading the department in the interim. The leadership team for New Malden Diagnostic Centre told us that an internal promotion to the role of lead radiographer would be made imminently.

The provider told us that it was the lead radiographer's role to peer review, provide support to develop team members' skills, access to training and access to development opportunities. At the time of our inspection, the lead radiographer was not yet in post so we were not able to assess if staff received this. We were told that with the appointment of a lead radiographer, the focus for staff in radiology would be in identifying and highlighting any areas of development, further training and continuing professional development (CPD).

All staff spoke highly of the senior leaders and spoke of good teamwork. They commented on the friendliness and visibility of the senior leaders and that they felt able to approach them.

Vision and Strategy

The service had a vision for what it wanted to achieve and a strategy to turn it into action. The vision and strategy were focused on sustainability of services.

The service had a vision which was included being "the leading fully integrated diagnostic and multifaceted outpatient centre in outer London."

They had a philosophy which was built on 5 pillars: "Excellent and continuous care for patients intended to reach an accurate diagnosis and clear management plans, investment in leading medical consultants and therapists providing the highest quality of care, investment in cutting-edge technology, from therapeutic interventions to diagnostic technology, pricing to compete with competitors, communicating clearly and helpfully to ensure that the service's message reaches those who can benefit most."

Staff were generally aware of the vision of the service.

Culture

Staff felt respected, supported and valued. They were focused on the needs of patients receiving care.

Requires Improvement

Diagnostic imaging

Staff we spoke with felt respected and valued at the service. The culture was centred on the needs of the people who used the service. Staff we spoke with were positive about working at the provider and commented that the registered manager was approachable.

Governance

The service did not operate effective governance processes. Not at all staff were clear about their roles and accountabilities and it was not clear if the radiology department staff had had regular opportunities to meet, discuss and learn from the performance of the service.

The provider did not have processes in place to effectively assess, monitor and improve the quality of the service.

Portable appliance testing of equipment in the radiology department were out of date at the time of inspection. We requested to see the quality assurance programmes for the equipment in radiology but were not supplied with these. This meant that the service was not ensuring that consistent, reliable results were provided by the machines and were not fully monitoring deterioration of equipment performance which could negatively impact on patient safety.

We were not assured there were discussions in the radiology department around learning from incidents, updates around medical alerts, complaints and feedback from patients. We asked to see minuted radiology team meeting minutes however the service was unable to produce these. We also asked to see radiation protection committee meeting minutes and the latest annual radiation protection advisor audit report from March 2022 but these were not provided to us.

Senior management meetings and heads of department meetings were held monthly however the minutes of these meetings were not detailed and did not include detailed discussions or review of actions from the previous meeting.

Management of risk, issues and performance

Leaders and teams did not use systems to manage performance effectively.

Staff told us the service did not undertake routine clinical and governance audits, which would allow the service to benchmark against other similar providers, and to identify changes that would improve the service based on information.

We requested a clinical audit programme but this was not supplied to us. The service audited infection control, scan reports and records but did not conduct other clinical audits. This meant that the service was not able to ensure effectiveness of the service as they were not monitoring areas to identify improvements.

The service had a risk register but it was unclear if this was reviewed regularly as we did not see the risks mentioned within minutes of team meetings.

The service did have a documented business continuity plan in place for major incidents such as power failure or building damage. The service did have a back-up generator but if there was a power outage, appointments were cancelled and rescheduled.

Information Management

Requires Improvement

Diagnostic imaging

The service collected reliable data but did not analyse it. The information systems were integrated and secure.

The service had systems to collect reliable data but did not analyse it to understand performance, make decisions and improvements.

Staff received training for information governance and the General Data Protection Regulations. Computer terminals were password protected. There were effective arrangements to ensure the confidentiality of patient identifiable data. Computer stations we saw were logged out when not in use. The electronic booking system and customer database were maintained on a secure, encrypted cloud based server.

The service had appropriate and up to date policies for managing personal information that were in line with relevant legislation and the requirements of the General Data Protection Regulations.

The provider did not have access to an image exchange portal where images and reports could be sent securely between care providers. Although some files could be shared securely and electronically with specific clinics using the service's systems, some referring clinics did not have access to this and CDs had to be sent over to the clinic.

Engagement

Leaders and staff actively and openly engaged with patients.

The service used patient feedback to guide the service delivery and responded to any concerns raised or suggestions made by people who used the service. For example, in response to comments relating to customer service for non-clinical staff, the service booked staff on to additional training around improved customer service, telephone manner and complaints handling.

Due to the size of the team, the service did not have a staff survey however staff did have access to a staff feedback form which could be filled in and submitted anonymously.

Feedback from staff had been acted on by the service. For example, in response to feedback raised about the usability of the booking system and concerns around functionality, the service had changed to a new patient management system which was more comprehensive and integrated with the picture archiving and communication (PACS) system.

Learning, continuous improvement and innovation

The service was committed to continually learning and improving the service.

The service had worked closely with the company that provided the service's electronic patient records management system on the development of the picture archiving and communication system (PACS) from a booking and reporting perspective. For example, the service had worked with the company so that there could be an addition of extra information when scheduling on the system as well as better ways to alert radiologists of urgent scanning.

However, staff we spoke with had limited understanding of quality improvement methods for the service.

Requires Improvement

Services for children & young people

Safe	Requires Improvement
Effective	Requires Improvement
Caring	Good
Responsive	Good
Well-led	Requires Improvement

Is the service safe?

Requires Improvement

This was the first time we have rated this service for safe. We rated it as requires improvement.

Mandatory training

The service provided mandatory training in key skills to all staff and made sure everyone completed it.

Mandatory training met the needs of patients and staff. The training included a range of topics such as equality and diversity, fire safety, moving and handling, infection control, health and safety. Mandatory training was a combination of e-learning modules and some face to face modules, which included PILS (paediatric immediate life support) training. The lead nurse for the service was responsible for the training matrix and would ensure that nurses were up to date with completion of their mandatory training. Nursing staff were at 100% completion for their mandatory training.

The lead nurse told us that the previous system used for mandatory training had not been fit for purpose and New Malden Diagnostic Centre (NMDC) had since moved over to a new learning platform, which was more comprehensive and offered more learning modules.

Nursing staff completed educational sessions with non-clinical staff, providing them with a review of how to deal with basic clinical matters. BLS training was face to face and this was completed by all staff including cleaners and those working in finance.

Consultants working under practising privileges were required to provide evidence they had undertaken mandatory training, however the provider's granting and reviewing practising privileges policy did not set out what mandatory training was required. Data provided by the service showed mandatory training was monitored and completion was 63.5%.

Safeguarding

Staff understood how to protect children, young people and their families from abuse and the service worked well with other agencies to do so. However, not all staff had the appropriate training on how to recognise and report abuse and they knew how to apply it.

Requires Improvement

Services for children & young people

Staff received training specific for their role on how to recognise and report abuse. Safeguarding children and adults formed part of the mandatory training programme for staff. Records showed 100% of clinical staff had received safeguarding children level 2 and safeguarding adults' level 2 training. At the time of our inspection, staff did not have children's level 3 safeguarding training. Staff however were not clear on who the safeguarding lead was; there was no appropriately trained safeguarding lead who held level 4 training. Following the inspection, we were provided with an updated training matrix showing staff had completed level 3 safeguarding children training. In addition, the lead nurse had enrolled in level 4 safeguarding training.

Staff spoken with had a good understanding of children's safeguarding. Staff knew who to inform if they had concerns and could access support if needed.

Staff we spoke with had good awareness and knowledge about female genital mutilation (FGM) which was including within safeguarding training.

The service advised there had been no safeguarding concerns raised in the last 12 months.

Cleanliness, infection control and hygiene

The service controlled infection risk well. Staff used equipment and control measures to protect children, young people, their families, themselves and others from infection. They kept equipment and the premises visibly clean.

Clinic areas were clean and had suitable furnishings which were clean and well-maintained. Clinical staff were responsible for cleaning the consultation areas and the treatment room where blood samples were taken, with a complete wipe down of equipment between paediatric patients. The service advised that the clinical staff were responsible for the deeper clean within their respective areas. However, we found cleaning to a high level was not being undertaken routinely.

The service employed a domestic team who were responsible for cleaning communal areas both in the morning and evening. We requested details of these cleaning schedules, but these were not provided.

There were donning and doffing posters above sinks and next to disposable glove dispensers, as well as hand washing posters adjacent to sinks with hand wash and hand sanitisers available. Hand hygiene audits were undertaken annually. Data provided for September 2021 and 2022 demonstrated the service scored 100%. Hand washing facilities and hand sanitiser gel dispensers were available in line with infection prevention and control guidelines. Staff had access to adequate supplies of personal protective equipment (PPE) such as gloves and aprons. Staff were bare below elbow.

The service undertook monthly hygiene and PPE audits. Data provided for the period September 2022 to February 2023 demonstrated the service was mostly compliant. However, it was not clear what actions were taken when issues were identified or when the issue had been addressed.

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.

Requires Improvement

Services for children & young people

The service had enough suitable equipment to help them to safely care for children and young people. Staff had enough space for consultations to be carried out safely. Consultation room 1 was the biggest of the six consultation rooms used to see paediatric patients and was located opposite the nurse's station on the first floor. This room was used primarily to see paediatric patients due to its size and visibility from the nurse's station.

Staff carried out daily safety checks of specialist equipment and equipment used was appropriate for children. The resuscitation trolley was in the treatment room and was checked regularly by staff. Current emergency protocols were attached to the trolley. Oxygen cylinders were full, stored securely and in date.

Staff disposed of clinical waste safely. Clinical waste and non-clinical waste were correctly segregated and collected separately. Sharps bins were not overfilled, were signed and dated when brought into use, and had a disposal date listed. All waste was kept in separate waste bins in secure storage external to the service and was collected by a specialist waste company on a weekly basis.

The service had a back-up generator for use in the event of a mains failure.

Assessing and responding to patient risk

Staff completed and updated risk assessments for each child and young person and removed or minimised risks. Staff identified and quickly acted upon children and young people at risk of deterioration.

The service had exclusion criteria, which included not seeing patients under the age of 16 who may need a minor procedure, unaccompanied paediatric patients, or any paediatric patient needing sedation or general anaesthetic for a procedure.

The provider had a standard operating procedure (SOP) for a patient medical emergency, which outlined the responsibilities of staff if a patient became unwell whilst visiting the service. The SOP was issued in October 2020 and had a review date of every 2 years. The service had reviewed the SOP in March 2023 and confirmed that it had not made any amendments to it that would warrant a change in version.

The service ensured that paediatric patients had a parent or guardian with them, making sure the paediatric patient's paperwork was completed on arrival, signposting them to the necessary waiting areas and ensuring the paediatric nurse was available to support.

To ensure the security and safety of paediatric patients, a registered paediatric nurse would always be on site during paediatric clinics.

Blood sample collection was a nurse led service and was taken either by the lead nurse or the other paediatric nurse. The healthcare assistant and adult outpatients nurse working in the service were both trained in blood taking but were there to support the paediatric nurses with distraction techniques and holding paediatric patients where necessary.

The provider had a health and safety policy issued in December 2022 and the responsible person was the registered manager. The policy covered areas like: access and egress, fire safety, equipment safety, manual handling; reporting of injuries, diseases dangerous occurrence regulation (RIDDOR); and staff training in health and safety.

Staffing

Requires Improvement

Services for children & young people

The service had enough staff with the right qualifications, skills, training and experience to keep children, young people and their families 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 staff to keep patients safe. Staffing levels and skill mix were planned and reviewed so that patients could receive safe care and treatment.

Staff included 2.5 whole time equivalent (WTE) nurses and 1 WTE health care assistant (HCA). Staff advised consultants book the treatment room in advance so appropriate staffing can be provided.

On the day of our inspection, there was one paediatric nurse and one adult nurse on shift. We were told that Wednesdays were a heavy day of paediatric activity, so two paediatric nurses would be on shift. Thursdays were a day where there was no paediatric activity so on shift would be one adult nurse and a HCA.

The lead nurse or the general manager would always be on-site when paediatric patients were visiting the service.

The service did not directly employ any medical staff. Of the forty-seven consultants who were able to work at the service with practising privileges, 8 of them worked as paediatricians. Practising privileges are a well-established system of checks and agreements, whereby doctors can practise in healthcare facilities without being directly employed by them.

Records

Staff kept detailed records of children and young people's care and treatment. Records were clear, up-to-date, stored securely and easily available to all staff providing care.

The service was in the process of transitioning over to a new patient management system, which when received was described to be efficient, with nurses being able to do investigation requests. The current system of record keeping was that consultants kept their own notes, however any nurse led procedures such as phlebotomy were uploaded to a shared drive.

Patient records saved in the shared drive were saved under a 'procedures' folder, with all patients' procedure forms being saved under corresponding months and years sub folders. Naming conventions were the patient's surname and name.

Only nurses had access to the shared folder and computer stations could only be accessed with appropriate credentials and passwords.

The procedure documentation forms that the nurse kept in the shared drive included patient's personal information, as well as procedure descriptions, the nurse undertaking the patient's care, procedure notes, any advice given and any follow ups.

Patients' personal data and information were kept secure and only staff had access to the information. We observed staff logging out of computers after use.

Medicines

Requires Improvement

Services for children & young people

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

Staff stored and managed all medicines. All medicines were stored securely in locked cupboards and fridges. The only patients that received medicines were the allergy patients. Consultants would generally administer antihistamines following skin prick tests. A local anaesthetic numbing cream could be provided in the service to paediatric phlebotomy patients. However, parents were advised by nurses to purchase the cream over the counter before they visited the service because it could take up to 45 minutes for the cream to be effective, as they didn't want paediatric patients and their parents having to wait around. Parents of children under the age of one year old had to get a prescription for the cream. Staff monitored fridge temperatures to confirm that fridge temperatures were within the range, and we saw these were recorded.

We reviewed a selection of medicines held by the provider and found they were in date. Medicines expiry dates were monitored to ensure medicine would be used in advance of their expiry dates.

The provider was not licensed to hold controlled drugs and no controlled drugs were stored at the service.

The service did not hold medicines to take out (TTO).

The lead nurse told us that medicines were supplied by an external supplier, as opposed to using the on-site community pharmacist, which only stocked certain medicines.

Incidents

The service managed patient safety incidents well. Staff recognised and reported incidents and near misses. When things went wrong, staff apologised and gave children, young people and their families honest information and suitable support.

The service used a central system to report and monitor incidents, so all clinical and non-clinical incidents were reported and logged.

The service had not had any serious incidents, never events or hospital transfers in the last 12 months, and had not needed to notify CQC of any significant events.

We were verbally told about an incident when the provider first started operating and a consultant had asked a paediatric patient to attend the service who had COVID-19. The episode of care was managed by the patient having to wait outside of the building until their appointment time; the doctor wearing a visor, mask, gloves and apron; the windows of the consultation room being kept open; the room being fully disinfected following the consultation; and subsequent patients not being able to enter the consultation room for a further 15 to 20 minutes.

Staff understood the duty of candour. They were open and transparent, and gave children, young people and their families a full explanation if and when things went wrong. Staff understood their responsibilities and could give examples of when they would use the duty of candour. Duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain 'notifiable safety incidents' and provide reasonable support to that person. This means providers must be open and honest with service users and other 'relevant persons' (people acting lawfully on behalf of service users) when things go wrong with care and treatment, giving them reasonable support, truthful information and a written apology.

Requires Improvement

Services for children & young people

Is the service effective?

Requires Improvement

We rated it as requires improvement.

Evidence-based care and treatment

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

The service had various policies relevant to paediatric services, which included safeguarding children, scanning children, and paediatrics in outpatients.

All staff had access to the provider's policies, procedures and guidelines, and staff demonstrated they knew how to access them.

The lead nurse subscribed to various online updates regarding NICE guidelines, in addition to HSE updates, CQC, Government field safety notices, and updates with the Care Inspectorate. It was not clear what the process was for signing off approval for new policies or changes to existing policies and how this was disseminated to staff. An agenda item within the senior management team's meeting minutes for February 2023 stated that policies needed to be reviewed but did not detail by whom and by which date.

Pain relief

Staff did not routinely assess and monitor children and young people regularly to see if they were in pain.

Due to the nature of the service being an outpatients function, the service were not routinely recording pain score for children and young people. However, there were conversations with the child or the parent regarding pain where necessary.

Patient outcomes

Staff did not monitor the effectiveness of care and treatment.

Managers and staff did not carry out a comprehensive programme of repeated audits to check improvements over time.

The service was not participating in any national audits.

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.

Requires Improvement

Services for children & young people

Staff were experienced, qualified and had the right skills and knowledge to meet the needs of children and young people. This was checked as part of pre-employment checks. To apply and be accepted for practising privileges at the service, consultants had to fulfil a number of criteria including: providing their CV, indemnity insurance, evidence of appraisals, and professional registrations. The medical advisory committee (MAC) would then approve this. Data provided showed that 81% of the consultants had an up to date appraisal.

Managers supported staff to develop through yearly appraisals of their work. The appraisal tracker showed staff were due appraisals within the next 3 months. One member of staff advised nursing staff appraisals had been booked for the following week. Staff we spoke with advised they had regular supervision.

Multidisciplinary working

Doctors worked together as a team to benefit children, young people and their families. They supported each other to provide good care.

Although consultants spoke amongst themselves, there were no formal arrangements for multidisciplinary working. Consultant care was not handed over to nursing staff. The nursing team assisted the consultants with their clinics and their procedures; however, the care of the patient was managed by the consultant on-site.

Seven-day services

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

The service was open from 8am – 8pm Monday to Friday and 8am – 6pm on a Saturday. There were no paediatric clinics on a Thursday.

Health promotion

Staff did not give children, young people and their families practical support and advice to lead healthier lives.

The service did not undertake health promotion activities.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

Staff supported children, young people and their families to make informed decisions about their care and treatment. They knew how to support children, young people and their families who lacked capacity to make their own decisions or were experiencing mental ill health.

The Mental Capacity Act and Deprivation of Liberty Safeguards was part of the mandatory training programme and 100% of nursing staff had completed this training.

We were not able to sit in on any consultations where we were able to observe where consent was gained from children, young people and their families for examinations they were about to receive.

A parent or guardian was required to accompany the child for their consultations. Staff we spoke with demonstrated an understanding around Gillick competence.

Requires Improvement

Services for children & young people

The provider had a consent policy, which had been reviewed in November 2022.

Is the service caring?

Good

We rated it as good.

Compassionate care

Staff treated children, young people and their families with compassion and kindness, respected their privacy and dignity, and took account of their individual needs.

Staff were discreet and responsive when caring for children, young people and their families. Consultants and the paediatric nurse took time to interact with patients and their carers/guardians in a gentle, respectful and considerate way. We observed a positive interaction between staff, a patient and their parent which demonstrated kindness and patience.

Staff followed policy to keep patient care and treatment confidential. We observed discreet interactions that protected patient's personal information.

Emotional support

Staff provided emotional support to children, young people and their families to minimise their distress. They understood children and young people's personal, cultural and religious needs.

Staff gave children, young people and their families help, emotional support and advice when they needed it. The main touch points for paediatric patients and their families to receive emotional care was with their consultants. The service was committed to imparting empathy and caring when things were not going well. There were doctors with different specialisms who could provide different support systems.

Staff described how they approached difficult conversations with paediatric patients and their families, such as by ensuring they were in a private environment and offering time and space for questions. The paediatric nurse would employ calming methods and distraction techniques when paediatric patients became distressed.

Staff understood the emotional and social impact that a person's care, treatment or condition had on their wellbeing and on those close to them.

Understanding and involvement of patients and those close to them

Staff supported and involved children, young people and their families to understand their condition and make decisions about their care and treatment. They ensured a family centred approach.

Patients and their families could give feedback on the service and their treatment and staff supported them to do this. We observed staff were proactive in engaging with patients about their experiences.

Requires Improvement

Services for children & young people

Is the service 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.

The service had paediatricians for the following specialities: neurology, endocrinology, respiratory, paediatric neurodevelopment, and had a general paediatrician paediatric allergist.

The registered manager told us that part of their service planning was to facilitate for its consultants to see patients at the New Malden Diagnostic Centre. The service had a number of paediatric allergists working in the service who would book two to three rooms at a time, so they could take a group approach to seeing their patients.

The facilities and premises were appropriate for the services that were planned and delivered. There was enough seating in the waiting area where there was a drinks machine and filtered water dispenser, and disabled toilet facilities on the ground and first floor.

Meeting people's individual needs

The service was inclusive and took account of children, young people and their families' individual needs and preferences. Staff made reasonable adjustments to help children, young people and their families access services.

The service had taken away all toys due to the risk of COVID-19 and health and safety but did ask parents to bring their own electronic tablets or toys for their children to play with whilst in the waiting areas.

The service were however using a charity to provide hand-wrapped single-use teddy bears which could be taken away by the patients.

The provider had considered putting some old computers upstairs and downstairs in the waiting areas but due to COVID-19 and for hygiene reasons, the provider had decided to put on hold that idea around computer gaming stations for paediatric patients but were considering the idea for the foreseeable future.

The current nurse's station on the first floor was previously a play area but due to COVID-19, was then converted to a nurse's station. We were unsure whether the provider had plans to revert the nurse's station back to a play area now that covid restrictions had relaxed.

Staff had access to a telephone interpreting service where interpreting services were required. There was also a member of staff working in the service who spoke Arabic.

Requires Improvement

Services for children & young people

Following on from the inspection, we were provided with an information sheet about a numbing cream used prior to a blood sample being taken, which had been produced in Arabic.

Patients had access to cold and hot drinks in the waiting room and could serve themselves whilst waiting for their appointment.

The provider had a portable hearing loop for patients with hearing impairments.

Access and flow

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

All appointments were booked in advance and the service was open 6 days a week.

Data provided for the period March 2022 to March 2023 showed there were a total of 10,599 appointments offered by the provider, with 84% (8917) attendances. The number of paediatric outpatients were not split out from the aforementioned numbers, so we could not assess what number were attributed to paediatric patients.

The provider commented on their booking system not being the most comprehensive from a reporting system ability. There were immediate plans, having recently signed a new contract, to move to a new platform for the monitoring and tracking of patient information, billing, and reports. The system would enable remote access to consultants and their secretaries to book patients, view clinics, and provide patient information for patients booked at New Malden Diagnostic Centre.

When the service opened in October 2020, they received a bespoke system, but they commented that there were a lot of functionalities missing and limitations to the system. The old system was soon to be merged with the new system, and once that had happened, staff would be trained in this new system, as well as the IT company who currently oversees the provider's existing system.

Consultants managed their own patient lists. Between 20 - 30 paediatric patients visited the service each week.

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 children, young people and their families in the investigation of their complaint.

NMDC's complaints procedure was available online and set out the process for how complaints could be raised. The procedure set out a time frame for acknowledging and investigating complaints. Complaints were acknowledged within two working days of receiving a complaint. The provider aimed to respond within 28 working days. Patients could access the provider's formal complaints policy online.

The service advised they had not received any formal complaints within the last 12 months. Information on how to make a complaint was available on the providers website. However, the service did not display information about how to raise a concern or complaint. The provider advised if patients raised any concern, they would call back within 24 - 48 hrs or the call could be transferred to either the operations or registered manager to resolve.

Requires Improvement

Services for children & young people

There was no record of complaints or concerns being discussed in senior management team (SMT) meeting or nurses' meeting. In the heads of department (HOD) meetings minutes provided we saw there was reference to one complaint.

The provider was not a member of the Independent Sector Complaints Adjudication Service (ISCAS). Leaders advised that if required complaints would be escalated internally to the chief executive officer (CEO), clinical director or chairman for arbitration.

Is the service well-led?

Requires Improvement

We rated it as requires improvement.

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.

New Malden Diagnostic Centre (NMDC) was under the ownership of Sterling Healthcare Group Ltd, a company led by senior clinicians, all of which owned other healthcare facilities. NMDC was made up of a chairman, a CEO who was a consultant, a medical director, an operations manager and a general manager. The CYP service fell under the reporting structure of the general manager and overseen by the lead nurse, with two nurses and a HCA.

All staff understood the leadership structure and reported how approachable and understanding senior management were. The CEO knew every staff member by name as the inspection team was shown around the building, and they appeared comfortable around him. The service had established priorities based around providing a high-quality service. These were outlined within their business strategy and future growth plans.

Vision and Strategy

The service had a vision for what it wanted to achieve and a strategy to turn it into action.

NMDC's philosophy was built on a number of pillars which included: excellent and continuous care for patients intended to reach an accurate diagnosis and clear management plans; investment in leading medical consultants and therapists providing the highest quality of care; pricing to compete with their competitors; and communicating clearly and helpfully to ensure that their message reached those who could benefit most.

The operational and general manager told us that the strategy for the service was to focus on greater marketing to develop services. Allergists working in the service had been appointed through word of mouth from other consultants working in the service.

The service wanted to ramp up its marketing efforts to local schools, GPs and wanted to try and tap into NHS waiting lists, increasing the number of referrals, which would in turn drive the number of consultants working for the service.

The provider was exploring the possibilities of expansion but not in the immediate term but more in its long-term outlook.

Requires Improvement

Services for children & young people

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 reported feeling able to raise concerns and were well supported from the service to do this. The service was focused on the needs of the patients and senior staff worked hard to create a positive place to work for its staff, having bonding sessions each month, where takeaway food would be ordered.

Staff told us that they felt supported from a leadership perspective, with communication and visibility from the leadership team being “very very good”.

Governance

Leaders did not operate 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 did not have an effective governance structure. The service did not have a formally constituted Medical Advisory Committee (MAC) and did not meet the criteria to be considered as formal or structured. The service advised the MAC had two members. We requested minutes of the meetings, but these were not provided.

Data provided showed senior management team (SMT) meetings were held weekly and heads of departments (HOD) meetings were held monthly. Minutes did not identify who was chairing the meeting; nevertheless, there appeared to be a standard format that the meeting followed. Minutes recorded very brief discussions which included incidents and patient feedback.

Nursing team meetings were held monthly. Minutes provided recorded very brief discussions; however patient feedback was not part of the standing agenda.

The provider had a clinical governance policy and process which had been reviewed in October 2022.

Management of risk, issues and performance

Leaders and teams did not use systems to manage performance effectively.

We requested a copy of the risk register which covered clinical, operational and technical risks which covered all aspects of the service, but this was not provided.

The service had a programme of internal audit which included health and safety risk assessments (October 2021), health and safety risk assessments walk arounds (January, March, June 2022) legionella (June 2022) and COSHH (April 2023). However, it was not clear what the process was disseminating the findings to staff. Minutes of SMT, HOD and nurses’ meetings did not reference any discussions related to finding from the risk assessments.

Requires Improvement

Services for children & young people

The service had a business continuity plan which had an October 2022 review date and had been reviewed by the general manager. The policy covered loss of power and loss of essential systems.

Information Management

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.

Electronic patient records were kept secure to prevent unauthorised access and could be accessed easily. Staff were able to locate and access records easily, this enabled them to carry out their day to day roles.

The service had a 'shred it' device, for the destruction of confidential records and paperwork, that was located adjacent to the reception desk in the main waiting area on the ground floor and in the treatment room on the first floor.

We observed the printing of documents being sent from a computer in the treatment room on the first floor, to the printer on the ground floor. The printer was accessible only to the receptionists downstairs.

The provider had a data protection policy, which was reviewed in November 2022. Records showed 100% of staff had completed GDPR training.

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 received feedback via online review platforms which were used to populate the providers website. However, the service recognised that this may not be convenient for all patients, a handwritten questionnaire is kept at the reception desk should patients wish to leave feedback whilst on site.

All staff we met were welcoming, helpful and friendly. The service advised staff met informally monthly, leaders also operated an open door policy to encourage discussions and staff were able to feedback anonymously online if have concerns.

The operations and general manager informed us that anonymous feedback was due to be implemented in the service as a medium for staff as part of their whistleblowing arrangements.

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.

The service commented that the one improvement that it wanted to improve on would be its marketing arrangements.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Diagnostic and screening procedures Treatment of disease, disorder or injury Surgical procedures	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment • The service must ensure all equipment are safety tested regularly. (Regulation 12(2)(e)). • The service must ensure that the doors to the MRI suite should be self-closing and locking with security locks that can be operated by MR authorised personnel only from the outside, but freely opening from the inside in case of emergency. (Regulation 12(2)(e)). • The service must ensure cabinets containing medicines are lockable. (Regulation 12(2)(g)). • The service must ensure staff are up to date with all mandatory training (Regulation 12(2) (c)). • The service must ensure checklist for the emergency grab bag matches the contents of the bag and that consumable items are in date. (Regulation 12(2)(a)). • The service must control infection risk well. This includes ensuring all staff are bare below the elbow. The service must ensure that their cleaning checklists are completed in patient toilets and patient gowns are stored appropriately where they can be kept clean and free of dust. (Regulation 12(2)(h)). • The service must ensure the use of the World Health Organisation (WHO) safer surgery checklist, and the New Early Warning System (NEWS2) to identify deteriorating patients are implemented. (Regulation 12 (1)(2)(b)).

Regulated activity	Regulation
Diagnostic and screening procedures Surgical procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance

This section is primarily information for the provider

Requirement notices

- The service must ensure there are effective systems for monitoring the effectiveness of care and treatment. This includes implementing a comprehensive audit programme in order to identify risks and improve patient outcomes. (Regulation 17(1)(2)(a)(b)).
- The service must ensure there are effective systems to monitor, escalate and mitigate risks appropriately. (Regulation 17(1)(2)(b)).
- The service must ensure there are effective governance processes in place. This includes implementing systems for reviewing audits, risks and practising privileges. (Regulation 17(1)(2)(a)(b)).
- The service must maintain contemporaneous record in respect of each service user. (Regulation 17 (1)(2)(c).
- The service must ensure that quality assurance programmes are in place for all modalities. (Regulation 17(2)(b).
- The service must ensure there are regular formal radiology team meetings that are minuted. (Regulation 17(2)(a)).