Cellular Pathology Services Limited

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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	Inspected but not rated
Are services safe?	Inspected but not rated
Are services effective?	Inspected but not rated
Are services responsive to people's needs?	Inspected but not rated
Are services well-led?	Inspected but not rated

Summary of findings

Overall summary

We did not rate this service. This is because CQC does not apply a rating to independent laboratory services.

We looked at four key questions: is the service safe, effective, responsive and well led. We did not inspect caring as the service does not have direct contact or interaction with patients.

• There were enough staff with the right qualifications, skills, training and experience. The provider controlled infection risk well. All areas and equipment within the laboratory were clean and well-maintained. The design, maintenance and use of facilities, premises and equipment kept people safe. Staff completed risk assessments for each test carried out, and for equipment used and the environment. The provider had a system to monitor safety incidents and staff knew how to report incidents and near misses.

• Managers monitored the effectiveness of the service and made sure staff were competent. The provider ensured testing was based on national guidance and evidence-based practice. Staff worked well together and with their partners for the benefit of patients and the service. The service was available seven days a week with urgent cover available out of working hours and during busy times to support the requirement of the service.

• The provider planned and provided a service in a way that met the needs of referring clinicians. Facilities and premises were appropriate for the services being delivered. Referring clinicians could access the service when they needed it and received the laboratory results promptly. There was an annual user feedback survey which referring clinicians and external partners were invited to complete.

• Managers had the skills and abilities to run the service and were visible and approachable. Staff felt respected, supported and valued. Staff were clear about their roles and accountabilities. They used systems to manage performance effectively. Managers ran services well using reliable information systems and supported staff to develop their skills. The information systems were integrated and secure. Managers and staff engaged well with each other and there were positive, collaborative relationships with external partners.

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Medical laboratories	Inspected but not rated	We did not rate this service. This is because CQC does not apply a rating to independent laboratory services. We looked at four key questions: is the service safe, effective, responsive and well led. We did not inspect caring as the service does not have direct contact or interaction with patients. • There were enough staff with the right qualifications, skills, training and experience. The provider controlled infection risk well. All areas and equipment within the laboratory were clean and well-maintained. The design, maintenance and use of facilities, premises and equipment kept people safe. Staff completed risk assessments for each test carried out, and for equipment used and the environment. The provider had a system to monitor safety incidents and staff knew how to report incidents and near misses. • Managers monitored the effectiveness of the service and made sure staff were competent. The provider ensured testing was based on national guidance and evidence-based practice. Staff worked well together and with their partners for the benefit of patients and the service. The service was available seven days a week with urgent cover available out of working hours and during busy times to support the requirement of the service. • The provider planned and provided a service in a way that met the needs of referring clinicians. Facilities and premises were appropriate for the services being delivered. Referring clinicians could access the service when they needed it and received the laboratory results promptly. There was an annual user feedback survey which referring clinicians and external partners were invited to complete. • Managers had the skills and abilities to run the service and were visible and approachable. Staff felt respected, supported and valued. Staff were clear about their roles and accountabilities. They used systems to manage performance effectively.

Summary of findings

Managers ran services well using reliable information systems and supported staff to develop their skills. The information systems were integrated and secure. Managers and staff engaged well with each other and there were positive, collaborative relationships with external partners.

Summary of findings

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Summary of this inspection

Background to Cellular Pathology Services Limited

Cellular Pathology Services Limited provides histopathology diagnostic analysis using a range of cellular pathology techniques, such as special stains, frozen section and Mohs technique. The service also provides a cytology management handling service and a specialist second opinion for doctors and patients on their pathology and cancer diagnosis.

This service was established in 2005. The service has had a registered manager in post since it was first registered under the Health and Social Care Act 2008 in July 2011 and is registered to provide the regulated activity:

• Diagnostic and screening procedures.

The laboratory is registered with the United Kingdom Accreditation Service (UKAS) (9997), which is the internationally recognised accreditation for medical laboratories. The most recent UKAS inspection took place March 2021, which resulted in the provider being accredited.

The service processes around 1500 specimens a month. It is a medium sized independent laboratory with an open office, a closed laboratory, staff changing room and toilets.

The laboratory does not have any direct contact with patients.

The laboratory is open from 9am to 6pm from Monday to Friday. There is a 24 hour on call system in place for more urgent requests.

We carried out an unannounced inspection on 16 November 2021 using our comprehensive inspection methodology.

How we carried out this inspection

The inspection team consisted of two inspectors and a specialist adviser and was overseen by Philippa Styles, a head of hospital inspection.

During the inspection, we inspected the pathology laboratory using our comprehensive inspection methodology. We spoke with six staff, including laboratory staff, who conducted the sample testing, office manager, the Clinical Director and the registered manager. We reviewed three staff records and contacted 16 clinicians using the service by email.

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

Summary of this inspection

Action the service MUST take to improve:

- There are no actions the provider must take to improve.

Action the service SHOULD take to improve:

- There are no actions the provider must take to improve.

Our findings

Overview of ratings

Our ratings for this location are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Medical laboratories	Inspected but not rated	Inspected but not rated	Not inspected	Inspected but not rated	Inspected but not rated	Inspected but not rated
Overall	Inspected but not rated	Inspected but not rated	Not inspected	Inspected but not rated	Inspected but not rated	Inspected but not rated

Inspected but not rated

Medical laboratories

Safe	Inspected but not rated
Effective	Inspected but not rated
Responsive	Inspected but not rated
Well-led	Inspected but not rated

Are Medical laboratories safe?

Inspected but not rated

We did not rate this service. This is because CQC does not apply a rating to independent laboratory services.

Mandatory training

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

All staff received and kept up to date with their mandatory training. Staff completed training modules tailored to their role including health and safety, Control of Substances Hazardous to Health (COSHH) and infection prevention and control. The mandatory training was comprehensive and ensured staff were able to meet the needs of clinicians using the service.

Managers monitored mandatory training, the electronic training matrix identified when a staff member's mandatory training was overdue or completed. Staff understanding of training was assessed through competencies, which made sure they knew their roles, responsibilities and how to fulfil these.

Staff working under practice privileges were required to provide evidence of mandatory training and certificates of other training they had completed which were specific to their roles. The service kept copies of these and professional certificates on the individual's staff electronic record.

Cleanliness, infection control and hygiene

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

The laboratory areas and equipment were visibly clean and well-maintained. The laboratory was cleaned daily and staff were responsible for cleaning the equipment at the start and end of the day.

Staff followed infection control principles, they took action to prevent cross contamination including the use of personal protective equipment (PPE). Staff we spoke with were familiar with the protocols and guidance and how to access them.

The provider had completed a risk assessment of their prevention of infection processes, which considered the impact of the COVID-19 pandemic. This was reviewed and updated regularly in line with national and professional guidance.

Inspected but not rated

Medical laboratories

Environment and equipment

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

The design of the environment and facilities followed national guidance, such as the Department of Health; HBN 15 Facilities for pathology services guidance. This included the laboratory size, clinical hand washing facilitation, eye wash station, first aid box, laboratory coat peg area, kitchen facilities, staff changing and shower areas, standardised information technology system and availability of a car park area. The office area was sited outside the laboratory zone and there was a boundary between the laboratory areas and non-laboratory space.

Staff had enough supplies of suitable equipment to undertake laboratory tests safely and spare equipment was also available for back up to ensure no disruption in the service provided.

The management of equipment including regular checks of equipment were systematic and staff knew who to go to if they encountered any problems. Staff carried out daily safety checks of specialist laboratory equipment.

We saw that staff completed daily laboratory equipment checks. Each sample analyser was registered with an external quality assurance company and serviced annually by an accredited company. All equipment had been serviced and PAT (portable appliance testing) tested to ensure it was safe for staff to use.

All equipment, reagents and chemicals seen were in date and stored safely in the appropriate cupboards.

Staff stored and disposed of specimens and clinical waste safely. Clinical and domestic waste bins were available, and waste was handled appropriately with separate colour-coded arrangements for general waste, clinical waste and sharps. Staff used sharps bins appropriately and complied with the Health and Safety (Sharp Instruments in Healthcare) Regulations 2013. The provider had contract arrangements in place to safely manage waste and clinical specimens; these were collected by the waste company once a week.

Assessing and responding to patient risk

Staff completed risk assessments for each test carried out, and for equipment used and the environment. They removed or minimised risks and updated the assessments.

Staff completed and updated risk assessments to remove or minimise risks. There were up to date risk assessments and risk management plans for various sample testing, equipment and chemicals used in the service which were reviewed regularly.

The provider had escalation protocols for unexpected or abnormal results that required immediate or urgent medical intervention. Abnormal or unexpected results that required attention were highlighted to the referring clinicians verbally and through the pathology report.

The provider had a system in place to respond to requests for clinical advice in a timely manner, which was provided by consultant pathologists. This was in line with the Key Assurance Indicators (RCPath, 2019) for pathology service.

Inspected but not rated

Medical laboratories

Laboratory results were available in a timely manner for clinical decision-making and the turnaround time for results was better than the national average. For complex cases where further test investigations, or a second opinion was needed, the turnaround times were agreed with the referrer. Clinicians using the service told us they had not had any difficulty getting results, which were reported quickly and sent securely. An interim report was provided to the referrer, this reduced risks by shortening the waiting time for clinical decisions to be made or treatment to be commenced.

Staffing

The service had enough office, laboratory and senior clinical staff with the right qualifications, skills, training and experience to run the service. Managers gave locum staff a full induction.

The laboratory was staffed by a laboratory/quality manager, one registered biomedical scientist, one associated practitioner, one laboratory support worker and three medical secretaries. The laboratory manager and biomedical scientists were registered with the Health and Care Professions Council (HCPC).

The service had enough senior clinical staff, to provide out of hours cover and advice and run the service safely. Staffing levels were in line with the KAI (2019) guidance. The senior clinical staffing consisted of the clinical director who was a consultant pathologist, the registered manager, who was also a consultant pathologist and 10 consultants working under practising privileges in the service. These staff were responsible for the analysis of samples and providing clinical interpretation or advice. The granting of practising privileges is an established process whereby a medical practitioner is granted permission to work within an independent healthcare service.

Either the clinical director or the registered manager was available on site every day to analyse samples and provide clinical advice. Referring clinicians said it was easy to contact either person at any time. Staff also had access to consultants who worked remotely for analysis of samples. The provider always had a consultant on call during evenings and weekends and there were arrangements in place for out of hours and emergency requests.

The provider had a system in place for the support and supervision of HCPC and General Medical Council (GMC) staff in the service. This was carried out through induction, appraisals, training, observation of practice and competency assessments.

The service had low vacancy rates. At the time of our inspection there was one vacancy post for a band 7 biomedical laboratory scientist, which the service were recruiting to.

The service had low turnover rates and low sickness rates, which resulted in a stable and reliable working team. Staff told us that staffing numbers were reliable and they never worked alone.

Records

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

Laboratory results were recorded electronically and staff could access them easily. The provider had a system in place to ensure specimens and records were not mixed up; this was through a second check process by staff. This ensured the information assessed and recorded was accurate. Staff had access to an electronic records system that they could update, ensuring information was available on the system in a timely manner.

Inspected but not rated

Medical laboratories

There was a system in place to ensure the specimen requests forms included enough information before tests were carried out. This included patient identification and other additional requirements such as type of sample, clinical history and date and time of specimen collection. This was in line with the Health and Safety Executive's (HSE) requirement in relation to the provision of enough information on specimen request forms in clinical diagnostic laboratories.

Referring clinicians were required to inform staff of any urgent specimen via email or telephone. Once these samples were received, they were monitored by senior staff throughout the process to ensure this was completed in the required timescale.

There was a contingency plan in place in the event of a system failure or continuing service disruption, and staff were aware of this.

Records were stored securely in line with the Data Protection Act 2018, General Data Protection Regulation policy and the Royal College of Pathologists (RCPath) (2015) guidance on storage and retention of pathological records and specimens. The electronic records were only accessible via a password protected system to authorised staff.

Incidents

The service managed patient safety incidents well. Staff recognised and reported incidents and near misses. Managers investigated incidents and shared lessons learnt with the whole team and the wider service.

Staff knew what incidents to report and how to report them. The provider had a policy covering the reporting and investigation of incidents.

In the 12 months prior to this inspection, the provider reported there had been 151 incidents, which were related to equipment malfunction or supplier errors. We saw that all incidents were reviewed by managers and included a root cause and action plan. If a sample was compromised, contaminated or had missing information, staff told us they would complete an incident form to report it and contact the referring clinician. Staff told us the most common cause of this was missing or incorrect information on specimen samples received and equipment malfunction.

The registered manager had a good understanding of duty of candour and they explained the actions they would take to make sure they fulfilled their duty. They confirmed there had been no incidents that met the criteria for 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.

Managers investigated and kept a record of all reported incidents. Staff and referring clinicians were involved in and notified of these investigations. Staff received feedback following the investigation of incidents, for both internal and external investigations.

Are Medical laboratories effective?

Inspected but not rated

Medical laboratories

Inspected but not rated

We did not rate this service. This is because CQC does not apply a rating to independent laboratory services.

Evidence-based care and treatment

The provider delivered services based on national guidance and evidence-based practice. Managers checked to make sure staff followed guidance.

Staff followed up-to-date policies to plan and deliver a high-quality service in line with best practice and national guidance. The provider had a range of policies, protocols and a standard operating procedure (SOP) to support the delivery of the service. They reviewed these regularly and included references to national guidance and best practice documents, from organisations such as the Royal College of Pathologists (RCPath).

The provider used the United Kingdom National External Quality Assessment Service (UKNEQAS) guidelines for scoring special stains used in pathology testing. This approach ensured scoring was in line with best practice and national guidance.

Managers and staff carried out a programme of regular audits which included external quality assurance (EQA) of tests offered and quality assurance of presentation and interpretation of laboratory results. The programme also included the calibration of measuring systems and verification which ensured results were traceable. The results of these audits were used to identify areas for improvement and compliance with national guidance and best practice.

Patient outcomes

Staff monitored the effectiveness of services provided. They used the findings to make improvements and achieved good outcomes for patients. The service had been accredited under relevant clinical accreditation schemes.

The provider and staff participated in relevant clinical and external audits, including repeated audits and the United Kingdom National External Quality Assessment Service (UKNEQAS) schemes for cellular pathology technique (CPT). Outcomes of audits were positive, consistent and met expectations, such as national standards. Managers and staff used the results to improve service delivery. Key assurance indicators were monitored regularly at management meetings and through regular audits.

All consultants working in the service participated in External Quality Assessment (EQA). Where results were not satisfactory, the management would develop an action plan that was monitored during appraisal and by professional bodies. The provider reported there had been one unsatisfactory external quality assurance result, which was resolved following an investigation into the reasons for the result.

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.

Inspected but not rated

Medical laboratories

Staff were experienced, qualified and had the right skills and knowledge. The laboratory director was a specialist medical consultant and a member of the Royal College of Pathologists. The laboratory staff had appropriate education, training and we saw evidence of continuous practice development. Managers provided all new staff with an induction tailored to their role before they started work.

Managers supported staff to develop through yearly appraisal, peer review of results and cases and constructive evaluations of their work and training needs. Staff told us they had the opportunity to discuss training needs with their line manager and were supported to develop their skills and knowledge. For example, two staff told us how they were supported to complete projects as part of their university qualifications. The office manager reported 100% of staff had received an appraisal.

Multidisciplinary working

Consultants, biomedical scientist, laboratory support and office staff worked together as a team to benefit patients. They supported each other to provide good care.

The clinical director and registered manager held regular and effective multidisciplinary team (MDT) meetings with partner organisations. This was to discuss pathology results, provide clinical advice and gain additional clinical information with the aim of improving patient care. The clinical director told us they attended weekly MDT meetings for different specialities at different independent health care services. These meetings included other professionals, such as medical consultants, nurses, doctors, and radiologists. One referring clinician told us Cellular Pathology Services Limited provided, “Good communication and present the pathology findings well. The MDT could not work without their input.”

Seven-day services

The service was available seven days a week to support timely service delivery.

The laboratory was open between 9am and 6pm, Monday to Friday. There was a 24 hour on call system in operation outside of normal hours for more urgent requests.

Are Medical laboratories responsive?

Inspected but not rated

We did not rate this service. This is because CQC does not apply a rating to independent laboratory services.

Service delivery to meet the needs of local people

The laboratory planned and provided a service in a way that met the needs of external services using the service.

The provider operated during the COVID-19 pandemic and provided histology and cytology management services for various specialities, which reflected the essential needs of the population being served.

Inspected but not rated

Medical laboratories

Relevant information was provided on the service's website, including a user guide for clinicians using the service. This set out the services provided, sample requirements, how the service could be accessed and COVID-19 information. The website also included information in downloadable e-Leaflets so these could easily be printed.

The provider carried out an annual user survey from professionals and providers using the service to obtain information about the service to plan and improve service delivery. The 2020 user survey results were positive and showed that respondents stated the service met their needs. The very few comments for improvement were found to be in regard to other organisations, however the managers worked with them to improve the overall service.

Meeting people's individual needs

The service was inclusive and coordinated care with other services and providers.

Staff ensured the service delivered met the individual needs of patients and referring clinicians. They were trained and able to collect specimens from external partners at short notice. The provider had engaged a dedicated courier service to collect specimens, which reduced risks of loss or damage in transit. The provider also made sure they obtained copies of consent forms and patient wishes when they completed testing of sensitive tissue samples.

All of the clinicians who responded to with information agree the service met their needs. They also felt both the clinical director and registered manager were easy to contact.

Staff ensured the referring clinician received test reports in a timely manner and they were advised of any delays as soon as possible. Staff sent laboratory reports directly to the referring clinician. This ensured the clinician could explain to the patient the diagnostic results and treatment options in a way they understood.

Access and flow

Referring clinicians could access the service when they needed it and received the laboratory test and results promptly. Turnaround reporting times were in line with national standards.

The provider had a system in place to ensure urgent specimens were prioritised during the day. This ensured patients were able to receive appropriate treatment in a timely manner. The registered manager told us they were able to process specimens, such as a small biopsy, within 24 hours. Urgent specimens could be processed within four hours and Mohs (a specialised technique for skin cancers) specimens could be processed within 30 minutes, which reduced the risk of treatment delays.

The Royal College of Pathologists (RCPath) national turnaround times guidelines are for 80% of diagnostic results to be available within seven days and 90% within 10 calendar days. The provider's turnaround target times from specimen receipt to availability of authorised results was five days. The provider's histology audits show turnaround times were well within these guidelines.

Learning from complaints and concerns

It was easy for referring clinicians to give feedback and raise concerns about the service received.

Inspected but not rated

Medical laboratories

Staff understood the policy on complaints and knew how to handle them including how to acknowledge complaints. No formal complaints had been received by the service in last 12 months, therefore they had not needed to refer any complaints to the Independent Parliamentary and health service Ombudsman. The registered manager said any complaints would be looked at using the corrective and preventative action process.

Are Medical laboratories well-led?

Inspected but not rated

We did not rate this service. This is because CQC does not apply a rating to independent laboratory services.

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 referring clinicians and staff. They supported staff to develop their skills and take on more senior roles.

The clinical director and registered manager had previously worked as consultant pathologists and clinical directors of pathology in the NHS for many years. This provided them with the skills and experience to run their own independent service.

There was a management structure with clear lines of responsibility and accountability. The office manager and laboratory/quality manager reported to the clinical director and the registered manager who were founders of the service. The laboratory/quality manager was responsible for the overall management of the laboratory and laboratory staff. While the office manager had responsibilities for the management of the office staff and administrative tasks.

Staff we spoke with told us that the managers were all approachable and visible. Staff told us they had received good support from leaders when needed and during the COVID-19 pandemic. One staff member told us how the clinical director had supported them to improve during their time working at the service. This included support for academic qualifications and promotion to a more senior role in the laboratory.

Vision and strategy

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

The provider's quality statement was, "At CPS quality is paramount to our business and company ethos with an emphasis on "getting it right first time and every time."" Their strategy focused on staff training and development, expansion of the service, investing in digital pathology and scanning. The strategy and plans were discussed at the team and governance meetings.

Staff told us they were aware of the overall vision and strategy and felt part of the vision for the service. One staff member told us that they had been promoted to more senior roles during the time they had worked at the service. They said this was because managers supported staff to improve.

Culture

Medical laboratories

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

The provider's culture encouraged openness and honesty. Staff told us they could raise concerns without fear and felt proud to work in the service. Managers supported staff to develop through regular appraisals of their work and external training, such as excel training or support with professional qualifications. We saw positive working relationships between staff and managers, and they reported that they supported each other. One staff member told us, "It's very friendly, it's nice working here. [The clinical director] likes to invest in staff." Staff also had access to the employee assistance programme for advice and support, wellbeing support workshop and a platform for trauma management support.

The provider had an emphasis on the safety and wellbeing of staff in the service. During the COVID-19 pandemic, staff had completed a risk assessment to establish whether they were at increased risk of the virus. Staff had access to COVID-19 testing, they had all received the COVID-19 vaccination and the provider continued to ensure personal protective equipment was available.

Governance

Leaders operated effective governance processes, throughout the service.

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 provider had a structured approach to the running and safety of the laboratory. There were clear lines of accountability and staff knew who to report to.

The provider had governance structures in place, for example for the assessment of user satisfaction, internal audit of quality management systems and reports from external assessment bodies. These arrangements ensured action was taken in response to external and internal audits and preventative action in response to the management of risks.

The provider gained assurance through various governance meetings, such as health and safety meetings, staff meetings and annual management review meetings. Staff and management review meetings were attended by staff at all levels including the clinical director and registered manager. Staff told us they were well attended and the process used was a two way interaction where staff could raise concerns felt they would be listened to.

The provider had processes and systems in place for the traceability of records and the retention and storage of pathological specimen such as stains and blocks, which ensured a robust audit trail was maintained. This was in line with the Royal college of Pathologists (RCPath) (2015) guidance on retention and storage of pathological specimen and the Human Tissue Authority (2021) guidance on record retention.

They operated an operational quality management system which was aligned to the UKAS ISO 15189. This included information management, equipment, record management, personnel management, facilities and safety management, audits and process control of specimen samples.

Managing risks, issues and performance

Leaders and teams used systems to manage performance effectively. They identified and escalated relevant risks and issues and took action to reduce their impact.

Staff knew how to escalate risks to the managers and senior staff were trained in the use of the risk register. The risk register included potential risks such as security, fire safety and problems with the building, as well as staffing issues related to COVID-19. Managers reviewed the risk register regularly and included a description of the possible impacts and mitigating actions. They had also developed a contingency plan for business interruption, and staff discussed relevant situations, such as lack of staff due to petrol shortages, at meetings.

The service was accredited for each test carried out. The recent United Kingdom Accreditation Service (UKAS), inspection took place in March 2021 and resulted in the service being requested to take one action, which had now been completed.

Managing information

The service collected reliable data and analysed it. The information systems were integrated and secure.

Staff could find data such as audits and user survey results, in easily accessible formats, to understand performance, make decisions and improvements. Managers submitted data and notifications to external organisations as required. The provider had systems in place to ensure the information used to monitor, manage and report on quality and performance were accurate, valid, reliable and timely. Governance meetings took account of the analysis and audit results and external quality assurance schemes.

There was a system in place to ensure the security of confidential patient data. The electronic record systems were password protected. Referring clinicians could access authorised reports of patients on the service portal following the completion of the registration process. This ensured only an authorised person could access patient confidential data. Paper copies of records containing confidential personal information were destroyed after staff transcribed the details onto the electronic system.

There was a policy to ensure compliance with the Data Protection Act 2018 and a General Data Protection Regulation policy. Staff had completed training on information governance and data security which covered their roles and responsibilities in relation to handling data and patient information.

Engagement

Leaders actively and openly engaged with referring clinicians and staff to plan and manage services.

The provider engaged with staff through various means such as emails, a suggestion box and regular staff meetings. Following staff suggestions, the provider had introduced new seating so that when the laboratory was fully staffed, all staff could work comfortably. Staff told us as they were a small team, it was easy to resolve any issue on the spot and receive timely responses to their feedback.

Managers made sure staff attended team meetings or had access to minutes when they could not attend. The team meetings were planned in advance, which enabled staff to be able to attend these meetings. Staff said they could give feedback about the service or share their ideas at the meeting. Managers also provided staff with a suggestion box and staff told us that using this had resulted in an increase in some equipment in the laboratory.

The provider sought user feedback through an annual survey sent to clinicians using the service. The response rate for the 2020 survey was 15% and the service received positive feedback on the range of available investigations, laboratory results, advice and support, the quick turnaround time as well as staff helpfulness.

Inspected but not rated

Medical laboratories

Learning, continuous improvement and innovation

All staff were committed to continually learning and improving services. Leaders encouraged innovation.

The provider acted on feedback to improve the service. For example, they had updated their website with information about the reason cytology testing of cervical smears was taking longer.

There was a culture of improvement and progress embedded in the service by the management team to meet the referring clinicians needs and to ensure the laboratory had up to date technology to aid staff and ensure their safety.