David Fraser Badenoch - Diagnostics

Quality Report

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

Ratings

Overall rating for this location	Good
Are services safe?	Good
Are services effective?	
Are services caring?	Good
Are services responsive?	Good
Are services well-led?	Good

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

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

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

Summary of findings

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

Overall summary

David Fraser Badenoch - Diagnostics is operated by David Fraser Badenoch and is a single, inepdent service. The service has one consultation room, one diagnostics room, one minor procedures room and one recovery room. The service discontinued the x-ray provision before our inspection took place and was in the process of deregistration. This did not affect any other aspect of the service. The x-ray equipment was marked as out of use and was due to be removed.

The service provides urologist consultations, eight types of ultrasound examination, intravenous urography, flexible cystoscopy, bladder installation, vasectomy, excision of minor skin lesions, minor orthopaedic procedures and phlebotomy on an outpatient basis. At the time of our inspection the service was registered to provide plain x-ray examination but had recently ceased this service. Several other providers use the service's facilities. Each service has its own registration and we did not inspect these. We inspected all aspects of the diagnostics service; surgical services will be inspected separately.

The service provides care and treatment to patients who self-pay or whose insurance company pays for their care. The team also provided care for patients referred from clinical staff based in embassies.

We inspected this service using our comprehensive inspection methodology. We carried out an unannounced inspection on 18 December 2018 followed by a telephone interview with the head of clinical service on 19 December 2018.

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

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

Services we rate

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

We found good practice:

- The service had enough staff with the right qualifications, skills, training and experience to keep people safe from avoidable harm and to provide the right care and treatment.
- The service team acted on audits and quality evaluations to continually identify opportunities for benchmarking and improvement.
- Safety and risk management processes were clearly embedded in practice and a strict referral system meant staff saw patients only when they had enough information to provide a safe level of care.
- Staff managed all areas relating to health and safety, such as medicines management and staffing, in line with established processes and protocols. The registered manager and the lead nurse ensured protocols were reviewed and updated in a timely fashion to reflect the latest national standards.
- Staff worked in a no-blame culture that encouraged open discussion of mistakes and reporting of incidents. This included use of the duty of candour, which staff used to ensure patients were kept informed when things went wrong. This approach included the incident, complaint and governance processes.
- The service did not have a waiting list and had no delayed or cancelled appointments for non-clinical reasons in the previous 12 months.
- Governance processes included all staff and helped the team to assess the quality of the service and to drive development and improvement.
- The registered manager had implemented an improvement plan for appraisals amongst non-clinical

Summary of findings

staff. In December 2018, 50% of this staff group had completed an appraisal, which was an improvement from 33% in October 2018. The manager planned to have completed all appraisals by February 2019.

We found areas of outstanding practice:

- The team maintained a proactive awareness of new and emerging treatments nationally and internationally. This resulted in the development of new and innovative procedures for patients.
- Administration staff had undertaken detailed analysis of the feedback behaviour of patients to understand what prevented more consistent completion of feedback. They had tested and introduced new feedback designs that had resulted in a significantly higher response rate, which staff used to improve the service.

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

- The management of sharps was not in line with Health and Safety (Sharps Instruments in Healthcare) Regulations 2013 and presented a safety risk. The service addressed this at the time of our inspection and should ensure the new standard is maintained.
- There was limited privacy and confidentiality in the recovery area. The service planned to address this by utilising more space following the discontinuation of the x-ray service.
- An established medical advisory board (MAB) was in place although attendance was sporadic, at only 59% of the expected attendances in the previous three meetings.
- The service did not have facilities for independent language interpretation for patients, which presented a risk when staff needed to discuss clinical issues or break bad news.

Following this inspection, we told the provider that it should make some improvements, even though a regulation had not been breached, to help the service improve.

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Diagnostic imaging	Good	We rated this service as good because it was safe, effective, caring, responsive and well-led. Some areas of infection control and privacy required improvement and were addressed after our inspection.

Summary of findings

Contents

Good

David Fraser Badenoch - Diagnostics

Services we looked at:
Diagnostic imaging.

Summary of this inspection

Background to David Fraser Badenoch - Diagnostics

David Fraser Badenoch - Diagnostics is operated by David Fraser Badenoch. The service opened in December 2010. It is a private service in London and provides medical imaging and diagnostic services for adults and children. The service serves a diverse community from across south-east England.

The service is registered to provided three regulated activities:

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

The service has had a registered manager in post since January 2011. At the time of the inspection, a new manager had recently been appointed and was registered with the CQC in July 2018.

The service provides clinical space to other consultant-led services. We did not inspect these.

We last inspected the service in January 2013 and found compliance with the five standards we checked.

Our inspection team

The team that inspected the service comprised a CQC lead inspector and a specialist adviser. The inspection team was overseen by Nicola Wise, Head of Hospital Inspection.

How we carried out this inspection

Start here...

Information about David Fraser Badenoch - Diagnostics

The service has one consultation room, one diagnostics room, one minor procedures room and one recovery room. The service discontinued an x-ray service before our inspection took place and was in the process of deregistration. The x-ray equipment was marked as out of use and was due to be removed.

The service is registered to provide the following regulated activities:

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

The service provides appointments from 8am to 6pm Monday to Friday.

During the inspection, we visited all areas in which care is provided. We spoke with seven staff including the head of clinical service, lead nurse, registered manager and reception and administration staff. medical staff, operating department practitioners, and senior managers. We reviewed policies, audits and meeting minutes. We observed the patient process from arrival to departure and looked at a sample of three patients' records.

There were no special reviews or investigations of the service ongoing by the CQC at any time during the 12 months before this inspection. The service has been inspected on two occasions and the most recent inspection took place in January 2013 and found the service was meeting all five standards of quality and safety it was inspected against.

Activity from October 2017 to October 2018:

Summary of this inspection

- Minor Procedures Unit: 1019 procedures
- Ultrasound Department: 2256 procedures
- X-Ray Department: 168 procedures
- Consultations: 1673 appointments

One urology consultant, two registered nurses, two imaging department assistants and a team of 14 reception and administration staff worked in the service. The service had a vacancy for a radiographer and had used four agency radiographers from July 2018 to October 2018. The accountable officer for controlled drugs (CDs) was the lead nurse.

Track record on safety:

- No never events
- One clinical incident with no harm
- No serious injuries
- No incidences of service-acquired Meticillin-resistant Staphylococcus aureus (MRSA),
- No incidences of service-acquired Meticillin-sensitive staphylococcus aureus (MSSA)
- No incidences of hospital acquired Clostridium difficile (c.diff)
- No incidences of hospital acquired E-Coli
- No complaints
- The service provides clinical space to other providers and these are not included in our inspection report.

Summary of this inspection

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?

Good

We rated safe as **Good** because:

- The service provided mandatory training in key skills to all staff and made sure everyone completed it.
- Staff understood how to protect patients from abuse and the service worked well with other agencies to do so.
- The service controlled infection risk well.
- The service had suitable premises and equipment and looked after them well.
- Staff completed and updated risk assessments for each patient.
- The service had enough staff with the right qualifications, skills, training and experience to keep people safe from avoidable harm and to provide the right care and treatment.
- Staff kept detailed records of patients' care and treatment.
- The service followed best practice when prescribing, giving, recording and storing medicines.
- The service managed patient safety incidents well.
- The service used safety monitoring results well.

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

- The management of sharps was not in line with Health and Safety (Sharps Instruments in Healthcare) Regulations 2013 and presented a safety risk.

Are services effective?

We do not currently rate effective and found the following areas of good practice:

- The service provided care and treatment based on national guidance and evidence of its effectiveness.
- Staff gave patients enough food and drink to meet their needs and improve their health.
- Staff assessed and monitored patients regularly to see if they were in pain.
- Managers monitored the effectiveness of care and treatment and used the findings to improve them.
- The service made sure staff were competent for their roles.
- Staff of different kinds worked together as a team to benefit patients.
- Staff understood how and when to assess whether a patient had the capacity to make decisions about their care.

Summary of this inspection

- Staff understood their roles and responsibilities under the Mental Health Act 1983 and the Mental Capacity Act 2005.

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

Only 50% of administrative staff had an up-to-date appraisal although a schedule was in place to address this.

Are services caring?

Good

We rated caring as **Good** because:

- Staff cared for patients with compassion.
- Staff provided emotional support to patients to minimise their distress.
- Staff involved patients and those close to them in decisions about their care and treatment.

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

- There was limited privacy and confidentiality in the recovery area although the service had an immediate plan in place to address this.

Are services responsive?

Good

We rated responsive as **Good** because:

- The service planned and provided services in a way that met the needs of local people.
- The service took account of patients' individual needs.
- People could access the service when they needed it.
- The service treated concerns and complaints seriously, investigated them and learned lessons from the results, and shared these with all staff.

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

- The service did not have routine access to language interpreters. Although processes were in place for patients referred from embassies, there was a lack of assurance around consent and safeguarding for patients who received language support from relatives.

Are services well-led?

Good

We rated well-led as **Good** because:

- Managers at all levels in the service had the right skills and abilities to run a service providing high-quality sustainable care.

Summary of this inspection

- The service had a vision for what it wanted to achieve and workable plans to turn it into action, which it developed with staff, patients, and local community groups.
- Managers across the service promoted a positive culture that supported and valued staff, creating a sense of common purpose based on shared values.
- The service systematically improved service quality and safeguarded high standards of care by creating an environment for excellent clinical care to flourish.
- The service had good systems to identify risks, plan to eliminate or reduce them, and cope with both the expected and unexpected.
- The service collected, analysed, managed and used information well to support all its activities, using secure electronic systems with security safeguards.
- The service was committed to improving services by learning from when things went well or wrong, promoting training, research and innovation.

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

- Attendance of members at medical advisory board (MAB) meetings was sporadic, which meant there was limited assurance of the effectiveness of the group.

Good

Diagnostic imaging

Safe	Good
Effective	
Caring	Good
Responsive	Good
Well-led	Good

Are outpatients and diagnostic imaging services safe?

Good

We rated safe as **good.**

Mandatory training

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

- Staff undertook a programme of seven mandatory training modules that reflected the needs of the service: health and safety, fire safety, infection control, diversity, safeguarding, manual handling and basic life support.
- At the time of our inspection all staff were up to date with mandatory training and the registered manager ensured staff had protected time to complete refresher training. This was scheduled in advance to ensure there were no lapses in training.

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.

- All staff had safeguarding adults and children training to level 1. The lead nurse, registered manager and head of clinical service held training to level 2 for adults and children and the registered manager was undertaking level 3 training.
- An up-to-date safeguarding policy was in place and reflected national best practice. All staff were required to maintain a detailed understanding of the policy, which was included in the induction and annual refresher training. The policy and training included guidance for staff on treating vulnerable patients and those at risk with respect and acting quickly when they identified a risk. This included identifying risks such as female genital mutilation (FGM), child sexual exploitation and human trafficking.
- The service had adopted structured safeguarding assessment tools and been recognised for effective use by a national community interests company specialising in safeguarding training.
- Two members of the reception team had completed safeguarding children training level 2 in recognition of their supervision responsibilities of the waiting area. This was in line with national intercollegiate guidance on child safeguarding. The service rarely provided care and treatment to children although they were regularly present in the waiting area accompanying patients.

Cleanliness, infection control and hygiene

The service controlled infection risk well. Staff kept themselves, equipment and the premises clean. They used control measures to prevent the spread of infection.

- Antibacterial hand gel was available at the entrance and reception staff encouraged people entering the building to use it. Gel dispensers were also located in the waiting room and in each clinical room. We observed consistent use of gel, hand hygiene practices and use of personal protective equipment (PPE) during our inspection. In one clinical room we found hand gel in use that was past its expiration date. The lead nurse replaced this immediately.
- Procedures were in place for the safe management of hazardous waste, including storage and disposal.
- All staff had infection control training.

Good

Diagnostic imaging

- The service carried out an annual transrectal ultrasound (TRUS) biopsy infection audit, in line with international best practice guidance.
- A registered nurse was the named infection control lead. They carried out a monthly infection control audit to ensure safe sterilisation processes were in place. An external independent nurse consultant carried out a supplemental annual infection control audit that provided an in-depth overview of standards. The audit for 2018/19 indicated 19 areas for improvement out of 31 measures. Most of the measures related to a need for more consistent oversight of the standard of practice of contracted cleaners. Other improvements indicated a need for more consistent monitoring of storage and stock control. The infection control lead and the registered manager had addressed all of these areas at the time of our inspection.
- The service underwent an external clinical equipment decontamination annually and was currently validated to July 2019.

Environment and equipment

The service had suitable premises and equipment and looked after them well.

- A schedule for fire safety checks and maintenance was in place, which included weekly testing of the fire alarm, emergency lighting and electrical systems. The registered manager carried out quarterly unannounced fire drills and used the outcomes to improve practice.
- In April 2018 an external organisation had audited fire safety standards to evaluate compliance with the Regulatory Reform (Fire Safety) Order 2005. The audit found overall good standards of practice and made six recommendations for improvement. This included improved completion rates and documentation of fire training, more consistent management of escape routes and more consistent testing of fire alarms. The manager had addressed all of these issues by the time of our inspection and implemented checklists to maintain them.
- A transit chair was available in the treatment room, which staff were trained to use to evacuate a patient with reduced mobility. The transit chair was fully compliant with the requirements of the Medical Devices Directive 93/42 EEC.
- Active service and maintenance contracts were in place for all clinical equipment, which meant equipment was always ready for use. There had been no cancelled or delayed appointments as a result of faulty equipment in the previous 12 months.
- Resuscitation equipment was located in the diagnostics room and included clinical items for adults and children in an emergency. A designated member of the clinical team checked resuscitation equipment daily. The lead nurse audited the equipment monthly to ensure consumables remained in date and equipment was serviceable.
- Staff did not always manage sharps in line with the Health and Safety (Sharps Instruments in Healthcare) Regulations 2013. For example, a sharps bin in the diagnostics room was in use and was fully open, with no safety lid. During our inspection a member of staff knocked this over, which demonstrated the risk of a sharps injury. In the theatre, the sharps bin was not easily accessible by clinical staff. This meant staff had to carry used sharps across the room, using an appropriate vessel, which was not in line with best practice and presented safety risks. We discussed this with the lead nurse and registered manager at the time of our inspection who implemented safer processes immediately.
- The registered manager used a monthly checklist to maintain oversight of health and safety standards. We saw evidence this resulted in prompt action to fix equipment or address faults. For example, recent health and safety checks had identified faults with patient emergency alarms and a malfunctioning cystoscopy light. In each case the manager documented the action they had taken.

Assessing and responding to patient risk

Staff completed and updated risk assessments for each patient. They kept clear records and asked for support when necessary.

- The service had an established recruitment strategy that included two previous-employer references and a Disclosure Barring Service (DBS) check. DBS is a national system used to check if a potential employee has a criminal record. All staff working for the service at the time of our inspection had a DBS in place.
- Clinical staff saw patients only after they received a medical referral and history from a referring doctor. This

was part of a process to ensure safe care and meant the consultant could establish if the service was able to provide safe and appropriate care. Patients were also required to complete a pre-procedure health assessment before staff undertook minor procedures or diagnostics.

- All staff had basic life support training and emergency equipment was stored in the reception area. This included a resuscitation mask, a biological fluid spill kit and PPE. We spoke with three members of reception staff about this, who demonstrated detailed knowledge of the equipment available and its safe use.
- A radiation protection advisor, medical physics expert and radiation protection supervisor were in post and had been responsible for monitoring the x-ray service. The provider had discontinued the x-ray service shortly before our inspection. However, we saw evidence of frequent involvement from the radiation safety team during the previous 12 months of x-ray operation and standards of care had been maintained in line with Ionising Radiation (Medical Exposure) Regulations (IRMER) and the Institute of Physics and Engineering in Medicine (IPEM).
- An emergency transfer protocol was in place, which guided staff in the event a patient became acutely unwell whilst in the service. Patients were medically fit when attending the service and as such staff had not had to arrange an emergency transfer. However, all staff demonstrated an understanding of the process.
- Staff administered local anaesthetic for some procedures and a recovery area was available. Patients were required to have pre-arranged transport home after a procedure and staff verified this before undertaking treatment.
- Up to date risk assessments were in place for patients, with separate assessments for adults, young people and infants. The risk assessments included 15 specific areas, such as for slips and trips, needle stick injuries and collapse.
- All staff had up to date training in basic life support, which was delivered to comply with Resuscitation Council UK (2010) guidelines.

Staffing

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

- The head of clinical service was a consultant urologist and led care and treatment. Three other consultant surgeons and two GPs provided care and treatment on a pre-booked basis.
- The service had a vacancy for a full-time radiographer and had regularly used agency radiographers. This had ceased shortly before our inspection with the suspension of the x-ray service. The head of clinical service had reviewed the credentials of each agency radiographer and interviewed them to ensure suitability for the service.
- A theatre nurse manager, a registered nurse and two imaging department assistants were in post. The theatre nurse manager was the lead nurse.
- The service had improved the system it used to screen agency or locum staff following concerns about the competency of previous locum radiographers. The service had discontinued the x-ray service prior to our inspection and employed no on-going locum staff.
- The clinica lead provided a telephone advice service for patients, which they could access if they became unwell and needed advice. Consultant cover was arranged in advance when the clinical lead was away from work by a professional in the same field. The service advised patients of this in advance and the covering consultant was able to see patients in the event their condition changed or deteriorated. The consultant was on the staff of two nearby hospitals, both of which provided consultant cover arrangements in the event of absence.

Records

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

- The consultant urologist shared the results of investigations and diagnostics with each patient's GP and referring doctor. Administration staff adhered to a checklist to ensure each summary included specific information as a minimum.
- Staff used a picture archiving and communication system that meant records and diagnostic results were readily accessible on site and could be shared electronically with referring doctors.
- Clinical staff adhered to standards set out in the medical records policy, which the registered manager reviewed annually.

Medicines

Good

Diagnostic imaging

The service followed best practice when prescribing, giving, recording and storing medicines. Patients received the right medication at the right dose at the right time.

- Systems were in place for the safe storage, administration, prescribing and disposal of medicines. This included temperature-controlled, secure storage with restricted access.
- The lead nurse was the responsible person for the safe and secure handling of medicine and audited stock monthly. They carried out a daily check of the temperature of medicine storage areas to ensure they were maintained within the safe range recommended by manufacturers. This included the fridge used to store chilled medicine. From January 2018 to November 2018 there were no gaps in recording and the storage temperature had been consistently maintained.
- Staff managed patient's prescriptions in line with guidance from the British National Formulary.
- Emergency medicine for anaphylaxis was kept on site as part of the emergency equipment and the lead nurse ensured the stock was in date.

Incidents

The service managed patient safety incidents well. Staff recognised incidents and reported them appropriately. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support.

- An incident-reporting system was well established and staff demonstrated good knowledge of this. Policies signposted staff to this appropriately, such as in the health and safety and safeguarding policies.
- An up to date adverse incident management policy was in place and the registered manager used this to embed an open culture of reporting incidents and discussing concerns. The policy established a no-blame approach to incidents, which the senior team used to ensure staff could report incidents without fear of reprisal. A critical incident policy supplemented this and guided staff in the event an incident resulted in harm to a patient or to the team.
- The head of clinical service and registered manager maintained the incident-reporting system and promoted its use amongst the whole team.
- There had been no reported incidents in the 12 months leading to our inspection. The registered manager coordinated learning from health and safety audits and staff feedback to lead a programme of preventative measures to reduce the risk of incidents.
- Staff reported one incident from October 2017 to December 2018, which related to the over-exposure of x-ray radiation amongst eight patients during care delivered by an agency radiographer. The head of clinical service and registered manager carried out an investigation and found the member of staff had not adhered to established procedures. For example, a dosimeter was in place and the member of staff had not reset this to zero before each examination. The radiation protection adviser reviewed the incident and found no harm had come to patients and that it was not a reportable incident.

Safety Thermometer (or equivalent)

The service used safety monitoring results well. Staff collected safety information and shared it with staff, patients and visitors. The manager used this to improve the service.

- Senior staff and the clinical team monitored clinical safety and identified opportunities for improved practice. For example, they secured an access ramp and wheelchair after identifying the high risk of falls among elderly patients. The service had experienced no falls and the team's approach demonstrated their preventative ethos of working.

Are outpatients and diagnostic imaging services effective?

We do not currently rate effective.

Evidence-based care and treatment

The service provided care and treatment based on national guidance and evidence of its effectiveness. Managers checked to make sure staff followed guidance.

- The service was in the process of obtaining ISO 9001:2015 accreditation for providing industry-standard clinical care. The registered manager had identified

areas of compliance and the service was due to be assessed in 2019. This was evidence of the approach of staff to identifying opportunities for benchmarking standards of care.

- Staff undertook a rolling programme of 19 audits to establish service standards and care outcomes in line with best practice. This included a Bacillus Calmette-Guerin (BCG) audit to determine the effectiveness of an installation to treat bladder cancer. BCG is a type of immunotherapy for, and prophylaxis against, recurrent tumors. Some audits were overdue because of a lack of staffing although there was evidence the risk management committee maintained oversight to ensure there was no risk to patients.
- Clinical staff carried out an annual intravenous urogram (IVU) audit to determine the level of risks and outcomes of adverse reactions to treatment. IVU is a radiological procedure used to identify abnormalities of the urinary system. Service protocol required staff to report any adverse reaction, no matter how minor. There had been no IVU adverse reactions since 2011.
- The consultant urologist held professional memberships of seven national and international urology organisations, which meant care was based on the latest understanding of best practice in care and treatment.
- The radiation protection advisor had carried out an annual safety audit in 2017, which meant the service was up to date with national safety standards to the point they removed the x-ray service.

Nutrition and hydration

Staff gave patients enough food and drink to meet their needs and improve their health.

- Staff offered patients refreshments on site and the waiting room had a fresh drinking water system.
- Where staff recognised patients as being at risk of malnutrition or dehydration they offered snacks and gave advice on maintaining healthy eating.

Pain relief

Staff assessed and monitored patients regularly to see if they were in pain. They supported those unable to communicate using suitable assessment tools and gave additional pain relief to ease pain.

- Staff asked patients about pain during pre-assessments, during and after treatment. They prescribed pain relief medicine where needed and used adapted communication tools to understand the pain levels of patients with complex needs.
- Staff established multidisciplinary pain management plans for patients with long-term, chronic pain.

Patient outcomes

Managers monitored the effectiveness of care and treatment and used the findings to improve them.

· The service provided diagnostic results immediately after screening, which meant patients could consider their long-term treatment options with staff on the same day.

- All staff undertook equality and diversity and person-centred care training and there was a clear care and treatment ethos based on individualised care.
- The service's statement of purpose detailed the focus on ensuring patient outcomes consistent with current best practice guidelines and meeting expectations.

Competent staff

The service made sure staff were competent for their roles. Managers appraised staff's work performance and held supervision meetings with them to provide support and monitor the effectiveness of the service.

- New staff were required to successfully complete an induction following by a probationary period before they joined the team permanently. This included the completion of role-specific training and successful completion of certified competencies before they could undertake their duties.
- The registered manager supported staff in continuing professional development and encouraged them to enrol on training programmes that would increase their qualifications. For example, staff had access to leadership development programmes and medical administration qualifications.
- The registered manager held regular formal and informal supervision sessions with each member of the team and used these to identify good performance and opportunities for improvement.
- All clinical staff had undergone an appraisal in the previous 12 months. Of the administrative staff, 50% had undergone an appraisal. The registered manager joined

the service in July 2018 following a gap in this post, which had reduced the opportunity for appraisals. The new manager had established a schedule for appraisals to address the shortfalls. Senior staff followed an established procedure to structure appraisals, which enabled each individual to reflect on their achievements and identify their planned progress in the coming year.

- The head of clinical service had addressed previous challenges with the professional competencies of agency radiographers, particularly in their understanding of radiation and examination protocols. They had addressed this with more stringent background checks on training and appraisals.

Multidisciplinary working

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

- Clinical staff liaised with colleagues in other services and in the community to coordinate care. Where patients primarily received care in NHS facilities, staff communicated with them and ensured care and treatment plans were well-coordinated.
- The senior team was proactive in identifying opportunities for new collaboration and multidisciplinary working. For example, a physiotherapist had operated out of the service in July 2018 and the registered manager was exploring future work opportunities to enhance patient service.

Seven-day services

- The service was available from 8am to 6pm Monday to Friday. Outside of these hours the clinical lead was available by telephone and identified appropriate services for patients who needed urgent review. Where the clinical lead was unavailable due to leave, consultant-led cover arrangements were arranged.

Health promotion

- Staff provided advice and signposting to health, wellbeing and holistic services as part of planned care and treatment. This was part of a wide-ranging service that aimed to support and empower patients to make healthier choices.

Consent and Mental Capacity Act

Staff understood how and when to assess whether a patient had the capacity to make decisions about their care. They followed the service policy and procedures when a patient could not give consent.

Staff understood their roles and responsibilities under the Mental Health Act 1983 and the Mental Capacity Act 2005. They knew how to support patients experiencing mental ill health and those who lacked the capacity to make decisions about their care.

- The clinical lead and lead nurse were trained in the Mental Capacity Act (2005) and carried out mental capacity assessments where they identified gaps in understanding or memory amongst patients. The team tailored care to meet the needs of elderly patients, who made up a substantial proportion of the care population. For example, where clinical staff identified a risk or early symptoms of dementia, they discussed this with patients and their referring doctor.
- Clinical staff obtained and documented consent prior to each procedure and adhered to best practice guidance from the General Medical Council 2013 for intimate procedures, including offering a chaperone.
- An up to date policy was in place that staff used as best practice guidance to obtain valid and informed consent. The policy was based on the principles of the Mental Health Act (1983) and the Mental Capacity Act (MCA) (2005). A separate policy provided guidance on obtaining consent from adults with reduced capacity, which included details of how to establish best interests care using MCA guidance.

Are outpatients and diagnostic imaging services caring?

Good

We rated caring as **good.**

Compassionate care

Staff cared for patients with compassion. Feedback from patients confirmed that staff treated them well and with kindness.

- The service had established standards for dignity and respect, which all staff demonstrated good awareness of.

Good

Diagnostic imaging

- The service gathered continual feedback from patients through a satisfaction survey. A member of the administration team had evaluated the effectiveness of the survey and re-launched it to improve the response rate.
- Privacy and dignity were embedded in the statement of purpose and detailed the standard of service patients could expect, which also acted as a framework for care delivery. This included providing assistance that was discreet and dignified and ensuring private areas were available for consultation and treatment. The recovery area provided limited privacy for patients as two trollies were separated only by a curtain, which meant private conversations could be overheard. The service addressed this shortly after our inspection by using the disused x-ray room for patient recovery, which meant patients were accommodated in two separate areas.
- We looked at a sample of feedback from 35 patients who received care in September 2018. Of these, 33 patients gave a maximum score of five when asked the likelihood of recommending the service. In the same sample 31 patients gave the service the maximum score for overall care. The remaining patients gave a score of four out of five.
- The service had a demonstrable focus on increasing the response rate of patient feedback and improving the quality and usability of the feedback. A member of the administration team had researched effective survey strategies and had adapted and enhanced NHS models of gathering patient feedback to the independent, private environment. This was demonstrative of the team's caring attitude to patient experience.

Emotional support

Staff provided emotional support to patients to minimise their distress.

- Patients received diagnostic results on the same day as screening and clinical staff provided emotional support and guidance when results were upsetting or unexpected.
- We observed staff deliver care with gentle, empathetic communication.
- Staff signposted and referred patients to counselling and psychotherapy services when they needed more structured support in dealing with a diagnosis or treatment.
- In a sample of 35 patient feedback questionnaires from September 2018, 31 patients gave a maximum rating of five for the care they have received and four patients gave a score of four out of five. This was reflective of the personalised and individual support staff delivered, including in situations in which they needed to break bad news.

Understanding and involvement of patients and those close to them

Staff involved patients and those close to them in decisions about their care and treatment.

- Clinical staff involved patients in care and treatment planning and discussed options and potential downsides to treatment before proceeding. This ensured patients had realistic expectations of the outcomes of their care and remained involved in on-going decision-making.
- Clinical staff routinely provided follow-up calls to patients after treatment to discuss any side effects and to answer questions about on-going care. The consultant provided each patient with out of hours contact details to ensure they had access to continuous support on demand.
- Staff recognised some patients required additional support measures to ensure they were involved in their care. For example, staff provided support for elderly patients who needed more detailed long-term treatment plans to ensure they could manage care at home.
- Involving patients in their care was a key element of the service's statement of purpose. This directed staff to provide care only when they were satisfied the patient understood the treatment plan. The directive paid attention to detail of the patient experience, such as instructing staff to establish how each patient wished to be addressed. We saw staff routinely adhered to this in practice.

Are outpatients and diagnostic imaging services responsive?

Good

We rated responsive as **good.**

Service delivery to meet the needs of local people

Good

Diagnostic imaging

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

- Staff were demonstrably committed to developing the service to meet the changing needs of patients. This included monitoring local, regional and national health trends to ensure the service remained viable and competitive.
- The service provided pathology results within 24 hours and shared these with patients and referring doctors immediately. Staff scheduled patients into return appointments the next day to discuss results.
- Staff had established details of clinical services available locally and signposted patients where they needed specific diagnostics or treatment that could not be provided on site. This included both independent and NHS services and staff worked with patients to ensure their preferred provider could meet their specific needs. For example, the service had recently discontinued the x-ray facility. Ahead of this, the team identified other local service providers that could provide the same service and worked with them to reduce delays in diagnostics. The team had planned the service suspension in advance and there were no appointment cancellations as a result.
- Senior staff monitored requests from NHS services to identify opportunities for patients on waiting lists. For example, they increased the availability of certain types of appointments in line with trends in demand.

Meeting people's individual needs

The service took account of patients' individual needs.

- Staff were trained to provide individualised care that they adapted to each patient's cultural and communication needs. For example, staff recognised when some patients valued being addressed formally and when others preferred a more informal approach.
- The service had adapted to meet the needs of elderly patients, who represented a substantial proportion of the population group. Staff had procured a wheelchair ramp they used to enable level access from the street to reception. A wheelchair was available on demand for use in the building and a lift was available in the building to provide step-free access to consultation areas.
- The service had installed a hearing loop system after recognising they needed to provide more support for patients who used hearing aids.
- Patients could request a male or female clinician for ultrasound procedures and the service had a chaperone policy in the event they could not secure a patient's first request.
- All staff undertook annual dementia training, which enabled them to understand the needs of people living with the condition and to recognise signs of undiagnosed dementia.
- Staff did not have access to language interpreter services and instead relied on family members to provide interpretation. This meant they were not assured of effective consent and safeguarding procedures. The lack of independent language interpretation provision meant there was no opportunity for staff to facilitate effective discussions directly with patients who did not speak fluent English that related to difficult news, such as a terminal diagnosis.
- Patients who were referred by the medical team in their embassy were always accompanied by a language interpreter. The provider's staff team collectively spoke three languages in addition to English. This meant staff trained as chaperones and who were fluent in another language provided interpreter support on demand. Although this reflected good practice, it meant patients who needed language support with specialist medical terminology did not always receive this.
- The service had an up to date discrimination prevention policy that was compliant with the Equality Act (2010) and ensured staff delivered care without prejudice to protected characteristics.
- Staff proactively contacted patients who did not return for planned follow-ups after a diagnosis or treatment.
- The head of clinical service monitored the success rates of x-rays and ultrasound screening and liaised with individual clinicians when these fell short of standards.

Access and flow

People could access the service when they needed it.
Waiting times from referral to treatment and arrangements to admit, treat and discharge patients were in line with good practice.

- Patients accessed the service on referral from their GP or another medical practitioner and the service could

accept up to 14 new referrals per week. Appointments were on a pre-booked basis only and patients could typically access the service within 24 hours of referral. Staff planned the service to be responsive without delays for assessment or treatment and they saw patients with urgent needs on a same-day basis.

- The service offered back-to-back appointments so that patients could have a consultation and diagnostic tests and discuss the findings in the same visit. This service was offered to any patients and staff promoted it for patients with reduced mobility who would find it difficult to travel on multiple occasions.
- Imaging department assistants managed patient flow and could accommodate urgent referrals following a consultation with the urologist.
- The service did not have a waiting list and had no delayed or cancelled appointments for non-clinical reasons in the previous 12 months.
- Two recovery beds were available in a dedicated room with nurse supervision. Patients were separated by a curtain, which presented the risk of a mixed-sex breach against national best practice. To address this, the service managed treatment lists to ensure only patients of the same gender were ever accommodated in the recovery area. Following our inspection the service converted the disused x-ray room into a recovery area, which would reduce the risk of mixed-sex breaches.
- In a sample of 35 patient feedback questionnaires from September 2018, 28 patients scored the service a maximum of five for the timing and efficiency of appointments. Six patients scored the service as four and one patient scored the service as three.

Learning from complaints and concerns

The service treated concerns and complaints seriously, investigated them and learned lessons from the results, and shared these with all staff.

- The service had an established complaints policy that was readily available in the clinic and on the website. All staff were aware of the complaints procedure and could signpost patients to the appropriate process to follow. The service set an initial acknowledgement time of 48 hours and a full response and resolution time of 20 working days from the date of receipt.
- The complaints procedure directed patients to escalate their concerns to the Care Quality Commission (CQC). CQC does not investigate individual complaints and the provider should instead have directed patients to a specialist complaints service for independent health organisations. After our inspection the registered manager addressed this and provided evidence the service had registered with the Independent Healthcare Sector Complaints Adjudication Services (ISCAS) and updated the complaints policy.
- From October 2017 to October 2018 the service received one formal complaint and 50 written compliments. The registered manager reviewed compliments to identify themes, which had included the quality of care and the knowledge of staff. The service had responded quickly to the complaint, apologised and provided a full and appropriate response. The registered manager had fulfilled the target response times laid out in the policy. The complaint related to miscommunications from the service regarding appointment times and inconvenience caused to the patient. The registered manger identified opportunities for learning to avoid future recurrences and introduced new standards for appointment bookings and communication as a result.
- The registered manager was responsible for investigating and resolving complaints and offered to meet patients to discuss their concerns to reduce the need for a formal written complaint.

Are outpatients and diagnostic imaging services well-led?

Good

We rated well-led as **good.**

Leadership

Managers at all levels in the service had the right skills and abilities to run a service providing high-quality sustainable care.

- The registered provider was the clinical lead and together with a lead nurse was responsible for clinical care and standards. A registered manager was in post and led the service on a daily basis in additional to the administration and receptionist teams.
- Senior staff had a clear understanding of the challenges to care quality and sustainability and had plans in place

to address them. They continually worked to understand the health needs of the local and regional populations and mapped these against gaps in service, which helped them to develop future service strategies.
- Staff spoke positively about leadership and said the registered manager and head of clinical service were accessible, visible and supportive. One new member of staff said they had been warmly welcomed into the service and felt the manager had clearly structured their initial period.
- The service had a leadership development programme, which all staff had access to as part of continuing professional development. For example, the registered manager was undertaking a level 5 health and social care qualification.
- The leadership team had a demonstrable focus on future planning, which included a succession plan.

Vision and strategy

The service had a vision for what it wanted to achieve and workable plans to turn it into action, which it developed with staff and patients.

- The service had a well-established vision and strategy that formed part of the statement of purpose. This was credible, had been developed by permanent members of the team and established the standards of quality the service aimed to achieve. Staff used results from patient feedback to shape the vision and strategy, such as by increasing appointment times to ensure patients had the time they needed to discuss their care and concerns.
- There was a robust and realistic strategy to deliver the service's priorities and to ensure care was sustainable. For example, the operating strategy included planning for consistent staffing levels and capacity management in line with trends and planning in the local health economy.
- All staff we spoke with had good knowledge of the service's core values and understood their role in achieving them. The core values centred on providing a high quality service with rapid access and results.
- The senior team reviewed the vision and strategy annually and updated it in line with service achievements and challenges and the needs in the local population.

Culture

Managers across the service promoted a positive culture that supported and valued staff, creating a sense of common purpose based on shared values.

- The service had established criteria and triggers for the duty of candour. All staff had training in the duty of candour, which formed part of the incident-reporting policy.
- The service had a whistleblowing policy and ensured all staff understood its purpose during their initial training and induction.
- Staff spoke positively about the working culture and environment and said consistent teamwork was embedded in practice.

Governance

The service systematically improved service quality and safeguarded high standards of care by creating an environment for excellent clinical care to flourish.

- The registered manager and head of clinical service shared responsibility for governance and contracted an external organisation for human resources support.
- The medical advisory board (MAB) convened quarterly as part of the clinical governance process and in accordance with an established committee directive. The board was made up of clinicians and external stakeholders with expertise in the service area and had XX current members. MAB members reviewed the service, including incidents and complaints, and identified opportunities for improvement. We reviewed the minutes of the most recent three MAB meetings and saw there was a continual focus on ensuring safety and managing risk whilst identifying opportunities to improve care and meet patient's needs.
- Although the MAB met consistently to the planned schedule and agenda, attendance was sporadic. In the most recent meetings from January 2018 to October 2018, 59% of expected attendees had not participated. This meant there was a risk the efficacy of the group could be reduced, although the service set a minimum requirement that three members be in attendance for the board to go ahead. We spoke with the registered manager about this who noted they were addressing attendance issues by rearranging MAB times to better suit the availability of members and by introducing a financial incentive. In November 2018 this resulted in the highest level of attendance recorded for a MAB.

- A team of 14 administration staff worked in the service, including a qualified medical transcriber. This team supported day to day administration, operations and non-clinical governance. The team also supported data collection and audit administration for the clinical team.

Managing risks, issues and performance

The service had good systems to identify risks, plan to eliminate or reduce them, and cope with both the expected and unexpected.

- The registered manager facilitated monthly whole-team meetings that acted as a forum in which clinical and non-clinical staff shared experiences and reviewed the service and discussed suggestions for improvement. We reviewed the minutes of two meetings that had taken place in the six months prior to our inspection and saw there was a focus on service and quality improvement and clinical safety. For example, in one meeting staff had strategized care a patient with a serious cancer diagnosis who had failed to attend follow-ups for two weeks.
- The service actively monitored incidents in services provided by other organisations as a strategy to implement improved practice.
- Reception staff provided a 'meet and greet' service for the patients of services who rented clinical space from the provider. The team encountered aggression from patients on occasion when their consultant was running late and had completed de-escalation training to address this.
- Senior staff formed a risk management committee that adhered to up to date terms of reference. These guided members in reviewing incidents and accidents and ensuring practice was geared towards the prevention of both. The committee maintained a continual, daily overview of health and safety issues in the service and meant the senior team were responsive to risks and issues. The committee prepared advisory reports for the MAB, which reviewed these on a quarterly basis as part of longer-term safety oversight.
- The MAB had reviewed the possibility of expanding the service to accept self-referrals by patients. However, the senior team identified this would involve an unacceptable level of risk and maintained the strict criteria that they would see patients only on receipt of an appropriate referral. This demonstrated the risk-averse nature of the service.
- The registered manager maintained oversight of all risks to the service using a risk register. At the time of our inspection this included 17 on-going risks such as slips, trips and falls. The manager used risk assessment criteria to identify likelihood and severity and documented mitigating strategies. For example, staff used hazard warning signs and cones when the accessibility ramp was in use to reduce the risk of someone tripping over it.

Managing information

The service collected, analysed, managed and used information well to support all its activities, using secure electronic systems with security safeguards.

- Systems were in place to ensure the secure handling, storage and destruction of confidential records. The service managed this in line with the European General Data Protection Regulation 2016/679.
- Computer screens in the recovery room were visible to patients, which reduced confidentiality. Although staff locked computer screens whenever they left the area, the layout of the recovery room meant patients could see information on the computer screen that may apply to other patients.

Engagement

The service engaged well with patients, staff, the public and local organisations to plan and manage appropriate services, and collaborated with partner organisations effectively.

- The MAB demonstrated a focus on improving patient engagement and input into the service. For example, a member of staff had developed a new, shorter feedback form as a strategy to increase the response rate. This had been introduced in September 2018 and had resulted in the highest response rate seen in the service, with a consistently goo response rate.
- The senior team had developed a social media presence to help improve engagement with patients and those considering using the service.
- The team used General Medical Council (GMC) guidance when planning to improve patient engagement, such as in the development of a scoring system and to decide the optimum number of questions. In September 2018 this had led to the highest ever number of returned questionnaires, at 35 in one week.

Good

Diagnostic imaging

Learning, continuous improvement and innovation

The service was committed to improving services by learning from when things went well or wrong, promoting training, research and innovation.

- The service had launched a new website to improve their online presence and provided prospective patients with more information about the care and treatment available.
- The team maintained a proactive awareness of new and emerging treatments nationally and internationally. This resulted in the development of new and innovative procedures for patients. For example, the service had developed new pelvic inflammatory disease (PID) treatment. This used less-invasive pre-cancer treatment using cream-based therapy and ultraviolet rays. The service was in development and the team was exploring more light-based therapy. Light-based therapy refers to treatment that involves a specific wavelength of light to treat conditions using a non-chemical method.

Outstanding practice and areas for improvement

Outstanding practice

- The team maintained a proactive awareness of new and emerging treatments nationally and internationally. This resulted in the development of new and innovative procedures for patients.
- Administration staff had undertaken detailed analysis of the feedback behaviour of patients to understand what prevented more consistent completion of feedback. They had tested and introduced new feedback designs that had resulted in a significantly higher response rate, which staff used to improve the service.

Areas for improvement

Action the provider SHOULD take to improve

- The provider should ensure the new standards of practice in relation to the safe management of sharps are consistently embedded into practice.
- The provider should ensure all staff receive an appraisal at least annually.
- The provider should ensure the new measures to improve privacy and dignity are maintained.
- The provider should review processes for language interpretation to ensure consent and safeguarding is assured.
- The provider should ensure attendance of key individuals at medical advisory boards is consistent and contributes to effective governance.